SCOTTISH DRUGS FORUM

EVALUATION OF LONG ACTING INJECTABLE BUPRENORPHINE PROVISION ACROSS SCOTLAND

AUGUST 2025

SCOTTISH DRUGS FORUM

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Finally, a huge thank you to all the participants who willingly gave their time and spoke so openly about their experiences.

Glossary

Espranor: A brand of buprenorphine delivered as a rapidly dissolving wafer, taken either via the cheek (buccal) or on the tongue.

Long-acting injectable buprenorphine (LAIB): In this report, LAIB refers specifically to the formulation of buprenorphine currently available in Scotland under the brand name Buvidal. Participants in the study may refer to "Buvidal" in direct quotes, as this is the name which is more familiar to them and therefore the one they generally used in discussions.

Subutex: A brand name for buprenorphine in tablet form, taken sublingually (dissolved under the tongue).

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

In August 2024, Scottish Drugs Forum (SDF) published an evaluation report exploring the varied experiences of people receiving different forms of Medication Assisted Treatment (MAT), using an observational approach. A key finding in the report was the varied views on long-acting injectable buprenorphine (LAIB). While some individuals described it as "life-changing" and highly positive, others reported feeling isolated while on the treatment and disappointed with the support offered alongside their brief monthly injection appointments. These experiences reflect feedback from SDF's living experience engagement groups, where participants frequently share reflections on gaps in support to manage unwanted effects and changes in substance use following the initiation of LAIB.

Scotland's Medication Assisted Treatment (MAT) Standards, introduced in May 2021, were developed to reduce drug-related deaths and associated harms by ensuring consistent, equitable, and barrier-free access to treatment across the country. As implementation of these standards continues, the use of long-acting injectable buprenorphine (LAIB) has steadily increased. Public Health Scotland estimated that 4,794 individuals, representing 23% of all those in MAT, were prescribed LAIB in 2024/25, marking a year-on-year rise (PHS, 2025). Despite this growth, limited evidence exists on how LAIB is experienced by both service users and frontline staff within the Scottish context.

This evaluation seeks to address that gap by exploring lived experiences of LAIB, identifying key enablers and barriers to its use, and providing insights to inform future delivery in line with Scotland's MAT Standards.

Aims

The aim of this work was to explore individual experiences of accessing and providing LAIB treatment and related support across four health boards: Lothian, Forth Valley, Dumfries & Galloway and Highland.

To achieve this we explored:

- Individual experiences of starting LAIB, receiving treatment and reducing/coming off LAIB in community settings.
- What support is offered or provided alongside LAIB, such as mental health, psychosocial interventions and relationships with staff.
- Individual experiences of short-term and longer-term outcomes from accessing LAIB treatment and support.
- Staff experiences of LAIB provision and support that is offered.
- Participant experiences of LAIB within custodial settings - HMP Dumfries and HMP Inverness.

DESIGN & METHODS

This evaluation was conducted across four health board areas in Scotland, selected to reflect a mix of rural and urban contexts and varying rates of LAIB provision. The aim was to capture a broad range of perspectives from people with different genders, ages, and lengths of time accessing LAIB. An additional sample was drawn from HMP Dumfries and HMP Inverness to include custodial experiences. The evaluation was approved by NHS Clinical or Information Governance in each area.

Participants were eligible if they were aged 18 or over and had recently or were currently receiving LAIB. A total of 46 participants (10–14 per health board) were recruited, alongside nine participants from the two prison sites.

Recruitment was supported by eight trained SDF peer research volunteers who had lived or living experience of substance use, six of whom had lived or living experience of receiving MAT, with two of the six having accessed LAIB themselves. Staff from NHS services, the third sector and local recovery organisations in the four health boards were also invited to take part in an anonymous online survey.

This evaluation used a mixed-methods approach. Peer researchers led participant interviews, which combined quantitative and qualitative questions. Three focus groups were also held, one in HMP Dumfries (n=4) and two in HMP Inverness (n=5), covering topics such as accessing or continuing LAIB in custody, support available in prison, and comparisons with other MAT treatments. In the community sample, interview participants received a £15 PayPoint voucher as a thank you, while in prison settings, monetary reimbursement was not possible; instead, refreshments and toiletry items were offered. Staff completed an online SurveyMonkey questionnaire, which was open for five weeks.

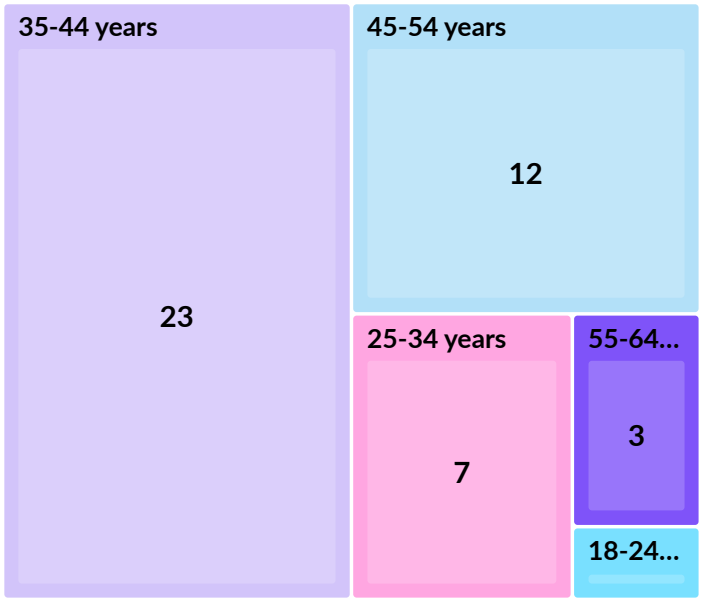
Open-ended responses and interview transcripts were analysed thematically to identify key patterns, treatment experiences, and support needs. The resulting themes were used to inform the findings presented in this report. All participants were informed of their right to withdraw or request data removal at any time; no withdrawals occurred, therefore all data has been included within the report.

DEMOGRAPHICS

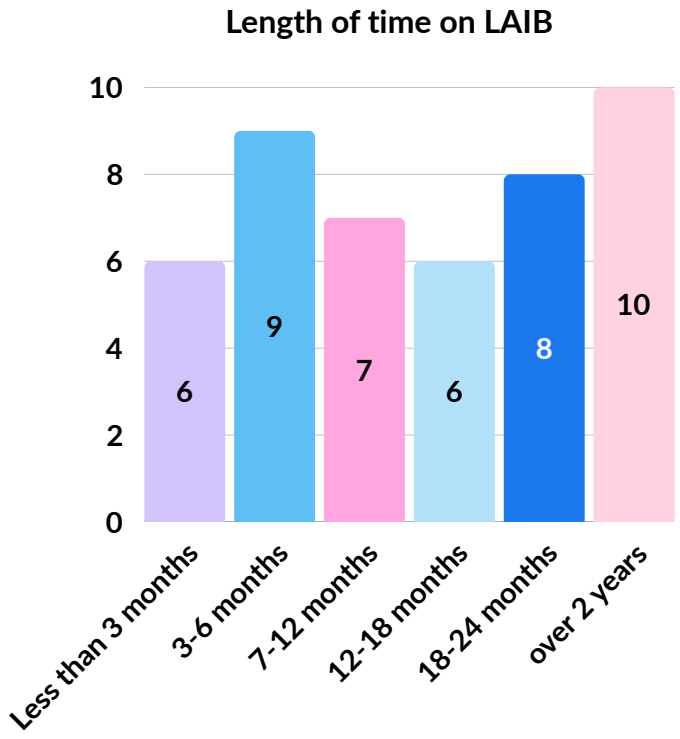
Of the 46 people who completed interviews as part of this evaluation, 52% (n=24) were male and 48% (n=22) were female. A range of localities were represented within each health board with the following breakdown achieved:

Lothian (n=12)	Forth Valley (n=12)	Highland (n=12)	Dumfries & Galloway (n=10)
• Edinburgh City • South East Edinburgh • South West Edinburgh • North West Edinburgh • East Lothian • Midlothian • West Lothian	• Falkirk • Stirling • Alloa	• Nairn • Thurso • Inverness • Strathspey • Helensburgh • Dunoon • Campbeltown • Oban	• Dumfries • Stranraer • Stewarty • Annandale • Wigtownshire

Age range of participants



Length of time on LAIB

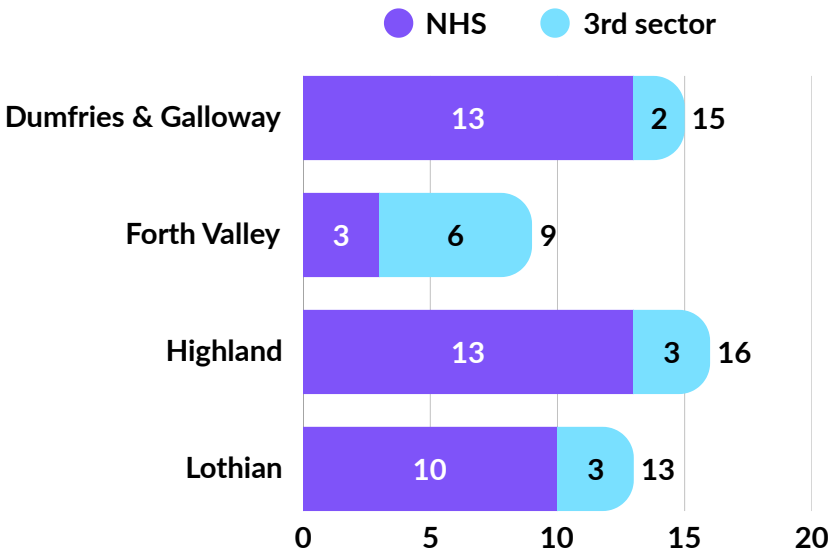


Prison participants

A further nine prison residents from HMP Dumfries and HMP Inverness participated in three focus groups to share their experiences of LAIB treatment in both custodial and community settings. All participants were male, aged between 29 and 43. Eight were currently receiving LAIB, one had previously been on LAIB and was now receiving Espranor. All nine participants in the focus groups were sentenced.

A total of 53 staff completed surveys about their experiences of supporting individuals on LAIB. The sample included 39 NHS staff and 14 working in third sector or voluntary services.

Staff by Health Board



Staff roles within NHS

Staff could select multiple answers:

29 = administration of injection & support
17 = prescriber for LAIB
3 = administer injection only
3 = provide support only
5 = other roles

Multiple localities were represented across each health board:

**Some staff were working across their entire health board.*

Lothian (n=13)	Forth Valley (n=9)	Highland (n=16)	Dumfries & Galloway (n=15)
• East Lothian • Edinburgh • North West • South West	• Falkirk • Stirling	• Argyll & Bute (including Cowal & Bute, Helensburgh & Lomond and Oban) • Caithness • Inverness • Mid/East Ross-shire	• Annandale & Eskdale • Dumfries • Nithsdale • Stewartry • Stranraer

Responses were received from staff with various roles in their sector. The most commonly reported NHS roles of respondents were Recovery Nurse (26%, n=10), Pharmacist (13%, n=5), GPs, Senior Recovery Nurse and Team Lead (all 10%, n=4 respectively). Additional roles mentioned by at least one respondent included Advanced Nurse Practitioner, BBV Clinical Nurse Specialist, Mental Health Nurse, Student Nurse Support Worker and Clinical Service Manager.

Among third sector staff, 29% (n=4) of third sector staff were Recovery Co-ordinators, 14% (n=2) identified their roles as Support worker, Project Worker, Peer Lead Facilitator, and Recovery Worker respectively. One person was a Lead Practitioner and another was a Night Concierge.

PARTICIPANT FINDINGS

> *"My worker spoke to me about Buvidal as I had been on methadone for some time, since I was 16 years old."*

Access

Initial stages

When asked how they first learned about LAIB treatment, 45% (n=20) of participants said they were informed by their addictions worker, while 48% (n=21) heard about it through peers. Two individuals mentioned receiving information from third sector workers, and one person stated they became aware of the treatment through a promotional poster. Two participants could not recall how they first became informed of LAIB.

The majority of participants (46%, n=21) started LAIB after being on methadone treatment. 24% of people (n=11) had previously been on buprenorphine (tablet) and 11% (n=5) transitioned from Espranor. 19% (n=9) had never been on MAT previously but were started on a short course of buprenorphine before transitioning to LAIB. One person started on LAIB during a stay in a detox clinic. The others had attended their local drug and alcohol service to commence treatment.

Over half of participants (53%, n=24) stated they had enquired themselves about accessing LAIB. 40% of participants (n=18) stated their NHS worker raised LAIB as an option, while three said that third sector staff had suggested it.

> *"My mental health wasn't discussed with intention as such but they are aware that I am on the books with psychology and have various diagnoses but there was nothing in particular raised about it."*

Before starting LAIB treatment, most participants reported they had a discussion with their worker around any current drug use (87%, n=40) and/or being drug tested, either via oral swab or urine testing (83%, n=38). Additionally, 26% (n=12) completed a Liver Function Test (LFT), whilst 24% (n=11) could not remember if this had been part of the access process.

74% of participants (n=34) reported discussing their routines and motivations for accessing LAIB. Mental health was discussed with 67% (n=31) prior to accessing and starting LAIB, though a third of these (n=10) felt that the discussion was not as thorough as it needed to be.

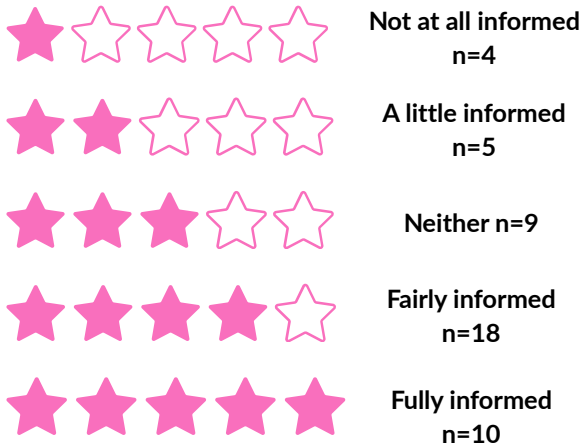
Information & expectations

Participants were asked about what information they received about LAIB and were able to select multiple responses. 69% of participants (n=32) reported that their primary source of information was through discussions with their worker. 65% (n=30) said they received a leaflet or booklet about the treatment to take with them. 37% (n=17) said they sought information about LAIB by speaking with people they knew were already accessing LAIB. All noted these individuals were friends or family, and that this form of peer support was not facilitated by the service.

17% of participants (n=8) said they chose to do their own research on LAIB, mainly using sources such as Google and online forums. Two people mentioned raising LAIB treatment at local recovery groups to get feedback. 11% (n=5) reported receiving little to no information from services about the treatment, leaving them unsure what to expect, especially around potential titration/side effects or broader impacts.

> *"A wee card was given to me about Buvidal that I could keep in my purse in case I ended up in hospital or anything and I was given leaflets and had a good chat with my worker."*

Participants were asked how well informed they felt about LAIB and what to expect after their initial prescribing appointment. Most (61%, n=28) said they felt fairly or fully informed, while 39% (n=18) felt more information was needed earlier in the process. Individual responses are outlined in the graphic.



Three participants noted that they had started over four years ago, when less was known about side effects, impacts and other details. Two female participants highlighted a lack of gender-specific LAIB information given, particularly around potential pregnancy and menopause. They felt this reflected a broader gap in the treatment information available.

More than a third of participants (37%, n=17) expressed initial concerns about starting LAIB, especially around how the treatment might affect them. These concerns were particularly related to mental health, as well as medical uncertainties, such as how the injection would function in the body. Some participants also voiced anxiety about the unknown long-term effects of LAIB and the lack of available experiences from others who had successfully reduced or stopped the treatment. One participant reflected this uncertainty, saying, "*you just feel like you're kind of looked down on and you have to accept what they're telling you*".

> ***"When I started, obviously it was quite new and getting told that I would have an injection instead of tablets and it would be administered to me once a month and I would have complete lack of control of my...like my medicine and my sobriety and it would all be managed by this one monthly jag, which sounded like a miracle cure em, was pretty scary and pretty daunting."***

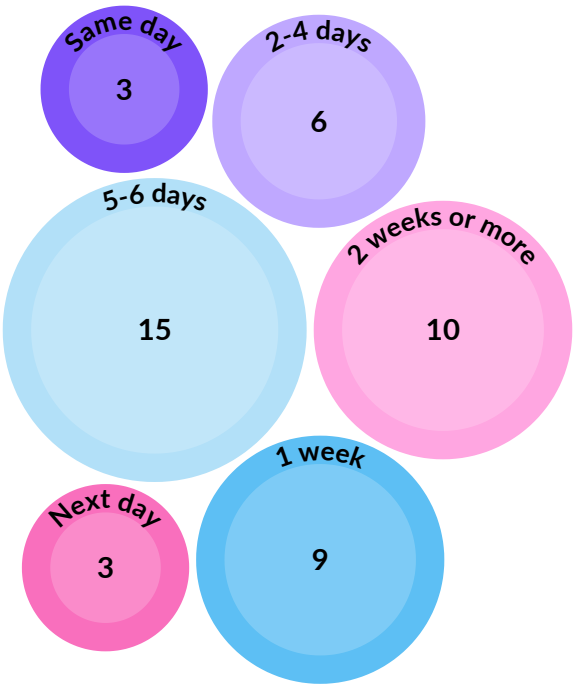
> ***"...I felt awfully anxious and sweaty (I also felt like this on methadone) but I don't think the Buvidal agreed with me, it just didn't feel right. I felt withdrawn, poor sleeping, heavy legs and awful sleeping. I was previously told that wouldn't be the case with Buvidal, but it was worse."***

When asked how support could be improved, three participants suggested that workers should spend more time with people during the early stages of treatment to better understand their background and family circumstances. Two participants felt that receiving more detailed information about LAIB early on would have been helpful. One recommended showing a video explaining LAIB and the available support, rather than relying solely on written materials.

Starting LAIB treatment

Participants shared how soon they started LAIB after their initial discussion or presentation. Over half (59%, n=27) commenced on LAIB within six days of presenting or raising change of treatment with the service or worker. 22% of participants (n=10) stated it took over two weeks to start. In five of these cases, the delay was chosen to align with the end of their previous MAT prescription. For three participants, additional time was required to taper off their methadone or Subutex doses before initiating LAIB treatment, with one of them attending a detox clinic to facilitate this process. For another participant, starting LAIB was delayed by six weeks due to childbirth, while a further delay occurred for one individual who needed to complete additional health checks following a surgical procedure.

Length of time to receive first injection of LAIB following initial discussion



Participants were asked "What was discussed?" during their first appointment when LAIB was administered, and could select multiple options. Almost all participants (96%, n=44) said they discussed their starting dose and how this could be adjusted over time. 87% (n=40) said they were told about the injection process, including rotating injection sites monthly. Three quarters of people (76%, n=35) said they discussed how often they would receive their injections. Over two thirds (69%, n=32) had a discussion about additional appointments for support in addition to injection visits. 41% (n=19) were informed about potential side effects and what to do if these occurred.

Regarding other support options, 62% (n=28) said mental health referrals and support were discussed. 45% (n=20) stated they were offered low-threshold psychosocial support, such as anxiety management, coping skills and relapse prevention.

Almost a quarter of participants (23%, n=10) said they were offered a referral or support with benefits, welfare or finances, while 34% (n=15) stated they could not remember if this was offered. Four participants were offered advocacy support to help complete a referral and 49% (n=21) had either never heard of advocacy or had not been offered it. At the first prescribing appointment, 25% of participants (n=11) reported being given some safer drug use advice, and seven of these participants were offered harm reduction equipment. Over half (56%, n=25) stated they were offered naloxone in their initial prescribing appointment, and 44% (n=20) were offered Blood Borne Virus (BBV) and/or Dry Blood Spot Testing (DBST).

> ***"The first three doses I got weekly and then it moved to monthly, I am on 96mg. I got referred into Citizens Advice then for some support with food banks and money issues."***

> ***"The beginning of the process there was not the information that was needed."***

> ***"When I got injection, I got like a timetable of the doses and when next appointments were etc so I was clear on the next steps."***

Participants rated their overall experience of accessing LAIB out of five stars. Around two thirds (65%, n=30) rated it as good or very good. The number of responses for each star rating is shown in the graphic.

Six participants described challenging experiences tapering off other forms of MAT in order to transition to LAIB, which contributed to their perception of LAIB as being difficult to access.

Experience of LAIB

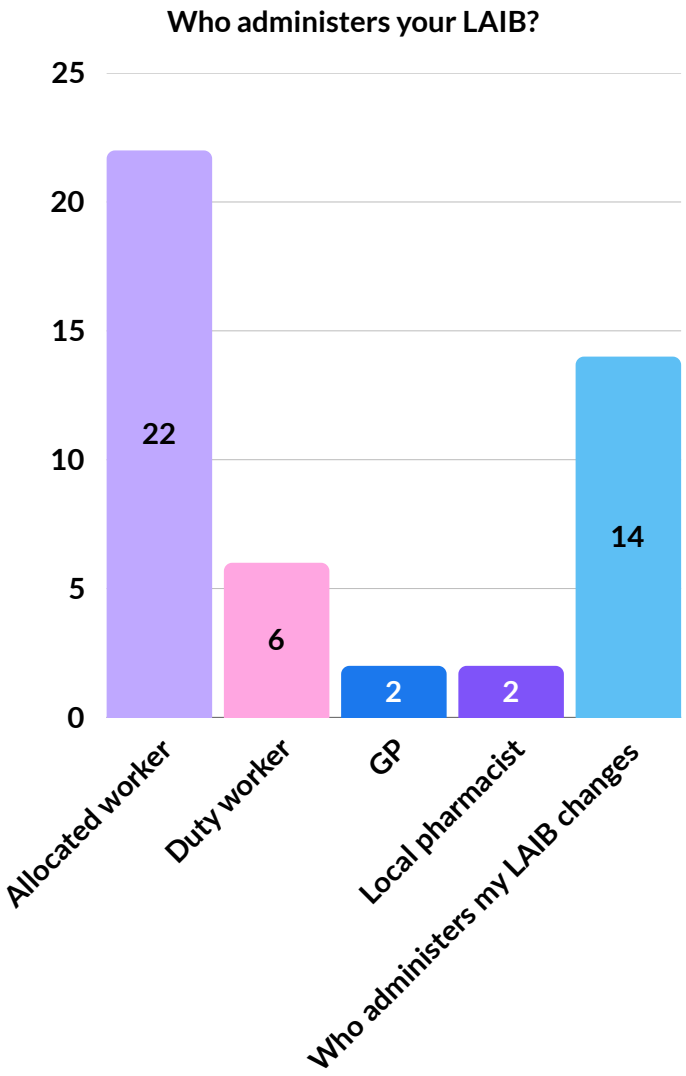
Choice

Injection administration

Most participants (72%, n=33) said they did not have the option to change where they received their LAIB injection. 22% (n=10) said they did have the option and two would have liked to have been offered this.

74% (n=34) said they attended their local NHS service for their injection. 15% (n=7) attended a specialist drop-in clinic. Four people could have their injection at their home, three people could attend the pharmacy, two could get it from their GP and one got theirs at the local hospital. Four people selected more than one location they could attend for their injection.

The majority of participants (84%, n=38) were not given a choice in who administers their injection. Almost half of participants (48%, n=22) were given the injection via their regular or allocated worker. 30% (n=14) noted that the person administering their injection could vary, but was usually someone they recognised from previous contact with the service, rather than someone unfamiliar.



Dose changes

When discussing dose or treatment changes, the majority of participants (85%, n=39) said they had an allocated worker who they would raise this with. Three mentioned they could only see a duty worker and another three stated they were not sure who they could speak to regarding their treatment. One person mentioned they could raise their dose with a third sector member of staff.

Flexibility in dose changes was widely reported by participants. An increase in dose was offered to almost all participants when needed (93%, n=43) and dose decreases offered to 85% of people (n=39). Choice of access to a top up dose of medication was offered to 84% (n=38) with 13% (n=6) stating they had never been offered this as an option. One person stated they would have liked to have been offered this.

Appointments

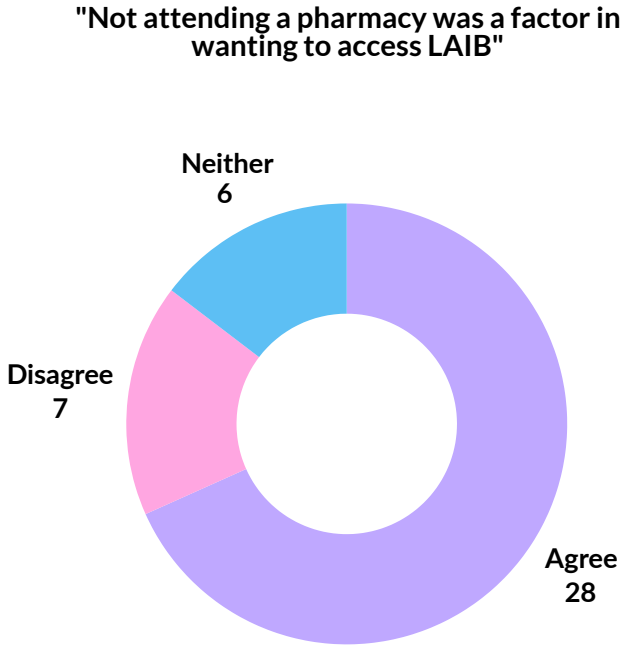
All participants were seen monthly for LAIB administration, with 28% (n=13) of them offered the choice to have their injection weekly if preferred. Two participants said they would have liked the choice of a weekly injection, but this had only been available during the initial three-times-weekly starting doses.

Approximately two thirds of participants (67%, n=31) stated they had been offered flexibility around contact and appointments they had with their workers. 22% of people (n=10) mentioned they did not feel they had any choice on contact. Five people stated they would have liked more choice in the frequency of contact.

The choice of having family and/or friends involved in their support and/or appointments was mixed. 46% (n=21) said they had been offered this choice, and another 46% stated they had not. Three participants said they would have liked this choice.

Motivations for choosing LAIB

Avoiding regular pharmacy visits was a key factor in choosing LAIB for many participants, with over two-thirds (68%, n=28) indicating it influenced their decision. 24% (n=11) described pharmacy attendance as restrictive. It limited their capacity to travel or sustain employment and this contributed to their decision to switch to LAIB. Some concerns about privacy were also raised, particularly by those living in smaller or rural communities, who preferred to receive treatment through local drug and alcohol services instead.



Most participants (89%, n=41) chose to answer statements about their experiences attending pharmacies. When asked to respond to the statement: *"Attending the pharmacy was part of a routine I liked"*, 71% (n=29) disagreed, 22% (n=9) neither agreed nor disagreed and 7% (n=3) agreed. Three participants elaborated and stated getting away from daily supervision of medications was a motivating factor for choice of LAIB. A further participant mentioned daily travel to pharmacy for Methadone was too lengthy so once a month LAIB was preferred.

When asked to respond to the statement *"Going to the chemist was challenging and I found I was stigmatised or treated poorly/differently"*, 61% (n=25) agreed, 27% (n=11) stated they did not feel strongly either way and five people disagreed.

The statement *"Going to the pharmacy meant I had frequent contact with pharmacists which I found supportive or helpful if I needed help"* was used to assess perceptions of pharmacist interaction. 49% (n=20) neither agreed nor disagreed. 29% (n=12) agreed with one participant stating *"when other services closed then the pharmacist is always there when it was needed the most"*. Two participants who received their LAIB via their local pharmacy felt this arrangement worked well due to the location and supportive staff. 22% (n=9) disagreed with the statement.

Additional motivations for choosing LAIB included a desire to transition away from other forms of MAT; particularly Methadone, which was mentioned specifically by four participants. Other reasons given by participants for wanting to access LAIB was such as seeking greater freedom and flexibility in treatment desiring to distance themselves from previous social circles and hearing about positive experiences from peers already on LAIB.

Substance use

Patterns of use

Nearly half of the participants (47%, n=21) reported using other substances alongside their LAIB. Within this sample, a greater proportion of men than women reported using substances while receiving LAIB: 67% (n=14) were men, and 33% (n=7) were women. The most commonly used substances were cannabis, crack and powder cocaine, alcohol and benzodiazepines.

> *"Yeah, I have always used crack cocaine. Buvidal dealt with heroin issue but not much else."*

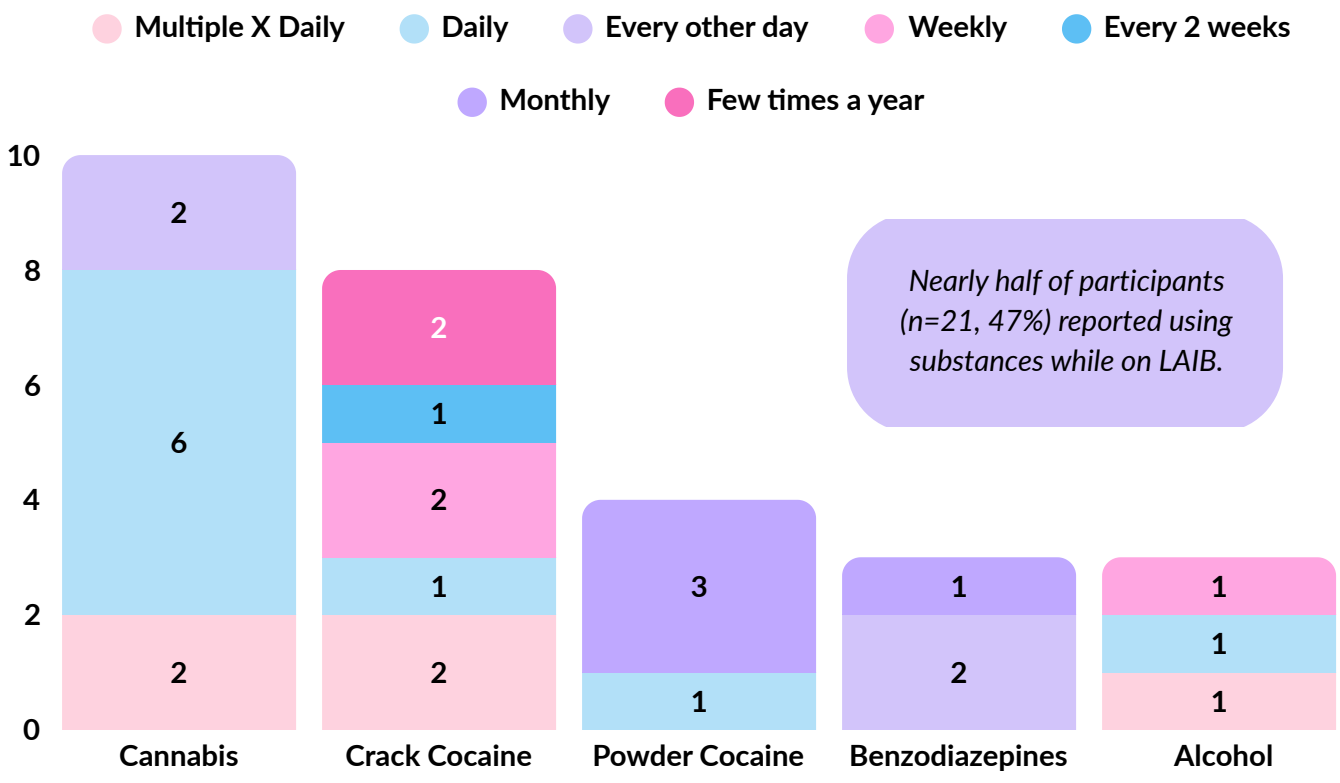
Cannabis was the most commonly used substance (n=10), typically used daily to manage sleep, anxiety or to unwind. Most saw it as "harmless" or not something they planned to stop.

> *"Buvidal helps with opiate based dependence but not much else. I think more work needs to be done around why people take substances and use alcohol as that's something that is never really explored."*

Crack cocaine was used by eight participants, with frequency ranging from occasional to daily, often linked to paydays, social circles or emotional triggers, and sometimes related to being on LAIB. Powder cocaine was reported by four people, used less frequently and typically described as a "treat" or used during social occasions.

Alcohol use was reported by three people. Two drank daily, and some reported seeking detox due to concerns about dependency.

Diazepam and other benzodiazepines were used more sporadically. Pregabalin (n=2), heroin (n=1) and gabapentin (n=1) were mentioned less frequently. Reported reasons included self-medicating pain or managing gaps in prescriptions.



Changes since LAIB

Participants who disclosed using on top of their treatment described a range of changes in their use since starting LAIB. 52% (n=11) reported reducing or completely stopping their use of opiates due to being on LAIB treatment, which was seen as a positive shift.

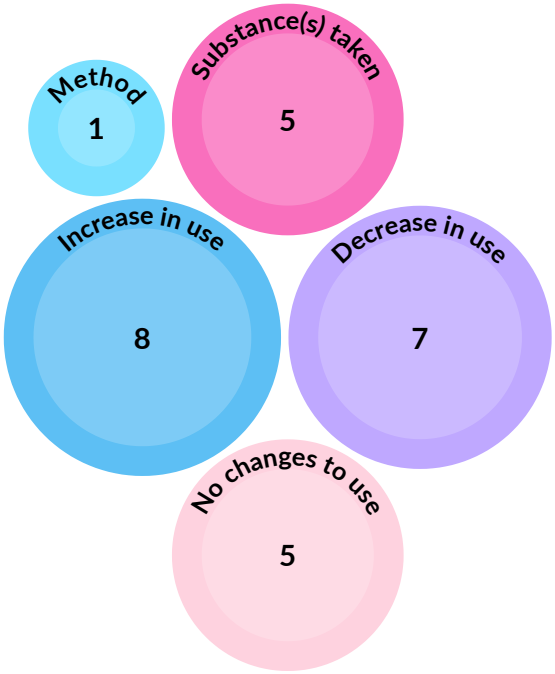
> *"My alcohol use has decreased since I stopped using opiates and that stopped when I started the Buvidal."*

> *"My use [crack] has increased since starting Buvidal as I can no longer use heroin because of that. If I use it daily, I use it all in one go usually and sort of chain smoke it, maybe piping it 30 times a day... it is sort of constant."*

Although LAIB prevented opiate use for many, others described a shift towards substances such as cannabis, crack cocaine, alcohol, benzodiazepines, and, in some cases, gabapentinoids. 40% (n=8) said their overall substance use had increased and reasons given for this was to manage sleep disturbances, anxiety, emotional distress, or physical pain: issues previously addressed through opiate use. For four others, increased use was linked to managing reported side effects of LAIB, including insomnia, anxiety, withdrawal-like symptoms, and mental health challenges. Nine said LAIB gave them a "clearer head", which made unresolved issues more noticeable or harder to ignore. Two participants reported using crack cocaine to manage their mental health, with one noting peer influence as another contributing factor. Two saw their substance use as a deliberate personal choice, with one stating, *"This is me making a choice, it is my life"*.

35% (n=7) described using fewer substances overall. Some of these people felt that, while LAIB had helped them stop using heroin, it had not resolved the reasons they used other substances, even if overall use was slightly lower. Three said their cannabis use had reduced since starting LAIB. Another person stated their alcohol use had also decreased after stopping other opiates. One person commented that previously they had used crack cocaine but felt this was not needed since starting LAIB as their mental health was in a better place.

25% (n=5) noted that the substances they used had changed. Two mentioned starting using crack cocaine for the first time since beginning LAIB and another turned to illicit Diazepam after their prescription for this was stopped. 25% (n=5) stated their cannabis or powder cocaine use had remained the same whilst on LAIB. One person reported starting to inject, which they had not done previously.

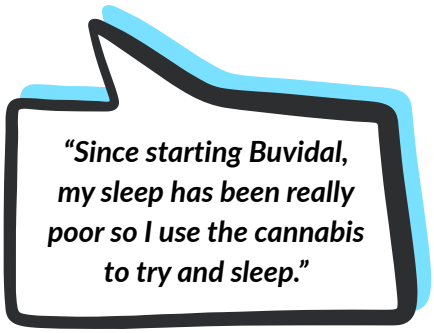


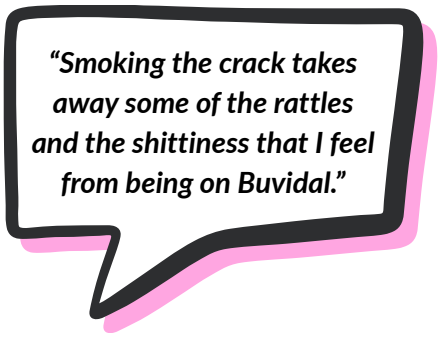
Changes to substance use since accessing LAIB

> *"Cannabis use has increased I would say and the Valium, I use as and when they are free and I can get them off my brother. Since starting Buvidal, my sleep has been really poor so I use the cannabis to try and sleep. I have been tried on other mental health meds but it just doesn't have any effect on me - and then it has been given up on by the service."*

> *"As I said, I have always used alcohol so you can say that hasn't changed much for me. The crack has been slip ups but man it is so easy to get hold of, there is a dealer on every street here."*

Participants shared a range of emotions around their changing substance use since starting LAIB. Many described a significant reduction or complete stop in opioid use, often surprised at how effective LAIB had been in removing cravings. Some felt more in control and spoke about a shift in mindset or making clearer, more conscious choices. Others, however, felt conflicted or guilty about ongoing use of other substances like crack cocaine, cannabis or alcohol. Some explained this was to manage mental health, poor sleep, or emotional distress, which in some cases was felt to have been exacerbated by LAIB. A few felt they had simply swapped one drug for another. Feelings of shame, frustration and fear of judgement were common, especially for those who wanted to stop but struggled due to routine, peer influence or how easily substances could be accessed.





Support & discussion with workers

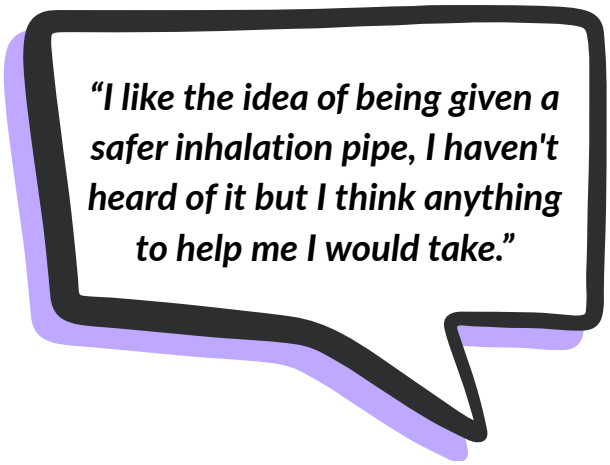
Most participants felt comfortable discussing their substance use with their worker, with 62% (n=13) stating their worker was aware of additional substance use. Many described open and non-judgemental relationships where they could be honest without fear of repercussions. A slightly higher proportion of men than women (65%, n=9 men compared to 57%, n=4 women) reported feeling comfortable discussing their substance use. Some felt their worker accepted their current use as minor in comparison to past patterns, while others appreciated practical support such as referrals to recovery groups, psychology or additional check-ins. A few people (n=3) shared that while their worker knew about their use, it often did not lead to meaningful support. Cocaine and crack cocaine were mentioned due to a lack of support for these substances. One participant stated, *"It has been clear there is nothing they can offer to help with the crack use"*. Some also said it did not seem to matter whether they were honest or not, as no real change followed. Three people felt judged or feared being seen differently due to their gender or role as a parent, which stopped them from being fully open with their worker. The quality of support depended heavily on the individual worker and the strength of the relationship.

Harm reduction

Nearly all participants who were using illicit substances (95%, n=20) reported being offered some form of harm reduction support. While most had access to naloxone (n=15) and BBV testing or treatment (n=14), many had not been offered other basic interventions. A smaller number were offered foil (n=5), injecting equipment (n=4), sexual health advice (n=4) and wound care assessments (n=2) and referrals (n=1).

Some gendered differences in harm reduction access were identified across the sample of 46 participants (24 men and 22 women). Naloxone training was offered to 84% of men (n=20) compared to 50% of women (n=11), and naloxone supply was offered to 92% of men (n=22) compared to 50% of women (n=11). Blood-borne virus (BBV) testing and treatment was the most commonly offered intervention for women, reported by 66% (n=14) though men were still more likely to be offered this support at 83% (n=20).

A few participants said they had never heard of potential harm reduction equipment such as safer inhalation pipes but when asked if this is something they could find useful or would use, 47% (n=10) stated they were open to using them. Several said they would have liked more tailored support, particularly for alcohol use or mental health. One example of good support came from an NHS Outreach Worker who provided regular check-ins and practical resources. Others felt left to manage alone, in some cases reaching out to crisis services without follow-up in times of need.



Support

Participants were asked to state their satisfaction with the level of support received whilst accessing LAIB. Two thirds of participants (67%, n=31) stated they were fairly or very happy with support. Men gave a slightly lower average rating for the quality of support received with LAIB compared to women. The individual ratings given with numbers of individual responses are outlined in the graphics.

♂ 29% (n=7) stated 'very happy' with support

♀ 45% (n=10) stated 'very happy' with support

"Workers either get it or they don't, you know what I mean? My workers have got it and thank God because that is tough when I hear people say they don't get on with workers, I always think like how do they cope? I see my worker monthly, jag and chat, talk about life, they are a CPN also so mental health is always discussed. I feel good. I feel positive."

"Moving on to the Buvidal I obviously had regular staff that I'm still seeing who helped me get started on Buvidal and have helped me move down, given me multiple information on how I can move down and different options of reducing. Staff in general at the unit have been fantastic and if I've ever needed them, I can phone up."

Contact & appointments

Participants were asked *"Do you see anyone for extra appointments or support beyond getting your LAIB injection?"* and they had a choice of responses. 31% (n=14) indicated they had separate appointments with their worker, distinct from their injection administration. 29% of participants (n=13) reported that contact with their addictions worker only occurred during injection appointments and these were also counted as support sessions. Three participants noted that their injection appointments typically involved only a brief 10–15 minute conversation, expressing a desire for more comprehensive support. They highlighted a lack of contact between monthly appointments and indicated that more frequent engagement would be beneficial.

18% (n=8) mentioned they had a third sector worker who they saw for extra support alongside their injection. 4% (n=2) stated they saw a third sector worker separate from their injection appointment for support.

16% (n=7) stated they did not see anyone for extra support or appointments alongside their LAIB but would want to access this. One participant described struggling to get an allocated keyworker, leaving them without any support.

13% of participants (n=6) stated they did not see anyone for extra support or appointments, they only received the LAIB injection and felt happy with this level of support. One of these stated they *"like to keep to themselves and get on with it"*. Another person mentioned they like that the choice is with them to *"reach out when needed"* and they felt confident to do this.

Men were slightly more likely than women to report receiving additional support appointments (35% of men, 27% of women). Women were more likely to say they only received the injection but were satisfied with that arrangement (15% of women, 9% of men).

Allocated workers

Participants described support as mostly positive when they had a designated worker or regularly engaged with a consistent, small group of workers each month. Continuity in support was seen as preferable, reducing the need to *"keep re-explaining the same things"*.

Two participants said that constantly seeing duty workers meant there was no consistency in their care. This made it harder to raise personal issues and get the support needed. Lack of trust in staff and wider service provision was mentioned by four participants, with this affecting the worker relationships. One person discussed how prior experiences in the service created a hesitation to open up and reach out for current support. Another mentioned that this is a feeling they have experienced throughout treatment, *"they don't take much seriously if you are an addict at the end of the day"*.

"I like the work that [Third Sector Organisation] do, they join up a lot with the NHS team and that makes a massive difference to your care and overall treatment as you don't need to re-explain anything to anyone."

22% of participants (n=10) mentioned they had an allocated worker from a third sector organisation who they saw for extra support appointments alongside getting their LAIB. One person felt their relationship with the third sector worker was stronger than with his allocated NHS worker. This was due to extra time being allocated to appointments: *"he was only one who sat and listened to me and said look, this needs sorted"*. Participants noted that third sector support was often flexible, offering adaptable appointment times and locations, including "walk and talk" or outreach meetings. In some cases, people were seen up to twice a week.

Worker relationships

Two participants mentioned their worker from a third sector organisation often attended their NHS appointments/offered joint appointments and this was useful for support and having both workers fully informed. One participant shared that both their NHS and third sector workers supported them to apply for rehab. This was key to the individual feeling positive about their support and that their goals were actively encouraged.

17% of participants (n=8) emphasised the value of being able to contact workers outside of scheduled appointments for additional support. One person shared: *"If you're having a bad day, you can call and they always get back to you."* Others highlighted the significance of receiving proactive "check-in" calls and text messages from workers during their treatment, describing these as reassuring and supportive, particularly when they felt unable to initiate contact themselves.

11% of participants (n=5) highlighted the importance of long-term support from the same worker(s), noting that continuity over time fostered deeper rapport and trust. Two participants retained the same worker from previous engagements with other forms of MAT, and one shared: *"He has known me a long time...knows how I am as a person...I'm always honest with him"*.

"I feel lucky like I've said to yourselves, I've got somebody that I've I can click with and maybe I'm a bit privileged to have the person I do have directly looking after my care as well as my worker, who's really good."

Many participants (43%, n=20) described their workers as "kind" and "non-judgemental" and described that they felt their workers genuinely cared and wanted them to do well in their treatment and wider life and this fostered positive relationships. Workers being supportive of personal goals was another reason given for positive worker relationships. 22% (n=10) spoke about discussing goals and how to achieve them, highlighting the value of both practical steps and emotional support. One person shared, *"He doesn't push me, but he does encourage me and I wouldn't have done that without him."*

Five participants mentioned a lack of trust or support from their workers or the service they attend. Two participants stated this was due to historical issues that left them feeling "hesitant" and "cautious" with what is disclosed or discussed with workers.

Almost half of the participants (46%, n=21) stated they had a recovery plan and were involved in designing this alongside their worker. 13% (n=6) did not have a recovery plan, while one third (33%, n=15) said they had never heard of a recovery or treatment plan. 9% of participants (n=4) were unsure whether they had a recovery plan or not. Several participants acknowledged that discussions took place with their worker regarding wider goals, though they did not think this was officially recorded anywhere.

"He phones me a lot just to check up on me, he is really good at attending like my children's hearings and things that like that, like putting in all the positive stuff like, no just the negative."

"If you say the wrong thing they take it literally and you know they just throw the book at you kind of thing and that's wrong, you know what I mean"

Unwanted effects

Almost a quarter (22%, n=10) of participants experienced side effects while on LAIB, experienced during titration or ongoing longer term. Nine of these people cited a lack of support for their adverse reactions as a major concern. Commonly reported effects included nausea, loss of appetite, weight loss, increased anxiety, and sleep disturbances. Four participants noted issues at injection sites, such as bruising, itching, raised skin, and lumps. Many described seeking help as difficult, feeling their concerns were dismissed or not taken seriously by workers. One participant raised they could only speak to duty workers about concerns and felt their issues were passed *"from person to person"* with no resolution or continuity of care.

"They just made it out like it was me, and I was an anomaly, they didn't have much concern or anything like that, they just continued to give me it and let me go away. There was no monitoring or anything".

"I was sick of telling them, look the Buvidal doesn't work for everyone, and their argument was well, yes it does, its a wonder drug you know. No, it isn't."

Two participants experienced particularly severe side effects that exacerbated pre-existing health conditions and said they received no follow-up or signs of care from workers, leaving them feeling unsupported and unsafe. One participant said they were made to feel as though they were *"attention seeking"* and this affected their mental health and had a knock on effect for their loved ones who were concerned for them and their wellbeing.

Further referrals & support

Support for participants extended beyond statutory NHS and third sector services. Some reported being referred to additional resources, either within their primary service or through local community organisations, which they viewed as valuable additions to their support while on LAIB. Two participants spoke positively about being referred to women-specific support groups, where they were able to build friendships; one described it as: *"the best thing since sliced bread—it is brilliant"*. Four others mentioned attending recovery skills courses that helped with anxiety management, relapse prevention, and general coping strategies.

Two participants highlighted being signposted to local recovery cafés, noting that the "sense of community" they experienced there had positively contributed to strengthening their own recovery networks. Extra mental health supports such as Cognitive Behavioural Therapy (CBT) were mentioned by three participants who had accessed this since starting LAIB via their worker at NHS or a third sector organisation.

"I've also done courses with them, I've done a emotional resources group, I've done a decider skills course. It's all about giving you little almost like I would call it, a toolbox of things to do when you find yourself having a craving or I mean I don't have that now, but in those early days and all that kind of thing you need it. It's fantastic."

"So with [third sector service], I've just been offered like the coping mechanisms skills and all the different other things to go with the anxiety I am dealing with,"

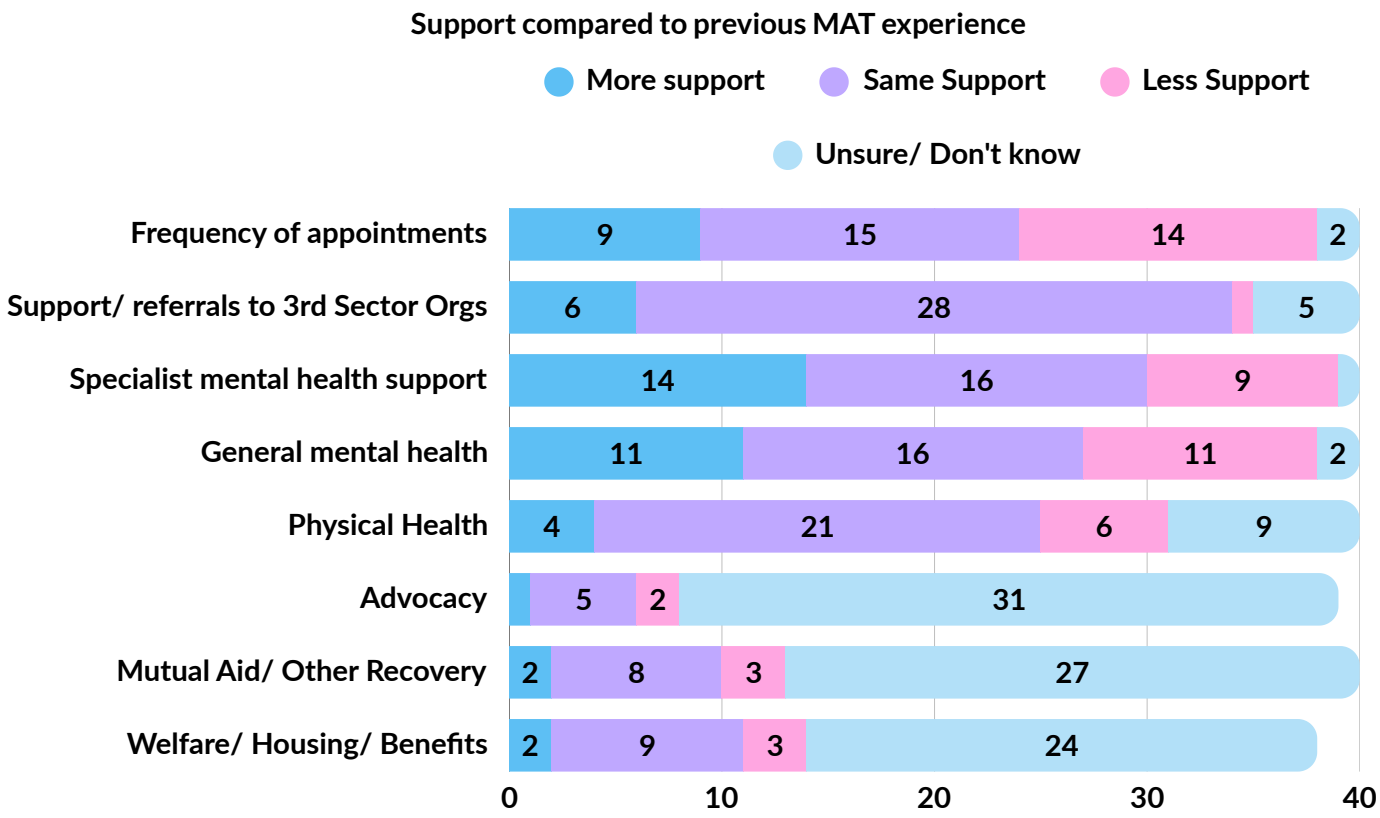
Comparisons to previous MAT

Out of 46 participants, 70% (n=40) answered questions on support they received whilst accessing LAIB compared to other forms of MAT (Methadone, Buprenorphine tablets and Espranor). On the whole, most participants felt the level of support was the same, with same number of total responses across all options for less and more support. The majority of participants (70%, n=28) felt that access to third sector referrals and support remained the same regardless of MAT treatment.

For frequency of appointments, nine participants said they preferred the set up with LAIB and the guaranteed contact they would have every 4 weeks, with one commenting: *"I could go months before being on Buvidal with never being seen"*. Another commented: *"I actually think Buvidal is better for consistent contact with the service in general"*.

35% (n=14) people mentioned they get more specialist mental health support now due to needing extra support for the "mental clarity" gained with LAIB treatment; this included psychology, psychiatry, CPN or talking therapy input. One participant stated "'I couldn't be left without the help, my worker saw that". In contrast, nine others felt specialist mental health support remained a gap across treatments with waitlists and lack of quick access support. For general mental health support, there was a split result from participants about increased or decreased support.

"Buvidal support in some ways is the same and in others, the same things remain a problem - no real, quick access to mental health services and help. That is an ongoing issue, we have to fight and get to be seen".



Participants were most uncertain about whether support had improved in areas such as advocacy, welfare/benefits, housing, and mutual aid or other recovery services which may suggest these options are not being offered routinely.

"Overall, I feel between methadone and Buvidal, it is much of the same support. The workers do as much as they can but they are stretched and we all feel that. I don't feel I am missing anything though."

"I feel the support is always the same or slightly better but I am not actually sure if that is just because I feel so much better in myself on Buvidal and that might be affecting my thoughts on it in all honesty."

Two participants stated they felt treatment and the support remained consistent due to continuity of workers and these workers knowing what needed offered to them and what they would likely take up as support, *"My worker has known me years so knows exactly what to offer me and when and what I am most likely to take up in terms of support."*

Three participants commented that their personal circumstance impacted if support had changed or not on LAIB. Two of these participants raised that due to being on an order with Criminal Justice Social Work, they got access to extra supports but this wasn't necessarily just down to being on LAIB. Another raised that physical health reasons meant they were getting more support offered than previously in MAT treatment.

Five stated they felt unsure in general about support offered throughout their treatment, with one commenting: *"It is really just a jag at its most basic level and then I feel it is down to you to highlight what is missing or what you need but sometimes I just don't know what I need or want".*

Another three participants raised that services are stretched and they are aware workers have other clients to support so feel there is only so much that can be offered within the support structure of treatment pathways.

Reducing treatment

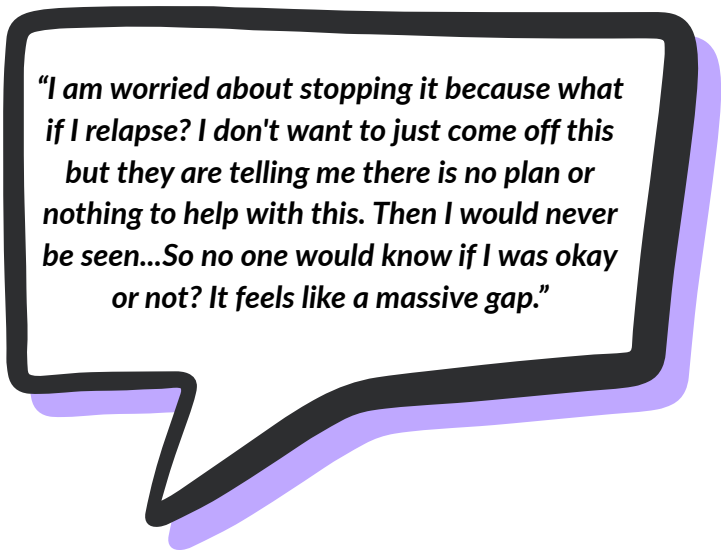
Most participants (70%, n=32) reported they were not currently in the process of reducing their LAIB. Of the 14 participants who were in the process of reducing their LAIB, just under half (43%, n=6) expressed concerns about future reductions or a lack of information regarding what to expect when eventually discontinuing treatment. They highlighted uncertainty about the potential impacts of coming off LAIB entirely. One participant shared worries about *"going back to old habits"* in the absence of adequate support. Another, who was accessing LAIB for the second time, reflected: *"I had no check-in once I came off it—anything could have happened to me."* None of the participants interviewed were offered support from peer mentors with lived experience of LAIB.

Of those reducing, 71% (n=10) described having some level of conversation with their support worker about the reduction process, its potential impacts, and the types of support available, such as top-ups. One participant shared that their worker had increased support during this period, stating: *"My worker has offered weekly calls to check in and ensure I am coping okay and sleeping/eating okay during this."* 21% (n=3) noted that their care plans were reviewed and adjusted to align with their reduction goals.

14% (n=6) said they were offered low-threshold psychosocial supports, such as anxiety management and relapse prevention to support alongside LAIB reduction. Additionally, 7% (n=3) were referred to third-sector or local recovery organisations for supplementary support. 4% (n=2) mentioned that mutual aid was included as part of their LAIB reduction plan.

7% (n=3) indicated that they had not been offered further support but would have welcomed it. One individual remarked: *"I feel like they don't know what to do with someone reducing... that is how it feels."*

One participant reported not receiving any additional support while reducing their LAIB dose but expressed satisfaction with this arrangement, stating: *"I know my doses and how I can reduce when I want, and they seem to be able to offer me a lot of flexibility."*



Participant beliefs & impact of LAIB

During interviews, participants were keen to share the impact LAIB treatment and support had on them and life in general. Participants compared different treatments based on their personal experiences, with these comparisons playing a central role in how they understood their treatment journey and perceived progress.

Shorter term impacts

15% of participants (n=7) reported that being on LAIB significantly reduced or eliminated their cravings, which had a profound impact on their lives and was something noticed quickly after starting LAIB. One individual shared they had remained abstinent from all other substances for the first time in over two decades. Four participants highlighted the stability they felt on LAIB, contrasting it with previous treatments. One of these remarked: *"there are no peaks and troughs like I have had on other treatment, this is just constant in how you feel – it feels like normal."* These positive effects led some participants to describe feeling *"empowered"* and *"motivated"* to pursue their recovery and broader life goals, experiences they noted had previously felt out of reach. Further examples of the daily impact being on LAIB on participants were more freedom of time (n=6), flexibility of holidays/routine (n=5) and the ability to work (n=4).

"Ultimately the main thing is the stopping of the illicit drug use."

"This doesn't feel like opiate treatment, it just feels normal and like a depot jag and then you get on with your life and that is the difference with this."

While most participants described their experiences with LAIB positively, some also highlighted challenges and negative aspects. For ten individuals, managing unwanted physical and psychological effects proved difficult and for four of these participants, it led to using substances alongside their LAIB treatment. Two participants expressed a desire to explore discontinuing LAIB and returning to an alternative form of MAT due to ongoing side effects and concerns about other use on top of treatment.

Mental health was one area where there was a clear difference mentioned by participants in comparison to other MAT treatments. Discussions of having a "*clearer mind*" and feeling more *"switched on to old emotions"* was described by nine participants. This was something that people felt was not present with other MAT medications and which they had often been unprepared for. The emotional impact of LAIB on participants' mental health largely depended on the support they received alongside the treatment.

"Yes, em at the beginning obviously I struggled with mental health, my anxiety was crazy because you had 20 odd years of being an addict of an opiate and then suddenly you're getting an opiate blocker and you're, you don't know how to cope with your life."

"...it's just these side effects pal that are really debilitating, you know, very horrible, especially the lack of sleep as well I mean."

Longer term impacts

A recurring theme among participants was the reduced stigma they associated with LAIB compared to other forms of MAT, particularly methadone. More than half (56%, n=26) felt that the lower level stigma was a very important factor in their decision to remain in and engage with this treatment, while an additional 39% (n=17) considered it quite important. Six participants noted that not having to attend pharmacies for daily prescriptions contributed to this reduced sense of stigma while on LAIB.

> ***"...you don't feel quite as stigmatised or in the same kind of way, like the same kind of category as you were before with your addiction."***

11% of participants (n=5) spoke about the positive effect LAIB had on their relationships with partners, children, and other family members, with one describing this as the "greatest impact" of the treatment. Three of these people noted that switching to LAIB had shifted their families' perceptions of their recovery, as it signalled visible and meaningful change. Two described how their families now expressed pride in them—something they had not experienced while on methadone, which they felt carried more stigma.

One participant shared a particularly significant outcome. After years without contact, social services reviewed their case and reinstated access to their children. The individual attributed this development to the reduced stigma surrounding LAIB: *"Within six months on LAIB, social work did a review and I now have them back in my life. That was never happening on methadone, never."*

> ***"It's the best thing I've ever done, but eh as I say other people may get the support and I'm no getting it I dunno, I would tell them to be prepared, there's a couple of things I got told, that eh the trauma that I've had in my life would come back, I didn't feel the emotions but then they came back with a vengeance."***

"One thing"

When asked, "What is the one thing you would tell someone who was looking to access LAIB?", all participants said they would encourage others to try the treatment, even if their own experiences had not been wholly positive. 19% (n=9) stressed the importance of having appropriate support in place, particularly for mental health, when starting LAIB. Five specifically cautioned about the feeling of the "mental fog lifting", describing it as a significant shift that should be openly discussed beforehand. Another participant highlighted the potential disruption to daily routines, emphasizing the need to plan for how to fill newfound time.

> ***"I would tell them be aware that if you're you're not going to have that, that mental fog, you know what I mean? How about that opiate struggle, you know, I mean or the methadone struggle? It's not going to be there. So if you've got something in your head that worried about you're going to be worried about it more, you know what I mean?"***

PRISON FINDINGS

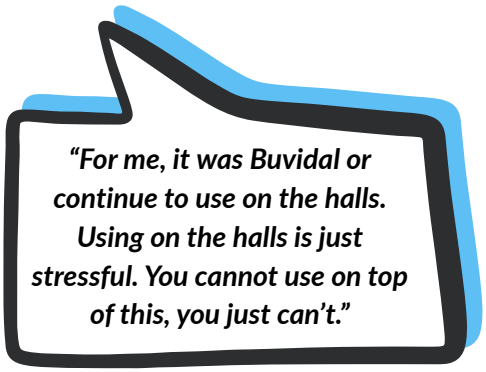
Participants in the prison-based focus groups shared their experiences of the establishment in which they currently reside, as well as their experiences of other estates and in the community. They spoke of both their own direct experiences but also shared examples of their peers in prison.

Access

Starting LAIB

Participants described varied pathways into LAIB treatment, both in the community and in prison. Of the nine men in the focus groups, two thirds (n=6) accessed LAIB in custody, one through a Drug Treatment and Testing Order (DTTO), and another via community services before entering prison. One participant was no longer on LAIB but had been accessing this previously. 22% (n=2) had been on LAIB for over four years, while the other 78% (n=7) had been receiving it for three to eight months. Although all were on Medication Assisted Treatment (MAT), only two were aware of the MAT Standards.

33% of participants (n=3) discussed completing drug testing on entering custody and commencing LAIB shortly after this. Two participants discussed requesting LAIB during sentences to get away from "chasing" substances on the hall and running up "debts". Both participants said that LAIB had achieved this for them, which has helped ease some of their day-to-day stress and worry.



Information

The focus group participants had received varying information about LAIB. Of the two thirds (n=6) who had started LAIB in a custodial setting, all mentioned they had a brief discussion with a worker about the treatment and how this might work. One participant discussed that when they started LAIB it was still in *"the experimental stages"* during Covid-19 and said that, at the time, staff were not aware of details of this treatment and potential unwanted effects, and therefore felt that information was limited.

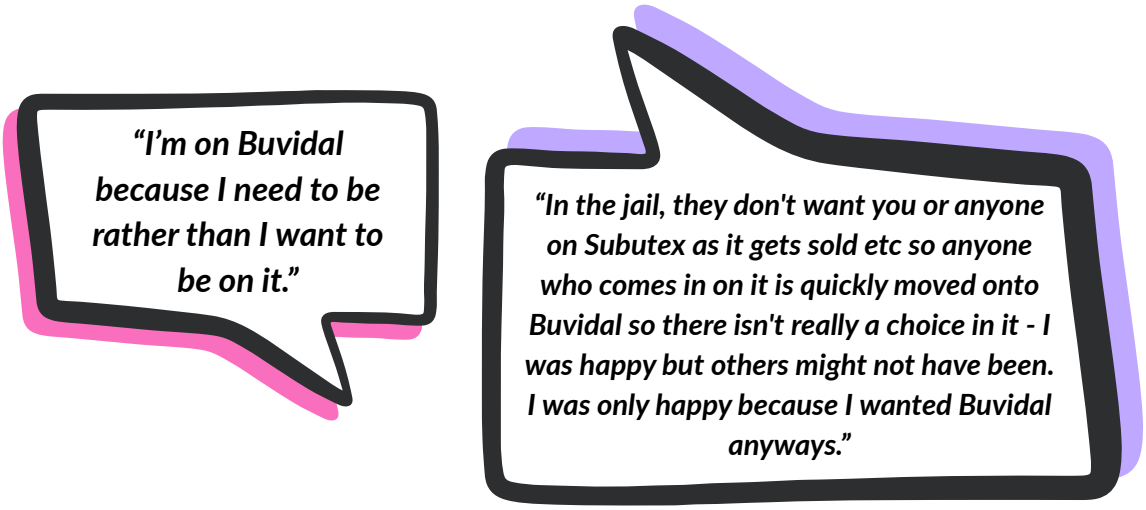
One third (n=3) stated that they were given information sheets on LAIB and another third (n=3) stated that they were not given any leaflets or further printed information. One participant acknowledged that they were not in a position to ask questions about the medication at the time, as they simply needed something to stop the withdrawal symptoms and the *"constant chasing"* of drugs. As a result, they were prescribed LAIB but could not recall receiving much information. One participant who started LAIB in the community stated that he had been given a leaflet but had not read it as it looked *"too complex"* to understand.

Choice

Type of medication

Participants mostly felt that they had little to no choice in their MAT, which emerged as a significant point of discussion. 44% (n=4) felt that they were directed toward LAIB as other options were either unavailable or limited to methadone only. Methadone was widely viewed as stigmatised and increasingly outdated by 56% (n=5) members of the focus groups, with one describing it as *"not a real option"* and another stating that LAIB was *"100 times better than methadone"* as it meant they had no desire to use other substances in addition. Another participant said the decision felt like having their *"arm twisted"*, suggesting that it was driven more by concerns about medication diversion within the prison than by a meaningful conversation about which treatment would best meet their individual needs.

A third of the total nine participants (n=3) expressed a preference for tablet or wafer form buprenorphine, explaining that these options gave them a greater sense of control in managing their medication. However, discussions took place across all groups that these medications are not available in the custodial setting due to concerns about diversion and currency value they can have. One noted that the act of taking something daily helped establish a psychological sense of routine and personal agency and that they would return to Subutex if given the option. There was a sense, especially in one focus group, that people wanted a greater autonomy over their medication than they had been offered so far. Two people shared that, while in the community, they would occasionally reduce or skip doses based on how they felt — something they could not do with LAIB.



Dose

One third of participants (n=3) stated they were on the highest dose of LAIB (160mg) and described difficulty in accessing additional support when they felt the medication wearing off before the end of the month. They described withdrawal symptoms such as sweating and feeling uncomfortable in themselves but were not eligible for a top-up dose due to being on the highest one already. One felt "stuck" in this cycle and acknowledged nurses were unable to help due to their prescribing guidelines. Another said the withdrawal feelings and inability to increase dose sometimes left them considering illicit use on the halls. 56% of participants (n=5) were on a lower range of doses and acknowledged that they could access top-ups when required if they felt that they were struggling, with this usually being accommodated within a week of requesting.

Injection site & frequency

The eight participants who were currently on LAIB reported being given a choice of injection site on their body and that this had to be rotated each month. One individual noted that the location of the injection seemed to influence how long the effects lasted, though this factor was not consistently taken into account.

> ***"I get hot and cold flushes sometimes and you get like a wee lump at the place where the injection has gone in."***

Two people described the medication as most effective during the first week, with its impact diminishing over time. One commented: *"It's like putting petrol in your car—you see the tank fill up at first, then watch it go down as time goes on. Same with the jag."* All participants received monthly injections. One person would have preferred weekly, but noted this was not an available option in the custodial setting.

> ***"In jail, once you get seen for the monthly jag, you can't just decide to go back to weekly even if that is better for you."***

Support

Addictions staff

Participants generally viewed experiences with the prison's addictions nurses positively. They described being able to submit healthcare forms directly to a nurse, bypassing non-medical staff working on the halls, with most stating that they could be seen by the next day or within a week.

Those currently on LAIB reported receiving their monthly injections from staff members whom they were familiar with. While there was only one nurse in one of the establishments, this nurse was described by these four participants as supportive and responsive to any requests for support. These participants also said that they were able to raise concerns with the nurse directly and appreciated their efforts to fast-track access to be seen when needed.

> ***"There's a few in the addictions team you can go to. They are all nice and do their best to support and listen to what's going on. They've got a lot of time for you so I engage with them."***

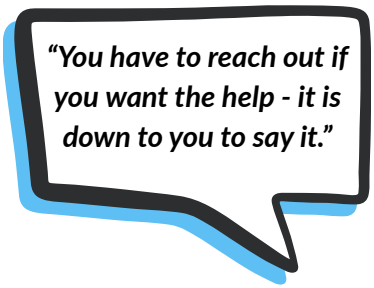
In the other focus groups it was raised that there were a few members of staff in the addictions team who people could see if they needed extra support. Again, there was agreement that these staff were supportive, checking in to ensure doses were being managed adequately. One individual noted that the smaller number of staff contributed to building a stronger relationship. Lower caseloads meant people were seen both more quickly and frequently if needed.

Barriers to support

Stigma was a common theme, raised as a barrier to feeling able to seek support within the prison setting. Several participants said they often felt judged by the hall staff for being in recovery or on medication. All members of the focus groups said at some point in the community or in prison, they had been labelled *"prescription seeking"*, particularly when trying to discuss alternatives to LAIB. This made them more wary about speaking up if they were struggling. One participant said that they avoided saying too much to staff in case it *"came back on them."*

56% of participants (n=5) mentioned reliance on prison officers to pass on requests to the nursing team was seen as a barrier to accessing support. 22% (n=2) reported that messages were not always passed on and it felt their needs *"weren't a priority"*.

Two people shared that upon entering custody, they were provided with a sheet listing emergency contact numbers for support if they were struggling. One third of participants (n=3) noted that the responsibility to seek out specific support was placed on the individual, rather than it being proactively offered, and that it could take time. One individual reported that it typically took four to five weeks to access a doctor. They felt this approach was similar to their experience in the community when trying to access help.

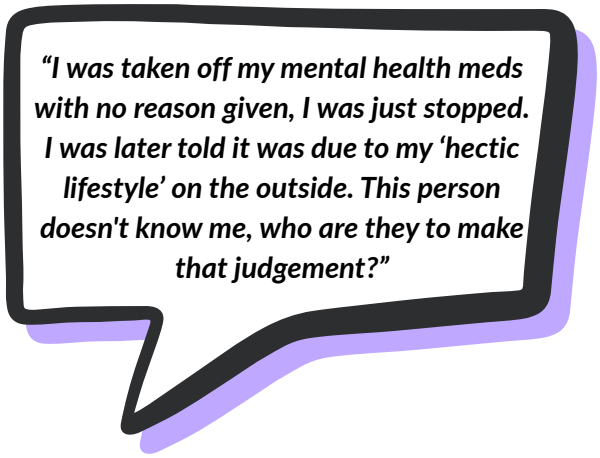


Mental health

Participants expressed little trust in formal mental health services. They said that they were unlikely to access counselling in prison due to stigma, fear of looking *"weak"* to others on the halls, or a belief that it would not help. One person said *"no comment"* when asked about mental health specific support.

Another participant expressed a lack of trust in mental health support after their prescribed medication - originally given by their community psychiatrist - was discontinued upon entering custody. They voiced frustration over the abrupt halt to treatment that had been maintained long-term in the community, particularly in an environment where their mental health was likely to be vulnerable.

Two participants said they would go to the addictions worker for mental health support. One person saw a psychiatrist, but only every three months and mainly for medication reviews. Another highlighted the need for better coordination between community and prison services to ensure essential prescribed medication continued without disruption.



Two stated they had never needed to access specific mental health support as they felt they did not need it.

Peer & recovery support

A consistent theme across all three focus groups was the positive impact of peer support. All nine participants spoke of its value, with one describing it as *"the most helpful"* and readily accessible form of support available in custody. For two people, sharing a cell with another person on LAIB helped alleviate feelings of isolation and fostered mutual support, particularly around challenges such as sleep disturbances and mental wellbeing.

Members of one focus group suggested that individuals with lived experience of LAIB should be employed in both prison and community settings. They felt that this would enable others to make more informed choices and feel better supported throughout their treatment journey. There was a shared belief that lived experience offers a level of credibility and understanding that clinical staff may not always be able to provide.

Participants also appreciated the availability of recovery cafés within the establishments, which they saw as valuable spaces to connect with others and openly discuss personal challenges. Three people spoke about the presence of a 'Recovery Wing' in their establishment, which offered recovery-focused groups and provided those living on the wing with additional support for their substance use.

> ***"The recovery wing here works well, you get access to groups, Abbeycare and recovery cafe. I feel you get a bit more monitoring and support there."***

The 'Prison to Rehab' scheme was also highlighted by a third of participants (n=3), who praised its promotion and recognised that it gave residents an opportunity to access rehabilitation — something they noted can be difficult to achieve in the community.

Unwanted effects

Unwanted effects and impacts associated with LAIB were discussed in all three focus groups. Six people shared a need for support to manage these during titration or on a longer term basis. Four participants reported experiencing continued adverse effects such as excessive sweating, sleep disturbances, weight loss, anxiety, low mood, paranoia, restlessness, and reduced libido. Three participants expressed disappointment, saying they had been *"sold the dream"* of LAIB as a *"wonder drug"*, but found the reality to be quite different due to the effects experienced.

> ***"It just keeps everything ticking over, it feels very consistent in your system, like you're not up and down. Your feelings and emotions do come flooding back, that was a shock for me."***

Two people reported experiencing unwanted effects only during the initial months of titration, with one noting that symptoms such as anxiety and paranoia "stabilised" once the appropriate dose was reached.

One third (n=3) commented that the mental clarity brought on by LAIB was difficult to manage in a prison environment, where there were limited opportunities to distract themselves from their emotions.

Long-term plans

There was shared frustration that no exit plans were in place once they started on LAIB and there seemed to be no long-term pathway for tapering off or coming off of the medication altogether. One participant mentioned that this concerned them because the longer-term effects were not known and, given that they were on various other medications, they wanted more detailed information. Another participant mentioned their anxiety around community release if parole was granted and that planning for this had not been discussed.

> ***"When I get out, I don't want to be back at a chemist and having to see people so that is a benefit of Buvidal."***

> ***"There is unknowns about the jag, we don't know longer term how that will affect us. I have to think about Parole and what this will look like in the community."***

STAFF FINDINGS

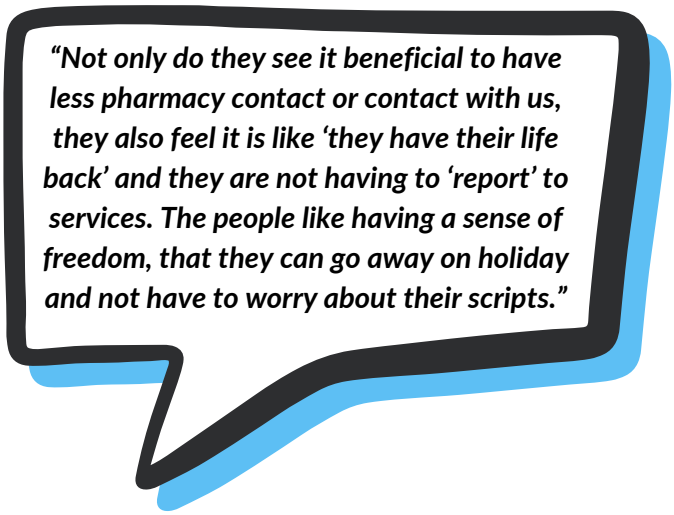
39 NHS staff and 14 third sector staff completed surveys about their experiences of providing support for people receiving LAIB.

Access

Motivations for LAIB treatment

NHS and third sector staff were similar in their responses to what the most common reasons people give for wanting to access LAIB were. Most staff selected multiple reasons they felt people would have for this.

Over 92% of each group (n=37 NHS, n=13 third sector) said having less contact with the pharmacy and over three quarters of each (n=29, n=12) said discussions from peers about LAIB contributed. Two thirds of each group (n=26, n=9) said people felt LAIB was the next step in their treatment and 39% of NHS staff (n=15) and 50% of third sector staff (n=7) said it was due to wanting a change of treatment. Other reasons given included people preferring the injection as a treatment option, getting more flexibility/freedom for daily activities (e.g. work, education and family responsibilities) and LAIB being less sedative/providing *"clarity of mind"*.



Starting LAIB

35 NHS staff answered a question on when they feel it is appropriate to discuss LAIB as an option for people; they were able to select multiple responses. A substantial majority said: when the person has shown an interest in moving to LAIB (94%, n=33); if the person is looking to engage in extra social/community activities and LAIB would support this (86%, n=30); and if the person was struggling to regularly attend the pharmacy (77%, n=27).

Over two thirds of NHS staff said it would be appropriate to discuss LAIB if the person had been on another MAT long term (69%, n=24) or when the person is looking for less contact/support from the service (63%, n=22). 29% (n=10) said they would discuss LAIB when no other substances were being used. Staff were provided the option to provide further information. In this section, six respondents advised that LAIB should be discussed when people first access MAT and as an ongoing option such as at reviews or assessments. Three staff mentioned it is appropriate when a person is, or is looking to start, working or engaging with education. One person said if they are on a low enough dose of alternative MAT and if they can tolerate buprenorphine and being *"more clear headed"*.

We asked third sector staff how people access LAIB with the option of multiple response options. Almost all (93%, n=13) said via their NHS MAT worker. Just over half (57%, n=8) said they could make a direct referral via phone or email on someone's behalf. Just over a third, 35% (n=5), stated people can self-refer using drop-ins services or the phone. One staff member said someone can access via their GP and another said people had to reduce methadone to 30-40mls to access.

37 NHS staff answered what the most common timescale was for someone to be able to start LAIB in their service from initial presentation or discussion. Responses with specific timescales were:

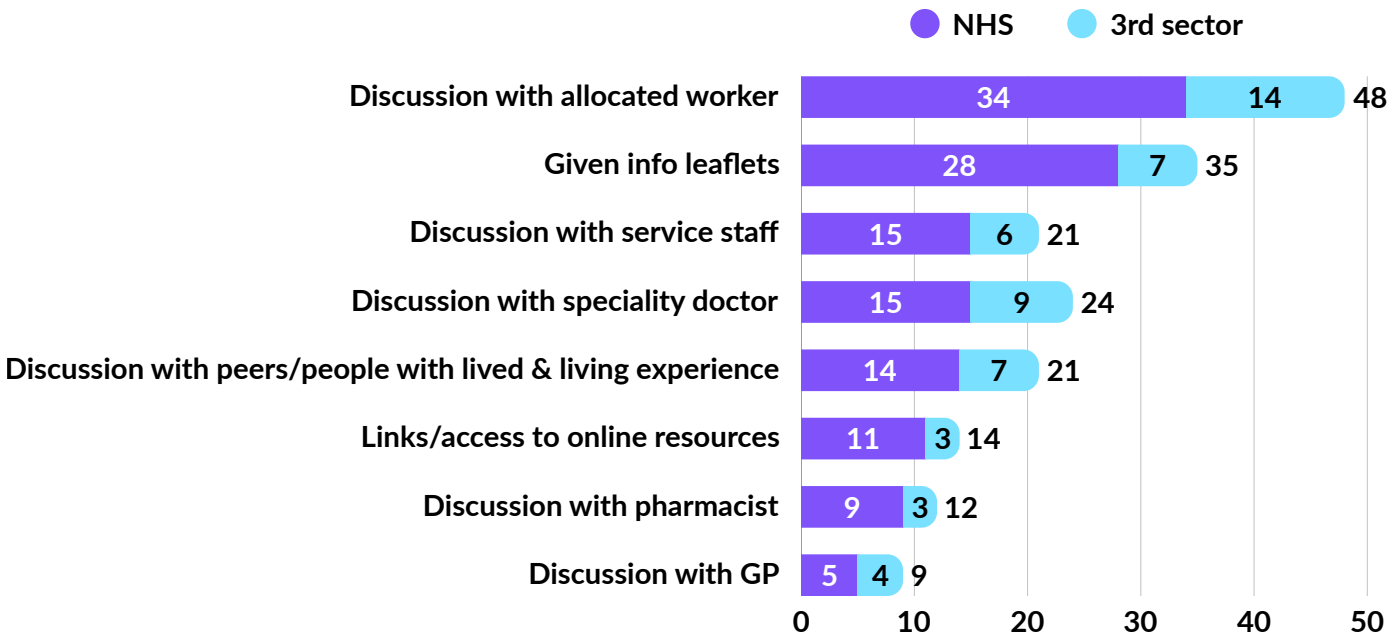
- Same day - 11%, n=4
- Next day - 19%, n=7
- 2-4 days - 30%, n=11
- 1-2 weeks or more - 11%, n=4

11 staff selected the "other" option and four of these did not provide a timescale as they were not the service who initiated LAIB treatment. Five of these staff members advised that time scales are dependant on individual circumstances such as being known to the service, history and being in current receipt of non LAIB MAT. Two staff said timescales can vary based on availability/staffing in the service. One said this can be several weeks and the other stated they try to start people within a week but recently this had taken longer.

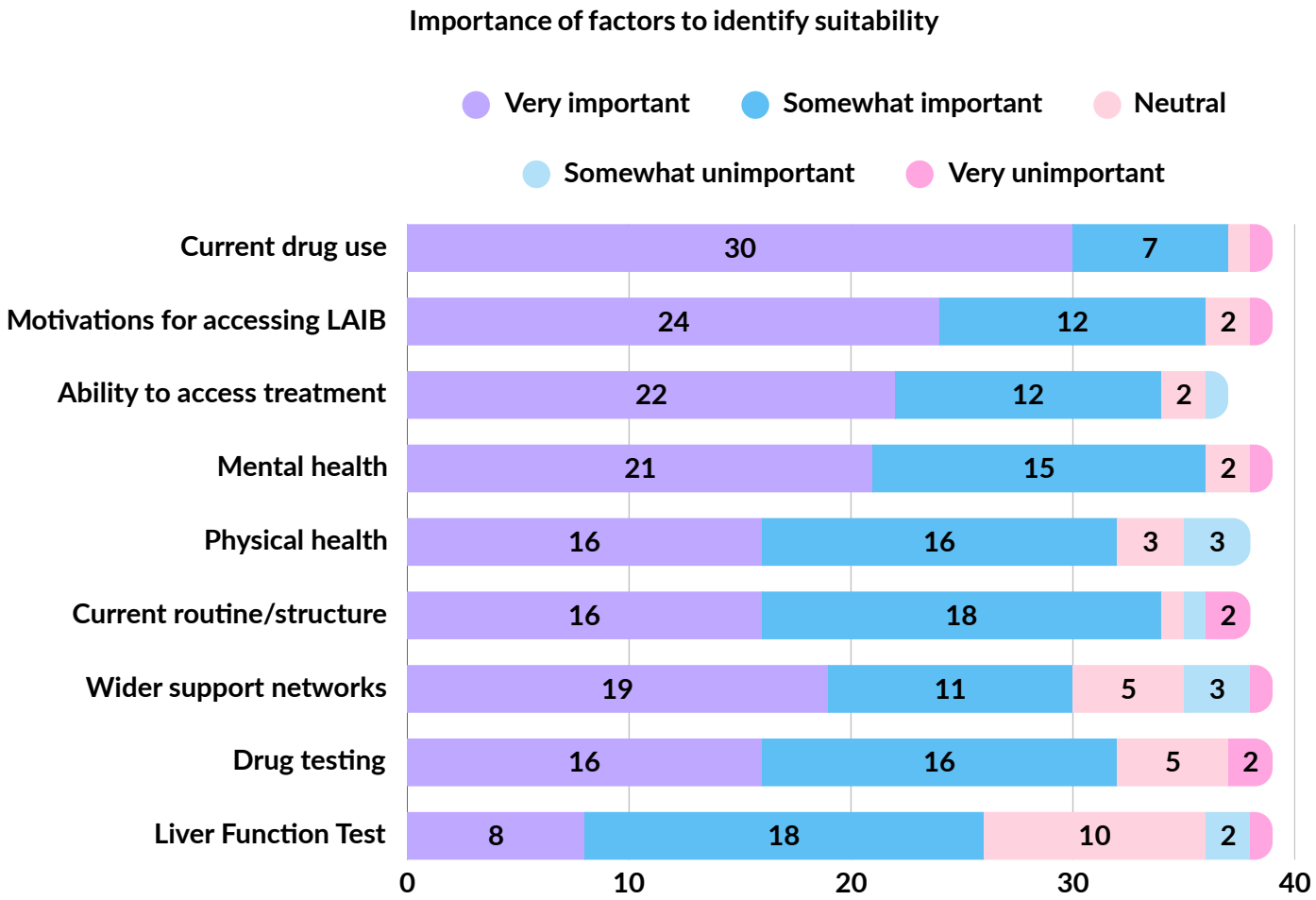
37 NHS staff reported there are multiple reasons LAIB treatment could be a delayed. The most common explanation given by 35% (n=13) of staff is capacity issues within the service. This includes staff/prescriber availability, limited access to appropriate clinical space, waiting lists and geographical restrictions. One staff member described a "bottleneck" when initiating LAIB treatment, noting that they were unable to transfer "stable" people to community services. This limited their capacity to take on new individuals to start treatment.

36% (n=14) of staff mentioned factors relating to prescribing decisions that could delay starting LAIB. Half of these said the person being on another form of MAT will influence it, for example if they have to move to oral Buprenorphine first before LAIB. Eight said considerations of prescribing safety could influence starting LAIB. For example, some said if they had taken other opiates prior to attending and others said if they had taken any substance. 23% (n=9) of staff said other factors about the person can cause delays, such as their "readiness", physical health issues, and availability/whether they attend appointments. 15% (n=6) mentioned issues with getting immediate access to LAIB as this has to be ordered on a named-person basis so could take time. 10% of staff (n=4) mentioned the need to refer to a specialist service being another cause of delays, such as from GPs who are unable to initiate someone on LAIB directly.

Information/supports found to be most useful for people considering LAIB treatment



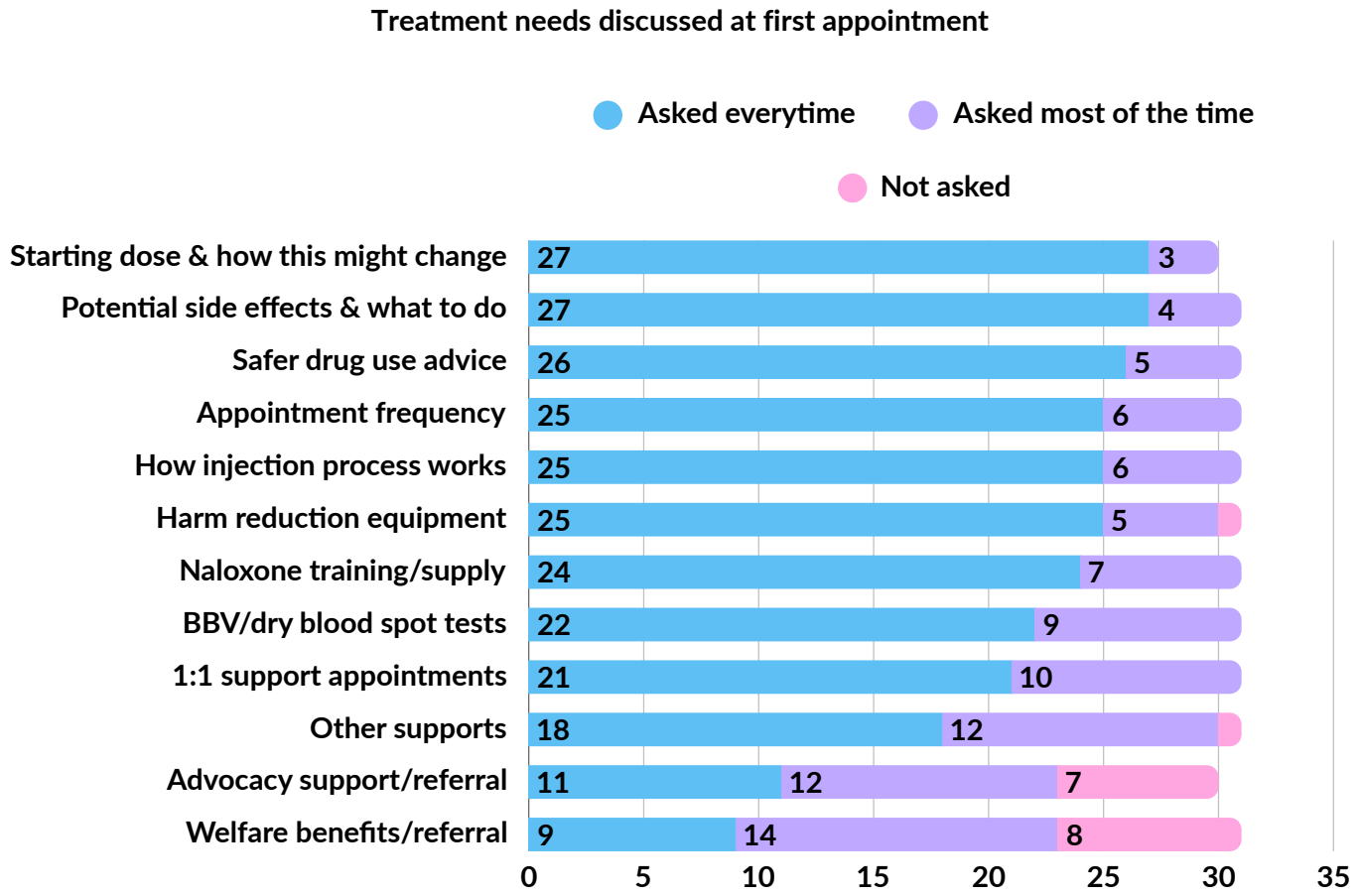
NHS staff were asked how important various factors were to discuss/check to identify peoples suitability to start or transfer to LAIB. The chart below shows the rates of responses.



At least two thirds of staff felt all of these things were at least somewhat important. Staff felt the most important things were discussions on current drug use, motivations for wanting to access LAIB and the person's ability to access treatment, such as travel to clinic and outreach arrangements. In additional responses, one staff member said they would also discuss a plan in case of disengagement. Another said they would bring up the mental clarity LAIB provides and that they could be moved to another form of buprenorphine if they *"cannot tolerate this clarity"*.

First appointments

31 NHS staff answered what is discussed with people at their first appointment when starting LAIB, and how consistently. The most consistently discussed things reported were: the starting dose and that this might change, potential side effects and what to do if these occur and harm reduction advice around safer drug use. The least consistently discussed things were advocacy support/referral and welfare/benefits referrals. Three staff did not answer this question as they said they do not initiate LAIB. One added a comment that all will be discussed but the frequency of how often things get asked can vary greatly between individuals. Full rates of responses are shown in the chart below.



Choice

Injection administration

34 NHS staff gave answers to where people can be seen to receive their LAIB; they could select multiple responses. Almost all (94%, n=32) said the local drug and alcohol service and half (n=17) said at specialist LAIB drop-in clinics. 44% (n=15) said at their GP practice and 35% (n=12) said at their local pharmacy. Four staff mentioned there were pilots currently going on or being discussed to allow access at GPs and pharmacies. 35% (n=12) said people can receive treatment at their home and 24% (n=8) said they could do outreach to meet people in the local area for this. One staff member commented that they will only do home visits or pharmacy provision in *"rare cases"*, such as when someone is temporarily immobile as a result of accident/illness or is very frail.

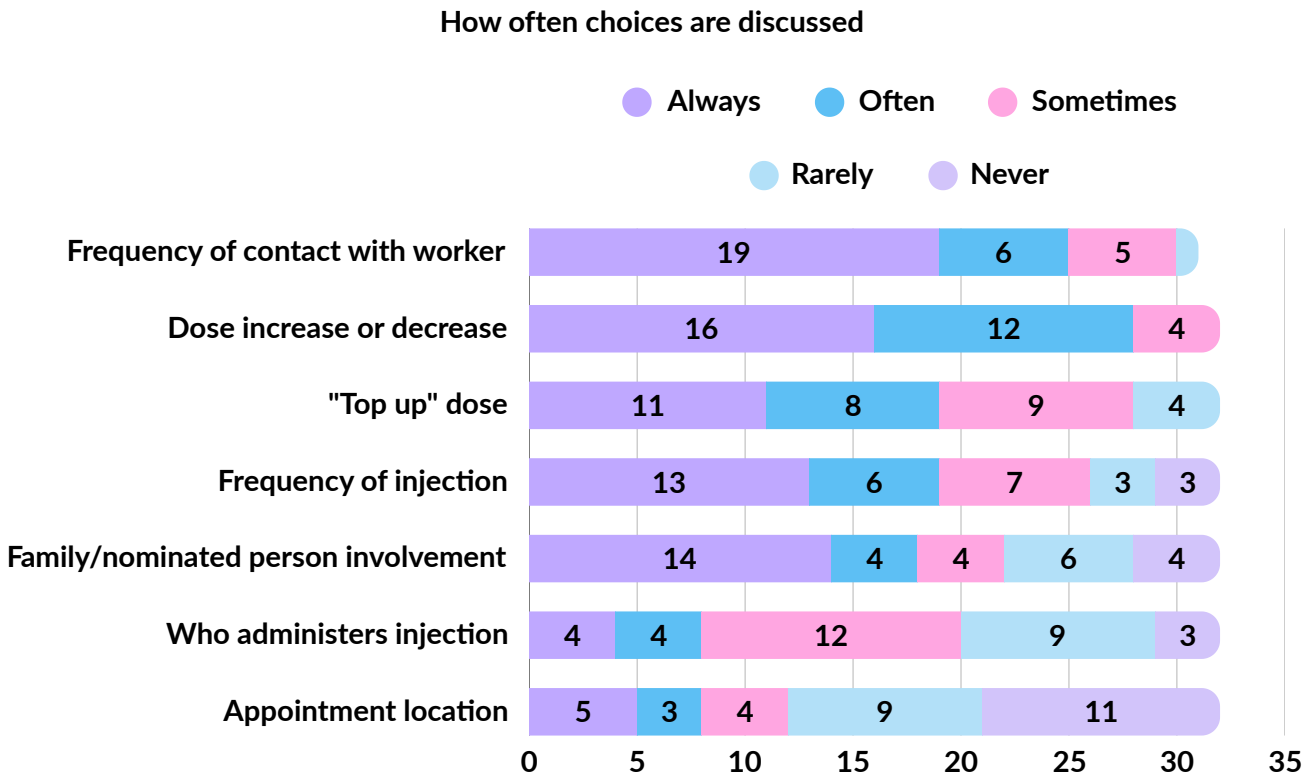
33 NHS staff answered who in their service/locality can administer LAIB; again, they could select multiple responses. 79% (n=26) said it is always them or an allocated addictions worker and over half (52%, n=17) said duty workers will administer. One person commented that the drop-in clinic can be attended if someone misses their key worker appointment. One third (33%, n=11) said shared care is offered so people can attend their GP for the injection and 27% (n=9) said shared care allows people to attend their pharmacy for the injection. One person commented they hope to be able to offer the injection to be administered in primary care settings.

"Where possible, person is seen by named nurse. Can be seen by service duty nurse if person is unable to attend scheduled time with named nurse/covering nurse absence etc. Where suitable, person will be offered transfer to GP or pharmacy support."

Dose & other choices

33 NHS staff answered how often LAIB dose is discussed throughout someone's treatment; they could select multiple responses. 73% (n=24) said people can raise dose whenever they want a change. Within this 24, 20 staff also said dose can be raised at every weekly and/or monthly appointment and 8 said it can be raised at reviews, either every 3 or 6 months. 24% (n=8) said dose will only be discussed at weekly and/or monthly appointments and one staff member said it will only be discussed at 3-monthly reviews.

32 NHS staff answered how often various other choices are offered/discussed during someone's LAIB treatment. The most consistently offered/discussed choices were related to frequency of contact with their worker, dose (including need for a "top up") and frequency of their injection. The chart below shows all responses.



Substance Use

Rates & patterns of use

47 staff (33 NHS & 14 third sector) answered whether people they worked with used other substances (including alcohol) on top of their LAIB. 81% (n=38, 28 NHS & 10 third sector) said yes, 11% (n=5, 3 NHS & 2 third sector) said no and 9% (n=4, 2 NHS & 2 third sector) were not sure. The average percentage of people staff thought were using other substances on top was 48% for NHS and 28% for third sector. There was a large range of responses: NHS answers ranged from 0 to 100%, with 17 staff saying 50% or more, and third sector responses ranged from 0 to 80%. When asked how the topic of substance use is raised with people accessing LAIB, 84% (n=27) of NHS staff who responded said this is routinely asked about in other appointments. 72% (n=23) said regular drug testing takes place and results can lead to discussions and 53% (n=17) said people will often raise substance use with them/their worker directly.

NHS and third sector staff were similar in their responses when asked which substances were most commonly reported as being used on top of LAIB. Alcohol, powder cocaine, benzodiazepines and pregabalin were the five most frequently reported as being used by individuals in LAIB treatment.

> ***"Use of crack and cocaine is on the rise due to low quality heroin available and the fact that using heroin on top does not get them 'high' enough."***

> ***"Cannabis is very common and seems to be regarded as almost 'not' a drug. There seems to be an increase in crack cocaine use lately. Benzodiazepines remain very popular. Some people will still smoke heroin, injecting is rarer, but they tend to agree its 'not the same' on Buvidal."***

Reasons for use

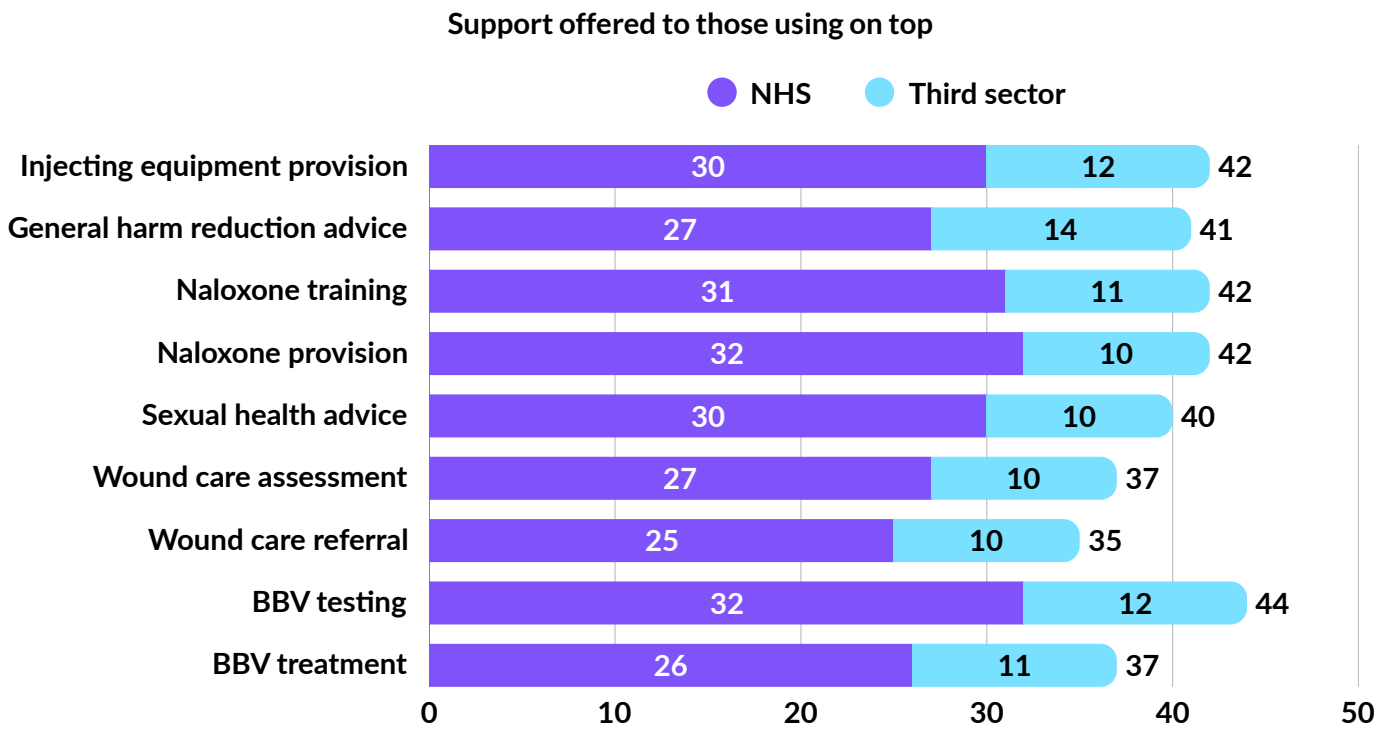
43 staff (31 NHS & 12 third sector) answered what common reasons people give for using substances on top of LAIB. The most common reason mentioned by 72% of staff (n=31, 23 NHS & 8 third sector) was to manage mental health symptoms. 65% of staff (n=28) said due to availability of substances in the local area, social functioning or peer pressures and because people want to use substances/have always used substances respectively. Three staff added additional comments relating to the latter, with one saying people may see "*their addiction*" as being under control. Another said people may enjoy still using occasionally and the last said people often say *"it's just a habit"*. 44% of staff (n=19) said people use on top to cope with physical health symptoms and 16% (n=7) said it can be due to changes in routine since starting LAIB, such as not going to the pharmacy. Two staff made comments referring to the clarity of thought people get with LAIB being a factor for topping up as well.

> ***"The general trend is to distance themselves from services which means they get less psychosocial support and less support for their trauma background which means they are still looking for drugs to numb their pain and subdue their memories."***

> ***"Not being able to cope with clarity and all the feelings that come up. These seemed to be subdued more so with methadone. Basically they have not learned to deal with their trauma so the initial reason for using drugs is still there, it has not been dealt with."***

Support & harm reduction

47 staff (33 NHS & 14 third sector) answered which support can be offered if someone is using on top of their LAIB; they could select multiple responses. All things were selected by over 70% staff. Three NHS staff mentioned mental health support, such as from psychology or psychiatrists could be offered in the open text space for additional answers. Full rates of responses are shown in the following chart.



16 staff (11 NHS & 5 third sector) made suggestions for other support or interventions they would like to be able to offer people but cannot currently do so. Nine people said safer inhalation pipes, four said sexual health interventions, such as contraception and guidelines, three said vaccinations and two said more psychosocial/wellbeing support. Other suggestions mentioned by one person respectively included: literature to keep in their clinic, drug testing, ability to offer antibiotics and more in-depth wound care, naloxone provision and access to psychological therapies at referral stage.

> ***"Access to safer inhalation pipes would be great to be able to engage with those using crack. If we had more trained staff, we could catch more of them for impromptu one-to-one support meetings."***

Support

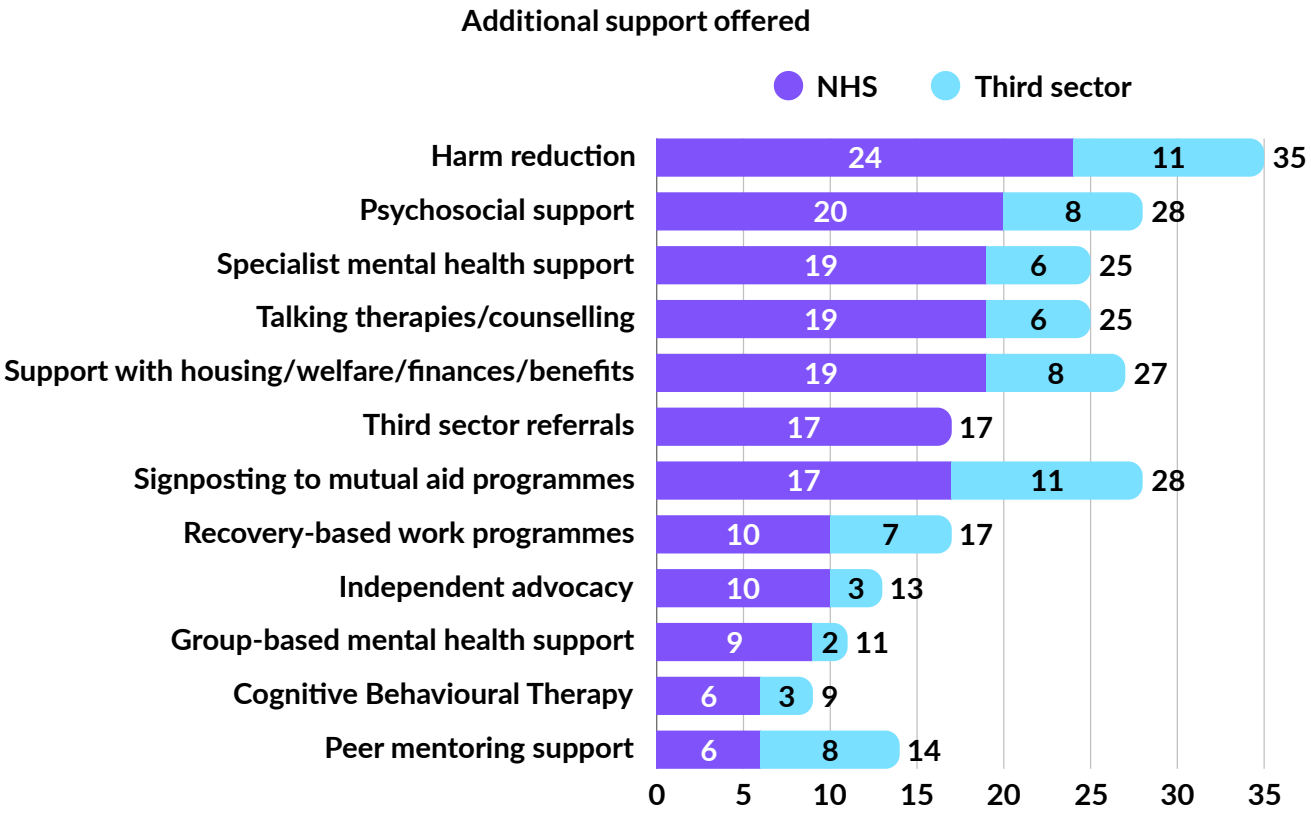
Frequency of contact

25 NHS staff answered how often they typically see people who are accessing LAIB; they were able to select multiple responses. 36% (n=9) said once a month - for injection only, 72% (n=18) said once a month - for injection and 1:1 support appointment, 12% (n=3) said once a week - for injection only and 8% (n=2) said once a week - for injection and 1:1 support appointment. One staff member explained they see people monthly as they are "all stable" but there is the option to see weekly or fortnightly, as other staff do. 12% (n=3) staff said they are only involved in the review process, so see people at review once every 3 or 6 months. 28% (n=7) said they will see the person as often as they want. One staff member expanded that extra contact between appointments can be on the phone as deemed necessary/appropriate.

12 third sector staff answered how often they typically see someone when they are accessing LAIB; again, they could select multiple responses. Half (n=6) said they could see the person as often as they wanted and that they can offer weekly support appointments respectively. One quarter (25%, n=3) said they can offer two-weekly support appointments and 17% (n=2) said they can offer monthly support appointments. One staff member commented they can offer telephone check-ins as well as face-to-face appointments and another said most appointments were monthly but can be every 2-3 months if someone is *"stable and have been for a long period of time"*.

Additional support options

37 staff (25 NHS & 12 third sector) answered what other supports could be offered and/or referred to people accessing LAIB by them/their service. The most common things selected by NHS staff were harm reduction, psychosocial support (e.g. safety and stabilisation, decider skills and coping strategies), specialist mental health support (e.g. psychiatrist, psychologist or CPN) and talking therapies/counselling. The most common things selected by third sector staff were signposting to mutual aid programmes (e.g. 12-step fellowships or SMART Recovery), harm reduction, peer mentoring support and support with housing/welfare/finances/benefits. Things mentioned in the "other" option included vocational support, food voucher provision, support with babies/children and referrals to rehabilitation services. Full responses are shown in the chart below.



The staff were then asked which of the supports mentioned they found to be the most requested/utilised by people accessing LAIB. The most commonly selected by NHS staff were harm reduction (chosen by 68%, n=15), specialist mental health support (chosen by 59%, n=13), support with housing/welfare/finance/benefits (chosen by 50%, n=11) and psychosocial support (chosen by 41%, n=9). The most commonly selected by third sector staff were support with housing/welfare/benefits/finances (chosen by 92%, n=11), signposting to mutual aid (chosen by 67%, n=8), peer mentoring support (58%, n=7) and recovery based groupwork programmes and psychosocial support (both chosen by 50%, n=6).

Comparisons to other MAT

15 NHS staff described any differences they experienced in managing people receiving LAIB compared to other forms of MAT:

- Two staff felt it was a "safer" medication, with one of these mentioning the "protection" offered with opioids.
- Three people mentioned positive things related to its administration: means they do not have to communicate with community pharmacies and thus there are less professionals involved in people's treatment; easier to manage people's prescriptions when they are going on holiday; and that there is still coverage from the medication if they miss their monthly appointment.
- Two staff said they feel they see people more frequently than those on other forms of MAT.
- One person said they feel their people on LAIB are *"generally much more stable"* and another felt people were *"more motivated"*.
- Three staff felt interactions with people in LAIB were more limited than with people on other medications. It was mentioned people can be hard to get hold of, struggle to attend additional support appointments and could be at risk of disengaging completely if changed to weekly administration. One person felt people on LAIB were "less visible" due to not attending the pharmacy.
- Two staff members mentioned things relating to LAIB provision in prison. Both said it was harder to conceal and divert and therefore could be a less popular option than other forms of MAT, at least until someone was close to liberation.

"They attend! I feel that I see my Buvidal people more frequently than I see the ones on oral buprenorphine or methadone, yet I offer the same amount of appointments and support."

"A conscious effort needs to be made to see them for one to ones and follow ups. We are finding that they are much less likely to engage and because we are not seeing them as often, they can hide when they are deteriorating or have relapsed."

Reducing/ending treatment

26 NHS staff answered questions about when people want to stop/decrease their LAIB treatment. The most common reason people were said to do this was due to wanting to come off MAT altogether, selected by 88% of staff (n=23) followed by if they change their mind about treatment (42%, n=11). Other reasons were increased their use of other substances, moving to another form of MAT or experiencing a negative impact on their mental health/other adverse effects from LAIB.

Various support was said to be offered to those stopping/decreasing, with the most common being a review of their care plan and additional planning for next steps (mentioned by 88%, n=23) and discussions around impacts of decreasing and what this process involves (mentioned by 85%, n=22). More than 60% of staff (n=16) mentioned referrals to third sector or community agencies for support, increased psychosocial intervention work and discussion/referrals to mutual aid programmes. 27% of staff (n=7) said they would like to peer mentors with lived experience of LAIB and decreasing/stopping treatment. One staff member also mentioned they could refer back to the specialist service for advice/support and another said they have an Occupational Therapist in the team who can support person with routines and structures.

Staff attitudes

26 NHS staff and 12 third sector staff answered how much they agreed or disagreed with various statements about LAIB treatment. The statements staff agreed with most, and with similar rates of agreement between both groups of staff were:

"Buvidal is most effective when combined with other recovery support services, such as counselling or peer support groups".

- Strongly agree: 42% (n=11) NHS and 58% (n=7) third sector
- Agree: 39% (n=10) NHS and 25% (n=3) third sector
- Neither agree nor disagree: 15% (n=4) NHS and 8% (n=1) third sector
- Disagree: 0 NHS and 8% (n=1) third sector
- Strongly disagree: 4% (n=1) NHS and 0 third sector

"Buvidal offers a more convenient treatment option compared to other forms of MAT."

- Strongly agree: 50% (n=13) NHS and 25% (n=3) third sector
- Agree: 31% (n=8) NHS and 75% (n=9) third sector
- Neither agree nor disagree: 15% (n=4) NHS and 0 third sector
- Disagree: 0 both
- Strongly disagree: 4% (n=1) NHS and 0 third sector

"Ensuring timely access to mental health support is essential for people starting, adjusting and continuing their Buvidal treatment."

- Strongly agree: 38% (n=10) NHS and 33% (n=4) third sector
- Agree: 35% (n=9) NHS and 42% (n=5) third sector
- Neither agree nor disagree: 23% (n=6) and 25% (n=3) third sector
- Disagree: 0 both
- Strongly disagree: 4% (n=1) NHS and 0 third sector

Both groups of staff were more varied in their level of agreement about the following statements:

"Buvidal is the most effective option for Medication Assisted Treatment (MAT)."

- Strongly agree: 23% (n=6) NHS and 8% (n=1) third sector
- Agree: 31% (n=8) NHS and 25% (n=3) third sector
- Neither agree not disagree: 35% (n=9) NHS and 50% (n=6) third sector
- Disagree: 8% (n=2) NHS and 17% (n=2) third sector
- Strongly disagree: 4% (n=1) NHS and 0 third sector

"The reduced frequency of clinic visits with Buvidal leads to better treatment adherence for people."

- Strongly agree: 19% (n=5) NHS and 0 third sector
- Agree: 27% (n=7) NHS and 42% (n=5) third sector
- Neither agree nor disagree: 35% (n=9) NHS and 50% (n=6) third sector
- Disagree: 15% (n=4) NHS and 8% (n=1) third sector
- Strongly disagree: 4% (n=1) NHS and 0 third sector

"The requirement for people to attend the chemist for medication plays a crucial role in overall monitoring of their health and progress."

- Strongly agree: 4% (n=1) NHS and 8% (n=1) third sector
- Agree: 42% (n=11) NHS and 25% (n=3) third sector
- Neither agree nor disagree: 35% (n=9) and 33% (n=4) third sector
- Disagree: 15% (n=4) NHS and 33% (n=4) third sector
- Strongly disagree: 4% (n=1) NHS and 0 third sector

For the remaining statements, there was more variation between NHS staff and third sector staff responses. In the following, NHS staff leaned slightly towards neutrality or disagreement, and third sector towards agreement:

"Buvidal is most appropriate for individuals who are committed to achieving abstinence."

- Strongly agree: 15% (n=4) NHS and 8% (n=1) third sector
- Agree: 15% (n=4) NHS and 67% (n=8) third sector
- Neither agree nor disagree: 15% (n=4) and 8% (n=1) third sector
- Disagree: 46% (n=12) NHS and 0 third sector
- Strongly disagree: 8% (n=2) NHS and 17% (n=2) third sector

In the following, NHS staff were more split in responses and third sector staff leaned slightly towards agreement:

"One of the key advantages of Buvidal is that it reduces the need for frequent or intensive support from healthcare services."

- Strongly agree: 15% (n=4) NHS and 8% (n=1) third sector
- Agree: 19% (n=5) NHS and 58% (n=7) third sector
- Neither agree nor disagree: 19% (n=5) NHS and 17% (n=2) third sector
- Disagree: 31% (n=8) NHS and 17% (n=2) third sector
- Strongly disagree: 15% (n=4) NHS and 0 third sector

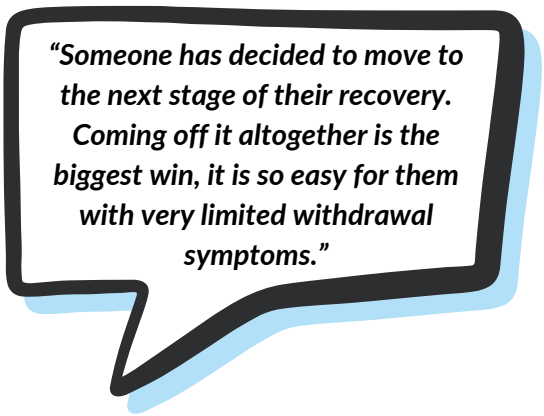
In the final statement, there was most discrepancy between NHS and third sector staff responses. Here, NHS leaned towards disagreement and third sector were more split, with a slight leaning towards agreement:

"Buvidal should be considered as a short-term treatment option, rather than a long-term solution."

- Strongly agree: 0 both
- Agree: 0 NHS and 50% (n=6) third sector
- Neither agree nor disagree: 15% (n=4) NHS and 8% (n=1) third sector
- Disagree: 58% (n=15) NHS and 33% (n=4) third sector
- Strongly disagree: 27% (n=7) NHS and 8% (n=1) third sector

"LAIB works best when..."

When asked when they think LAIB works best, seven NHS and four third sector staff said it was when the person was *"ready"/"motivated"/"committed"* to change or within their recovery. Three NHS staff said this is linked to being abstinent from all illicit drugs or opiates. Two of these staff also mentioned other support being provided, along with readiness. Two staff highlighted the person must be in the *"right place/state"* for this, with one stating this includes physically and mentally. Three other NHS staff suggested the person must be ready to engage with their treatment appointments and/or other support, such as psychological therapies and relapse prevention. It was mentioned about attending *"on time"* and *"regularly"*.



Four NHS and six third sector staff said LAIB works best when combined with other supports/services. Specific supports mentioned included psychosocial, general health and mental health, with staff commenting that it should be based on what the person needs and holistic/wraparound. Another NHS staff member said when someone is given other treatment options that are *"not pharmacological"*, along with them being well informed and given choices. Two other NHS staff said when preparation work is done well so the person knows what to expect. A third sector staff member also said the person must be informed and given *"realistic access"*.

Other responses given by one NHS staff member respectively were: when worker/prescriber allows time to speak with the person when administering treatment; when there is *"structure and openness"*; whenever it is the right treatment for an individual which can vary over time; and when it reduces their *"daily focus on drugs"* and contact with other people who use/dealers at the pharmacy.

DISCUSSION

Access

Timely and equitable access to all forms of MAT is a key component of the MAT Standards (Scottish Government, 2021). Participants reported mainly positive experiences of initial discussions but less consistency in terms of the information they received, especially regarding what to expect from treatment. The findings highlighted two routes through which individuals became aware of LAIB, by workers or via peers. Staff described various aspects to determine if someone was "ready" for LAIB, for example: levels of current drug use and "stability", desire for less clinical involvement, and being in the "right" physical and mental state. However, almost all staff felt readiness was shown simply when an individual showed an interest in the treatment. A majority of individuals in treatment reported feeling able to request LAIB with their worker, and nearly half of the participants noted that staff often initiated these discussions. These findings reflect much of the fundamental spirit of the MAT standards, that treatment should be driven by the individual, with staff offering choices and being open to explore options throughout the course of treatment (Scottish Government, 2021).

LAIB remains a relatively new treatment in Scotland, having been introduced in 2019 and adopted at varying rates across local areas. The latest National Mission report notes increased uptake of LAIB overall but also highlights ongoing geographical disparities (Scottish Government, 2025). Due to the newness of the treatment, the experiential evidence and available information resources around LAIB are more limited compared to other forms of MAT, such as methadone. This was reflected within this evaluation, where participants in the community and prison settings described a mixed picture in terms of how informed they felt when starting LAIB, and, where this information came from. The few individuals who started treatment 3-4 years ago felt especially limited in their understanding of LAIB.

Most participants got information about LAIB through conversations with workers, and some received written materials. However, the clarity and usefulness of these resources was inconsistent, with some people reporting never reading them due to their complexity. There are patient leaflets available from the pharmaceutical company who distributes LAIB in Scotland (CAMARUS, 2025), however the findings suggest these need to be adapted to be more accessible for people. Other participants sought out their own information from online sources and just over a third valued hearing experiences from their peers. Staff suggested there were more sources of information utilised than people accessing LAIB described, especially in terms of access to health professionals to discuss this with. Indeed, almost half of participants in treatment felt they would have wanted more initial information, especially relating to titration effects, possible side effects and generally what to expect. To ensure that prospective patients fully understand what to expect prior to commencing treatment, it is important that staff clearly communicate the treatment process to all individuals seeking to access LAIB. Existing mental health needs, along with any possible additional support needs that may occur with greater mental clarity experienced whilst accessing LAIB, highlighted a need for this to be a greater focus of treatment discussions. Whilst some local prescribing guidance suggest a level of caution may be required in prescribing for people with poor mental health or trauma without the right support in place (NHS Lothian, 2023; NHS Forth Valley, 2023), this theme was not consistently discussed in guidelines in all areas. Many people in treatment reported the communication they received did not adequately prepare them for what to expect. Two female participants expressed they would have benefited from gender-specific information, such as LAIB during pregnancy or the menopause. In line with these findings, the need for clearer, more accurate information on LAIB has been identified in other literature as a gap in service provision (Fish et al, 2025).

Suggestions were made that having formal peer support within services to offer information from people who

had been through the treatment themselves would be useful. A recent peer-led review of LAIB showed positive impacts of workers arranging phone calls between individuals and someone with experience of LAIB treatment at initial stages (Gwent Drug & Alcohol Service, 2025). Involving people with lived experience is widely recognised as beneficial for individuals in treatment and recent research also highlights its role in addressing broader issues such as substance use related stigma (Falconer & Tang, 2023). These ideas were reflected in accounts from the prison settings where some level of in-house peer support was provided and highly valued by people, for example, opportunities to discuss the treatment and its effects with peers. Overall, many participants felt that more comprehensive and accessible information in user-friendly formats, such as short videos, would have been useful to have been provided with at the outset. There are good practice examples of resources soon to be published from Europe that have been co-produced with people with lived and living experience and clinicians, these include peer-to-peer training, film and written information resources (UNITAID, Coact & PATH, 2025). As understanding of LAIB continues to evolve, ensuring everyone considering LAIB receives up-to-date and accessible information to support informed decision-making would meet MAT standard 2. Information provision can be supported by training for staff, so they feel confident in holding treatment discussions, including what to expect within LAIB treatment.

Most participants had transitioned to LAIB from methadone or other buprenorphine-based treatments. This suggests that LAIB may not always be seen as a first-line intervention and can often be positioned as a later-stage or "progression option". Staff perspectives reflected this, with staff frequently introducing LAIB in response to specific needs such as difficulties with daily pharmacy attendance or a desire for greater autonomy. These factors are also highlighted in the NICE (2019) evidence summary on long-acting buprenorphine, highlighting LAIB as a suitable option for individuals with a history of long-term MAT use or those seeking reduced contact with services. However, a small number were started on LAIB after not previously accessing another form of MAT (except for short titration on another form of buprenorphine).

Just under a third of NHS staff said they would only discuss LAIB when no other substances were being used and over half of third sector staff felt it was most appropriate for those seeking abstinence. This contrasts with findings from Fish et al. (2025), who caution against defining an "ideal LAIB patient", particularly when such framing centres on abstinence. They argue that this approach can distort outcome measures and limit accessibility by excluding individuals who may still benefit significantly from LAIB treatment. Additionally, the Scottish Intercollegiate Guidelines Network position statement (Healthcare Improvement Scotland & SIGN, 2022) notes that the flexibility offered by LAIB may be particularly beneficial for individuals with "highly complex lifestyles," by supporting greater treatment engagement and helping to reduce harm. However, it is possible those presenting with greater complexity may have increased vulnerability to the possible emotional impacts of increased mental clarity that LAIB can provide where they are without the appropriate support in place, for example, those with existing mental health issues or experience of trauma. Therefore widening access should be responsive to these aspects, accounting for individual needs, preferences, and client potential for attendance, with the necessary support offered to facilitate engagement and prepare them for treatment commencement. These contrasting perspectives highlight the need for a more person-centred approach when offering LAIB and ensuring people have access to the information they need to make more informed decisions as part of pre-treatment discussions. Staff having access to regular training to ensure they are aware of the guidelines is key for prescribing LAIB to the full range of people it is suitable for (Health Improvement Scotland, Right Decisions 2024). Opportunities for health boards to share emerging best practice in local LAIB guidelines could also support greater consistency in treatment provision.

Staff noted delays in initiating LAIB treatment, with same-day starts being rare or perceived as unfeasible. Scottish Medicines Consortium prescribing guidelines (2019) outline how to commence someone on treatment of LAIB from either another from of MAT or initiation via sublingual buprenorphine. From our findings, these delays were attributed to factors such as the need to taper existing medications or begin with another form of buprenorphine before transitioning to LAIB.

These challenges align with the initiation protocols and clinical guidance outlined by Healthcare Improvement Scotland (2022). It is important that unavoidable timeframes relating to clinical safety are explained to people, as being unable to start LAIB immediately is contradictory to what people will expect from treatment, laid out in MAT standard 1. Other reasons for delays often centred around staff/service capacity as, currently, NHS addiction services are the main or only place LAIB can be prescribed and usually only a small number of staff within each do this. Work is ongoing in some localities, and was referenced by staff in this evaluation, to broaden provision such as to primary care locations. Building on this existing work across Scotland would support more timely access to LAIB, including quicker transfers of people currently receiving MAT, ultimately easing pressures on current providers and bringing Scotland closer to fully implementing all MAT standards.

The findings showed that core clinical aspects of LAIB initiation, such as dosing, injection site rotation, and appointment frequency, were generally well-communicated. However, broader support needs were less consistently addressed according to participants. Topics like advocacy, welfare, harm reduction, and mental health support were not discussed consistently, despite being key elements of MAT standards 4 and 8. Staff responses reflected similar variability, noting that while key clinical components are prioritised, wider support discussions often depended on time, engagement, and perceived relevance. This suggests a need for more consistent and standardised approaches to early LAIB conversations, ensuring that all relevant areas are covered either at initiation or shortly thereafter. As Parkin, Neale, and Strang (2024) emphasise, early treatment discussions are critical in shaping long-term engagement and outcomes.

Choice

Experiences of choice within LAIB treatment were varied from people in treatment. Community-based participants reported some level of choice and flexibility, particularly in terms of dose. Stigma tied to methadone and it's association with regular pharmacy attendance seemed to be linked to people's preference for LAIB. Choice was more limited overall within the prison environment, especially regarding medication type.

Participants and staff mentioned a varied range of settings for LAIB delivery. The majority accessed their treatment through local drug and alcohol services, followed by specialist "drop-in" clinics. Some could access GP surgeries or pharmacies and a few were offered occasional outreach or home visits. Staff responses suggested more people could access these alternative settings than was reflected in the participant responses, with some highlighting these arrangements are typically reserved for exceptional circumstances, such as temporary immobility. This suggests that choice around where individuals receive their LAIB injection is often limited, with some inconsistency observed between and even within localities. Whilst this evaluation did not explore these factors in depth, the NICE evidence report (2019) offers some insight to aspects which may limit how widely LAIB is offered, such as treatment cost, staff training and infrastructure. As mentioned, staff highlighted ongoing and planned pilots in a few areas to expand provision in primary care and community settings, with the aim to increase prescribing capacity and flexibility for people to choose where they attend. Expanding the range of settings in which LAIB can be administered, including greater use of primary care, could enhance access, whilst also supporting broader implementation of MAT standard 7 and choice within treatment overall.

Many community-based participants felt involved in decisions about their dose adjustments. However, fewer reported being offered alternatives such as weekly administration (beyond the initial titration phase) or options such as involving family in their care. A couple of participants were not offered the choice of weekly prescribing but stated they would have liked continued access to this instead of switching to monthly. It is unclear why this was not offered to all participants but from Scottish Medical Consortium guidelines (2019), both weekly and monthly LAIB should be made equally available to those receiving treatment. This is reflected in local prescribing guidelines (NHS Lothian, 2023; NHS Dumfries & Galloway, 2025; NHS Forth Valley, 2023; NHS Highland, 2024). Healthcare professional information by the pharmaceutical company which distributes

LAIB in Scotland stipulate that treatment regimens should incorporate flexibility to permit transitions between weekly and monthly products, based on individual patient needs and the clinical judgement of the prescribing physician (CAMARUS, 2025). However, service and staff capacity issues may impact on ability to offer such flexibility or weekly administration past titration. In these findings, weekly LAIB was not widely adopted but some participants were interested in having it as an option. This suggests the need for greater treatment discussions about suitability of LAIB as a weekly option beyond the titration phase where that is wanted and is clinically possible, and ensuring people understand the benefits of weekly or monthly administration for their individual circumstances. It is essential that staff are well-informed and appropriately trained to offer this information during such treatment discussions.

Whilst some had flexibility in how often they engaged with support staff, others reported limited control and choice in this. Inconsistencies in the amount and nature of contact with workers when in LAIB treatment has been highlighted as a theme in other recent work and can affect engagement and levels of support (Parkin, Neale, & Strang, 2024; SDF, 2024). It is essential that individuals are consistently offered meaningful choices regarding treatment location, frequency of contact, and dosing arrangements throughout their LAIB experience, ensuring equitable and person-centred care in line with the MAT standards.

Focus group participants reported having limited choice in their MAT options within the prison setting. Many felt directed toward LAIB, with buprenorphine tablets or wafers unavailable to them as an option due to concerns about diversion of this medication. Concerns with buprenorphine diversion have been documented and cited as reason for promotion of LAIB in custodial settings (Scottish Government, 2021). Methadone was cited as the only alternative, though it was not considered a “real” option, due to the stigma tied to it and feelings it would not stop their illicit drug use. While LAIB was recognised for its practical advantages in custody, particularly during the Covid-19 period (Sayers & Mogford, 2025), participants commonly described the treatment as imposed rather than selected. A strong desire for autonomy emerged, with several individuals expressing a preference for buprenorphine tablets or wafers, which were seen to offer greater structure and personal control. Some noted they would opt for these forms of treatment once back in the community.

These findings highlight a tension between institutional priorities and individual choice within custodial MAT provision. The latest Public Health Scotland (2025) report emphasises the continued need for focused efforts within the justice settings to fully implement all ten MAT standards. Based on these findings, achieving MAT standard 2, ensuring individuals in custody have access to the same range of treatment options as those in the community, appears to be one of the most significant ongoing challenges. A flexible and person-centred approach that ensures genuine treatment choice is key to meeting diverse needs across both custody and community settings.

Similarly to those in the prison setting, participants in the community often compared LAIB to methadone. Methadone was described as restrictive due to often requiring frequent pharmacy visits and supervised consumption, both aspects seen as burdensome and stigmatising. Half of the participants reported feeling judged in pharmacy settings, a concern echoed in previous evaluation work by SDF (SDF, 2024). Two thirds stated they chose LAIB specifically to avoid regular pharmacy contact. Existing research suggests that reducing the need for frequent pharmacy visits can indeed lessen feelings of stigma and enhance overall treatment satisfaction (Larance et al, 2019), and this was reflected in the findings of this report. Participants associated LAIB with greater autonomy, fewer pharmacy obligations and generally had positive feedback associated with treatment, with some commenting that they wished they had been able to access LAIB earlier in their life. Participants spoke of the enhanced lifestyle flexibility on LAIB due to less pharmacy visits, often describing a sense of regained time and freedom to focus on personal goals such as working or spending more time with family. Staff responses reflected this, discussing reduced pharmacy contact, peer influence, and general flexibility as key drivers behind individuals’ interest in LAIB.

As reduced pharmacy attendance was a key motivator for choosing LAIB and led to an increased sense of well-being for most, questions about how similar levels of autonomy and flexibility could be better integrated into other forms of MAT should be raised. This should be explored across Scotland, with considerations given to things such as allowing take-home doses of methadone for more individuals, as was largely offered during Covid-19 (Scottish Government, 2022).

Participants also noted that LAIB was less widely recognised, which they felt contributed to a lower level of stigma associated with the treatment. As LAIB continues to be a more established form of MAT it will be important for staff and services to actively challenge stigma across all forms of MAT to ensure equitable, non-judgmental care for everyone in treatment. The Stigma Strategy (Drug Death Taskforce, 2022) emphasises the importance of sustained efforts to address stigma through peer-led initiatives, advocacy, and ongoing education.

Substance Use

Participants' experiences and patterns of substance use while on LAIB were mixed and shaped by individual factors. There was substantial variation in how much people were using, which substances they used and to what extent use had been impacted by their LAIB treatment.

Almost half of participants reported some form of substance use alongside LAIB and staff findings suggested they had similar rates reported by people they supported. Cannabis use was the most commonly reported, typically pre-dating LAIB and used to support sleep and relaxation. Some participants reported a reduction in overall substance use, largely due to decreased opiate cravings. LAIB is broadly linked to reduced use of other opiates, as supported by a growing evidence base (Neale, Parkin & Strang, 2023).

Other participants reported increased use of other substances after starting LAIB treatment. This was often a response to effects from reducing opiate use or physical and mental health issues such as insomnia, anxiety, and previously supressed emotional distress returning. Some participants explained that the root causes for their drug use were not being effectively addressed in their treatment and support, so therefore needed to continue or increase illicit "topping up". This led to some using crack cocaine, gabapentinoids, or illicit benzodiazepines to cope, themes found in other recent work (Strike, D'Angelo-Kemp & Searby, 2023). A few individuals initiated riskier behaviours, including injecting drugs for the first time. Peer influence and changes to treatment, such as the discontinuation of other prescribed medication, contributed to shifts in substance use for some too. These findings highlight the individual nature of why people use substances and the importance of staff and services fully exploring the reasons for using on top of MAT and providing the necessary support for this. Whist LAIB was effective for reducing use of illicit opiates, the medication alone did not address fundamental reasons for individuals using substances.

Most participants were comfortable discussing their ongoing substance use with workers, often citing open, non-judgemental relationships that enabled honesty without fear of repercussions. However, while many appreciated supportive responses such as referrals, check-ins, or simply being listened to, others felt their disclosures led to limited or no meaningful follow-up and support. Some noted a lack of support for substances like crack cocaine where it was felt there was no response or thorough support provided. A few participants commented they felt workers did not know how to support with their particular substance use. A few reported feeling judged or hesitant to disclose due to concerns about stigma, particularly related to parenting roles. Overall, the quality and effectiveness of support varied, highlighting the importance of consistency in worker-client relationships and the need to address gaps in support around other substances being used such as crack and/or powder cocaine.

Participants reported access to a range of harm reduction interventions, including foil, injecting equipment, BBV testing, and naloxone provision. These could vary in how consistently they were offered or provided. Given the rise in new substances such as synthetic opioids (RADAR, 2025), it is essential that naloxone continues to be widely offered and that people are informed about the potential interactions with LAIB of these emerging substances. As LAIB is long acting, buprenorphine can re-attach to opioid receptors in an overdose. This means that more naloxone may be needed to work effectively and hospital observation is particularly advised to ensure opioids have cleared the system. Services and people using these treatments should be aware of this and follow advice for repeat doses of naloxone if breathing is not improving after 2-3 minutes, ensuring they always call an ambulance. Routine drug checking in services would also help to reduce harm for individuals using illicit substances. A recent evaluation by SDF of a pilot of nitazene testing strips showed testing can be a beneficial intervention for overall engagement as well as reducing risk (SDF, 2025).

Many participants said they would use safe inhalation pipes if available, and staff were also supportive of these as an intervention. The ongoing pilot Safe Inhalation Pipe Provision (SIPP) study (Harris et al, 2024) and initial emerging findings from this and other peer work (Coact, 2025) demonstrate the value of safer inhalation equipment as an essential harm reduction intervention. Other work has already been completed on the issuing of safer inhalation pipes and how this has supported in decreased harm and health related issues for those using crack cocaine (Prangnell et al, 2017).

A few staff highlighted a desire to offer earlier psychological interventions or more advanced physical health care, such as antibiotics and in-depth wound management. Limited availability of psychosocial interventions was also noted by people in LAIB treatment and particularly reported by people using cocaine/crack who felt these supports were crucial, in the absence of other treatment options for stimulant use. Existing harm reduction and intervention resources such as the Cocaine Toolkit (MAT SPMG, 2022) could be better utilised and adopted across Scotland to respond to the increase in cocaine use amongst LAIB people. Staff training to ensure staff are competent and confident to deliver interventions for stimulants may be required to successfully adopt use of such resources. To fully support individuals in line with MAT standard 4, it is important to consistently provide all available harm reduction interventions and prioritise the inclusion of safer inhalation pipes for this population.

Gendered differences in terms of substance use and subsequent support emerged in the findings. A higher proportion of male participants than females reported using substances on top of their treatment. A few females felt they were at more risk of judgement and stigma than men when they do disclose use to workers. These findings align with a large body of evidence which shows women experience higher levels of stigma related to their drug use in general, such as due to their role as a caregiver (European Union Drugs Agency, 2023). Other work has shown this fear of stigma can prevent women from disclosing their drug use or indeed accessing support at all (Brener, et al, 2024).

Differences in harm reduction provision were also observed between men and women in this evaluation. There is some evidence showing little to no differences in rates of specific harm reduction interventions, such as naloxone provision, between males and females (Tweed, et al, 2020). However, other evidence shows women and other marginalised genders do face significant barriers to harm reduction provision overall (Wolfson, et al, 2021). It is unclear why harm reduction was offered less to women in this sample, whether this was due to reduced substance use or whether they were less inclined to disclose illicit use. Further work is needed to examine the possible gender differences in substance use when in LAIB treatment specifically.

In Scotland, the gap between genders in terms of drug-related deaths has been narrowing in recent years (National Records of Scotland, 2024). This, paired with women being less likely to disclose and be offered harm reduction, suggests harms for women must be addressed.

Understanding and responding to women's substance use, such as with gender-focused interventions and spaces, is important for those in treatment and in general. Indeed, the European Harm Reduction Network (2024) illustrates the need for such services and to have gender-informed approaches embedded in harm reduction strategies. There is some work already ongoing in Scotland in line with this, such as development of good practice guidelines for supporting women who use substances in pregnancy and the early years (Supporting Women, Reducing Harm Working Group, 2025) and some targeted approaches in third sector settings, including a Women's Hub (Simon Community Scotland, 2025). Other good practice examples from the UK pertaining to harm reduction advice, provision and equipment for women include Woman to Woman- gender specific advice on injecting- (Hi-ground, 2021) and Mother 2 Mother- a collection of equipment, creative materials and online resources for women developed by Drug User Activist Anna Millington (Exchange Supplies, 2025); these services are designed and delivered by women with lived and living experience. It is important women feel safe to disclose their substance use and are offered effective, inclusive harm reduction tailored to their needs.

Support

Participants reported varied levels of support while on LAIB, for example approximately one third had contact only at their monthly injection appointments and another third had separate appointments with their worker, distinct from their injection. Whilst some people valued flexibility and autonomy, others emphasised the need for more consistent access to keyworkers and proactive communication between appointments, such as texts from their worker to "check-in". These findings are consistent with SDF's previous national evaluation of the MAT standards whereby level of contact with workers could vary within and between areas (SDF, 2024).

Experiences with LAIB compared to other types of MAT people had accessed varied, in terms of frequency and nature of contact. Some felt support was consistent across treatments, while others appreciated LAIB's predictable monthly contact, which offered more structured engagement than previous, often fragmented care. Many valued the flexibility LAIB provided, allowing them to seek help on their own terms, which supported autonomy and control. However, some were unclear about available support and felt it was their responsibility to initiate contact, which was difficult especially if they were unsure of their needs. Whilst some welcomed LAIB's minimal contact, others desired more frequent, structured support.

Staff perspectives in this evaluation reflected these variations further, although several staff highlighted the importance of structured engagement and the opportunity to speak with a worker during treatment administration. NHS staff commonly reported monthly contact for injection, with additional support provided depending on individual need and stability. Some were only involved at review points, while others noted the option for more frequent or flexible contact, including telephone check-ins. Third sector staff described more adaptable engagement models, often offering weekly or fortnightly support and tailoring contact based on service user preference. In some cases, participants benefited from coordinated support through joint meetings between NHS and third sector providers, an approach viewed as a valuable means of enhancing care. The importance of such collaborative, person-centred working was strongly emphasised in the final Drug Death Taskforce report (2022), which advises coordinated multi-agency collaboration and holistic care that can meet the multifaceted needs of those accessing services.

Continuity of workers and strong therapeutic relationships with workers were crucial to people feeling understood and supported throughout their treatment. These ideas are broadly recognised as key features of trauma-informed treatment (Scottish Government, 2022). In this evaluation, relationships with workers were more likely to be viewed positively when there was a consistent keyworker or small group of regular workers involved in someone's treatment. Within custodial settings, participants generally described positive experiences with prison addiction nurses. Timely access, the ability to bypass hall staff when seeking support, and strong relationships with a small number of consistent staff were all identified as facilitators of effective

care and valued support. The smaller teams and lower caseloads were seen to enhance responsiveness and foster trust, contributing to more personalised treatment management and support for participants from focus groups.

Overall, these findings highlight the need for balance between structured and flexible support in LAIB treatment and this should be participant led, regardless of setting. This idea is outlined in the MAT standards, where it states services should provide: "models of support that are flexible and offer different care packages that range from low intensity for people not requiring or wanting more involvement, to intensive recovery focused packages for others" (Scottish Government, 2021). It is important this is implemented consistently and for all forms of MAT, not just LAIB. As recommended in previous work (SDF, 2024) it is important for staff to engage in regular, collaborative discussions with individuals to explore their support preferences and broader care needs. Time to build meaningful relationships between workers and people accessing treatment is key to this, regardless of type of MAT. The differing preferences of individuals in treatment emphasises the importance of tailoring contact and support to individual needs and revisiting these regularly to ensure treatment remains appropriate, effective, and responsive over time.

In general, participants felt they received the same or slightly more support for some additional things such as general mental health and referrals to third sector organisations while on LAIB, compared to previous MAT experiences. Staff frequently reported providing or referring individuals to a range of supports including harm reduction services, psychosocial interventions, specialist mental health care, counselling, peer mentoring, and practical assistance with housing and welfare. This suggests active implementation of various MAT standards, such as 6 and 8, is taking place. It should be noted, however, most participants were unsure what level of support they were offered for things like advocacy and welfare support. This suggests these services are perhaps not fully or consistently understood by individuals, with possibilities for staff to offer more robust information about them in order to truly achieve full implementation of the standards, providing holistic person-centred care.

In some cases, extra support participants received was not always attributed to LAIB specifically; some linked this to other factors such as criminal justice involvement. Recovery-focused options like mutual aid and group programmes were particularly prominent in third sector settings. Some participants described being connected to other complementary services, such as women-specific support groups, recovery cafes and recovery skills courses. These services were credited with improving mental wellbeing, reducing isolation, and strengthening recovery networks. Staff generally felt that LAIB treatment is most effective when it is delivered as part of a holistic, wraparound approach, tailored to individual needs. Recent work (Fish et al, 2025) shows these factors are indeed central to how individuals evaluate the success and effectiveness of support received during LAIB treatment. Services and staff should consistently offer and actively promote all related support options to people as part of their treatment package, as our findings demonstrate the clear benefits experienced by participants.

Concerns about side effects were commonly raised by participants in both the community and prison settings, with many stating they had not been informed sufficiently or at all about these or how to manage them if they arose. Staff, however, reported that discussions about side effects were a routine part of service engagement. This highlights a disconnect between staff perceptions and people's experiences of communication and how informed they felt about LAIB treatment. Addressing this gap is essential to ensure ethically sound care that aligns with the principles of person-centred and collaborative treatment.

Participants described a range of unwanted effects, during titration or on an ongoing basis, including: sleep disruption, weight loss, nausea, anxiety, low mood, and injection site issues like bruising or lumps. Many of these have also been noted in other research on LAIB, such as Bozinoff, et al (2022) and Neale, Parkin & Strang (2023).

Whilst some participants found these symptoms eased after dose adjustments, others felt unprepared or unsupported, which in some cases contributed to additional substance use. For those who experienced more greater severity of unwanted impacts or side effects that lasted beyond the titration phase, it highlighted the need for thorough discussion on existing health needs and whether LAIB was the most suitable treatment for their needs. Managing these effects was particularly challenging in custodial settings, where limited distraction often amplified emotional distress. Several participants also felt their concerns (especially around mental health) were minimised or dismissed. This left them feeling unsupported and, at times, unsafe due to increased illicit use and extreme physical reactions.

One notable experience highlighted by many participants accessing LAIB was the increased psychological clarity sometimes resulting in difficult memories and associated feelings returning, something almost all participants stated they had not encountered with other forms of MAT. This change in clarity was often described as unexpected and intense, emphasising the importance of staff and services fully preparing individuals for the potential psychological impact of facing a return of emotions after prolonged suppression of these. These ideas are reflected in the recent Welsh evaluation of LAIB provision, whereby only one of 94 respondents had been told to expect their emotions returning (GDAS, 2025). However, many participants in that work experienced this effect and it was particularly difficult for those with pre-existing mental health issues and past trauma. Ensuring people receive clear and comprehensive information about both the potential benefits and side effects of LAIB is essential for setting realistic expectations and reducing anxiety around treatment, a point put forward in recent work by Neale, Parkin & Strang (2025). For people to identify if LAIB is right for them, it is important people receive support to differentiate between longer-term side effects compared to the likely titration effects to the optimal dose for them, or in some occasions, the possible dose related effects that can be seen at higher doses which may mimic some opioid withdrawal effects. In such cases it may be that a dose reduction is appropriate to try to see if that alleviates the symptoms (Jain et al, 2024).

Experiences of support in response to this increased clarity and for general mental health varied across participants. Several individuals reported increased access to specialist mental health services while on LAIB as a result of workers being responsive to concerns around their mental health. Access to supports like CBT and psychology was noted as a valuable resource but was this was reported by less than half of participants. Others highlighted persistent gaps in mental health support, citing long wait times and inconsistent access to the care needed to manage both their mental health and the resurfacing of difficult memories. Mental health support as a whole has recently been highlighted as a “the most prominent unmet need” across people accessing support in drug and alcohol services in the most recent Public Health Scotland report on the MAT standard implementation (2025). This suggests more work is needed to improve equity and consistency of provision for all people accessing treatment, in order to fully meet MAT standard 9.

The need for support around stopping or reducing LAIB was identified as an important aspect of care by participants and has been highlighted in previous work (Gendera et al, 2025). NHS staff noted the most common reason for reducing was a person’s desire to come off MAT entirely. Staff reported offering various forms of support to facilitate this process, including care plan reviews, future planning, and discussions about the tapering process and its potential impacts. Whilst most participants in this sample were not reducing their LAIB, those who were reported mixed experiences. Some had received flexible and proactive support as illustrated by staff responses, including care plan reviews and access to psychosocial or third-sector services. Others described limited or no support, pointing to inconsistency in practice and uncertainty about the process of full discontinuation. Concerns around relapse, lack of follow-up, and the absence of peer or lived-experience support were highlighted as key gaps in current provision and suggested as ones that could be strengthened. Experiences with care/recovery plans were mixed, while some participants described collaboratively developed plans, others were unaware of such plans or were unclear if one existed.

This highlights inconsistencies in how recovery planning is introduced and carried out across services. These findings are echoed in other experiential literature which highlights significant gaps in knowledge about what care plans are and whether they are in place (SURIA, 2024). Neale, Parkin, and Strang (2023) emphasise the value of actively involving people in their own care planning and reviews—an approach linked to greater treatment satisfaction. Supporting this level of engagement is essential for enabling safe, person-led transitions in and out of LAIB treatment, in line with MAT standard 5.

Impact of LAIB

Participants generally described LAIB treatment and support as positive and noted a variety of short term and longer term impacts as a result of accessing this treatment. In the shorter term, LAIB was seen as having a stabilising and empowering effect on participants with some noting a rapid reduction in cravings and improved emotional balance compared to other MAT options. For some, this marked the first time they had maintained abstinence in years. This stability fostered a sense of normality, motivation, and greater engagement with recovery goals. Longer term and more practical benefits were also described, such as increased freedom, more flexible life routines, and improved capacity to work. These benefits have been recorded in other work (Neale, Parkin and Strang, 2023). Altogether, these findings from participants suggest that LAIB is seen not only as a clinical intervention but also as a facilitator of personal recovery and improved quality of life.

However, not all experiences with LAIB were positive. As previously noted, some participants reported side effects that, in a few cases, contributed to continued or resumed substance use. A small number preferred to return to other forms of MAT due to these difficulties. It was not always clear if these unwanted effects were true side effects experienced over the longer term or whether they could be attributed to dose finding during the titration phase, or, in some occasions where people were on a maximum dose, a dose related effect. A higher dose of LAIB has potential to lead to higher 'side effect burden' as noted in recent work (Jain, Meeks & Blazes, 2024). These experiences point to the need for careful monitoring of individuals who may be struggling with side effects, as well as clear, supported pathways for transitioning away from LAIB when appropriate. They also reinforce the importance of having open, ongoing conversations about potential side effects, dose or titration related effects before and during treatment, ensuring that people are fully informed and that LAIB remains a suitable and manageable option.

As with potential side effects, the experience of increased mental clarity while on LAIB should be openly discussed with anyone considering this treatment. These conversations can help individuals prepare in advance and reduce the risk of experiencing emotional responses that are unexpected, such as feelings triggered by resurfacing of difficult memories. In this evaluation, LAIB's impact on mental health was distinct, many participants reported a sense of increased mental clarity and heightened emotional awareness. This was sometimes welcomed, when access to specialist supports were available and promptly accessible. For some individuals, the increased mental clarity brought on by LAIB could feel overwhelming, particularly in the absence of adequate support. This underscores the importance of ensuring mental health and psychosocial support are in place from the very start of LAIB treatments which aligns with MAT standards 6 and 9. Ensuring clearer communication and timely referrals for appropriate support aligns with the principles of the National Collaborative Charter of Human Rights (2024), which states that everyone accessing substance use services is entitled to the highest possible standard of physical and mental health.

Reduced stigma emerged as a strong theme across participant accounts, particularly in comparison to methadone. The lower visibility of LAIB and especially the absence of daily pharmacy visits, was seen as key to this shift, making participants feel more comfortable being and staying in treatment.

This perceived legitimacy also positively influenced some family relationships, with a few noting that LAIB signalled meaningful recovery and even restored pride among loved ones, experiences not felt with other MAT options. Several also reported improved family relationships, viewing LAIB as a visible marker of progress. Similar wider impacts of LAIB have been highlighted in recent work (Martin, 2025). In some cases, this led to major life changes, such as regaining contact with children, which participants felt would have been unlikely under previous MAT options.

All participants said they would recommend LAIB to others, even when their own experiences were mixed. The unanimous willingness to recommend it highlights a general belief in its value and impact as a treatment option. However, the emphasis by some on the need for adequate wraparound support, particularly for mental health, underscores that LAIB alone is not enough for everyone, nor might be the right choice for everyone. For LAIB to succeed as a person-centred intervention, it must be delivered within a system that prioritises holistic, responsive care.

LIMITATIONS

While efforts were made to promote the evaluation widely across multiple sites and peer networks to maximise participation, the evaluation sample may not be fully representative of all people accessing LAIB treatment at a national level. In some geographical areas, recruitment relied heavily on a small number of staff engaging with the people they supported for participant recruitment. Overall, the evaluation was designed to generate insights into a range of individual experiences with LAIB, which was successfully achieved.

The evaluation was promoted equally across all localities in health board areas for both the people in treatment and the staff participant sample. We were able to achieve representation across most localities, however there was occasional issues with successful recruitment which led to completed surveys or interviews. This was partly mitigated by targeting recruitment to under represented areas in the latter stages of the evaluation.

A limitation of the prison focus groups was that all participants were convicted individuals and all were male, with no representation from those on remand or women. Targeted evaluation work in prison which widens this sample out to both people on remand and women would provide deeper insight into a fuller range of experiences of people living in prison and the potential gendered differences.

CONCLUSION

The rollout of LAIB within Scotland's treatment and support response has shown promising outcomes, including: greater stability, enhanced autonomy and improved quality of life for many individuals. However, gaps in access, choice and support remain, with particular challenges within custodial settings. Information provision emerged as a priority area for development, with a need to have much greater emphasis on pre-treatment discussions to adequately prepare people for starting or transitioning to LAIB. There was an evident need to have a wider range of support for substance use which occurred alongside LAIB, this included widening harm reduction provision, offering tailored interventions for non-opiate drugs and greater support for women.

To maximise the impact of LAIB, services need to ensure equitable access and choice. This can be achieved by expanding prescribing flexibility and consistently offering clear, accessible information ideally through peer education and support interventions so that people can make truly informed choices about their treatment. Psychosocial support and access to more intensive mental health interventions must be prioritised, particularly for people who may be vulnerable to difficulties in coping emotionally with the increased mental clarity that LAIB provides. There was a clear demand for levels of engagement with services to be led by people in treatment, with many participants noting a desire to have an option for greater contact between appointments if, and when, they needed.

Whilst LAIB was widely recommended by participants and seen as a valuable treatment by staff, the findings outline its effectiveness depends on how it is delivered and supported by services throughout the individual's treatment journey.

RECOMMENDATIONS

Access

Information: Everyone should be offered consistent access to high quality and accessible information on LAIB prior to considering commencement of the treatment and at key transition points e.g. reducing or stopping. To achieve this it is recommended that:

- **Information about LAIB is reviewed and updated regularly as new evidence from research and experiential feedback emerges.**
- **LAIB resources give particular attention to fully exploring treatment expectations and explaining the initiation process and decreasing/stopping LAIB. This should include titration or dose-related effects, possible longer term side effects and the potential emotional impact of mental clarity for some.**
- **Information resources are co-produced with those with lived and living experience and should be made available in a variety of formats including audio, visual and written materials, to ensure accessibility for individuals who may experience literacy barriers or disabilities.**

Peer education and support: Services should expand existing living or lived experience roles within services to formally include peer education about LAIB to support informed decision-making. To achieve this is recommended that:

- **Peer-to-peer experiences are shared during early treatment discussions and peer support continued throughout treatment and beyond to aftercare.**
- **Peer education and support to commence LAIB treatment is made consistently available in both community and custodial settings.**

Prescribing: Regional disparities in access should be addressed by sharing best practices and ensuring equitable resource allocation, therefore supporting areas to scale up provision and provide more consistent access across all localities and for all people whom LAIB is appropriate for. To achieve wider access, it is recommended that:

- **LAIB treatment guidelines are shared across health boards to identify good practice recommendations that have been implemented elsewhere to encourage greater consistency. Local guidelines should also be supported by regular opportunities for staff training, which incorporate areas for consideration in person centred care e.g. levels of client presentation complexity and psychological safety for treatment.**

- **Prescribing is expanded beyond NHS addiction services by including primary care and other community health providers. This will help reduce waiting times and expand access, particularly in areas facing geographical or capacity-related barriers.**

- **Services communicate any necessary delays to initiation to people in treatment, fully explaining the clinical reasons and providing a clear plan/timeline for commencement.**

Choice

Choice within treatment: All individuals - whether in the community or custody - should have access to a full range of MAT options. To achieve this it is recommended that:

- **All forms of buprenorphine are made more widely available including LAIB, tablets and wafers. Where there are particular barriers to offering specific forms e.g. in custodial settings, institutional risk should be balanced with the person's right to choice and appropriate alternatives should be made available, avoiding imposing specific treatments on individuals.**

- **Shared decision making between people and prescribers is embedded in to routine treatment and support to enable collaborative decisions around the suitable forms of MAT for that individual, including dose and frequency of dose from treatment providers. Patients should be provided with clear information about all forms of MAT to enable them to make informed choices around this.**

- **There is continuity of LAIB between community and custodial settings via shared care plans which follow the individual rather than being tied to the institution for all individuals who are leaving/entering custody.**

Treatment delivery: LAIB delivery should be expanded across a broader range of treatment settings to allow more equitable access. To achieve this it is recommended that:

- **There is adequate investment allocated to traditional treatment and primary care settings to allow for the necessary multi-agency collaboration and staff training to expand LAIB delivery options.**

- **Options to attend for LAIB injections are widened to include GP surgeries, pharmacies, outreach settings and home visits.**

Stigma: Stigma surrounding other forms of MAT should be addressed to avoid treatment preferences being impacted by misinformation. To achieve this it is recommended:

- **People in treatment are given accurate and current information about all forms of MAT so they are informed of the evidence base and are aware of any potential benefits/contraindications of any form of MAT for their individual circumstances.**

- **Information should be made available in a variety of different formats with inclusion of lived and living experience insights to support understanding of the evidence that de-stigmatises all treatments. There are good practice examples from Europe soon to be published which may be able to be adapted for use in Scotland (UNITAID, 2025).**

Substance use

Harm reduction: Tailored harm reduction advice and equipment (including safer inhalation pipes and drug checking services) should be offered routinely in line with MAT standard 4 to reduce risk of overdose and other risks. To achieve this it is recommended that:

- **Safer inhalation pipes are piloted given crack use was regularly reported amongst people in LAIB treatment and they highlighted this would be an intervention they would like to see provided; a view also supported by staff. Services should also continue to provide consistent access to foil and safer injecting equipment.**

- **Services provide drug information resources that cover potential risks of poly substance use with LAIB and that incorporate information on the current threats of emerging drug trends such as synthetic opioids which may be less familiar to people who have been in MAT for some time.**

- **Naloxone continues to be widely promoted to people who receive LAIB with particular guidance around use with buprenorphine (i.e. may require repeat doses and of greater importance to attend hospital for monitoring due to the long acting nature of buprenorphine).**

- **Staff promote available options for drug checking services to raise awareness of unintended substances or contaminated batches being consumed by people in LAIB treatment.**

Person-centred support: Support offered for substance use should be person-centred, taking account of gendered issues and specific patterns of use. To achieve this it is recommended that:

- **The provision of women-focused resources and women-only spaces are increased to meet the particular treatment needs and preferences of women and reduce the gendered stigma that women can experience. Good practice examples include the Mother to Mother Resources created by drug user activist Anna Millington and The Simon Community women's centre.**
- **Tailored interventions are offered consistently for people using non-opiate drugs on top of LAIB, making use of already existing resources such as the Cocaine toolkit (NHS GGC, 2022)**
- **Staff receive the necessary training to feel confident in offering appropriate interventions for non-opiate users and to ensure they can meet the needs of women using services.**

Support

Person-centred support: Support alongside LAIB delivery should be tailored to the individual, balancing the flexibility that LAIB can provide with more structured and regular supports where needed and wanted. To achieve this, it is recommended that:

- **Greater levels of monitoring and contact is offered especially during transitions e.g. starting, reducing or stopping LAIB or during potential emotionally triggering periods. This could involve options for greater contact between appointments (e.g. check-in texts or calls), especially for those with minimal face-to-face contact or specific supports that respond to unwanted effects such as sleep disturbances or low mood.**
- **Levels of contact should be person-led with options for lower intensity check ins in combination with LAIB administration appointment to more structured and recovery focused care based on individual needs and preferences.**
- **Continuity of workers is prioritised wherever possible to ensure consistent care throughout LAIB treatment in line with trauma-informed care principles.**

Mental health and psychosocial support: There is an evident need to improve access to mental health and psychosocial supports, ensuring there is consistency and equity around what people can access across all localities and settings. To achieve this, it is recommended that:

- **Services embed psychological supports earlier in treatment journeys and improve access at referral points to respond to the potential impacts of increased emotional clarity when starting LAIB. This should include preparatory pre-treatment discussions and provision of easy-read information resources to inform people of what to expect. Access to support such as one-to-one support, talking therapies and CBT with options to access trauma-focused therapies or psychology is also essential to meet the needs of people with more complex mental health or trauma histories.**

- **Custodial settings should offer tailored supports due to the risks of exacerbation of emotional symptoms within the prison environment. This should include development of recovery-focused supports, such as Hubs, opportunities for peer support as well as provision of specialist mental health input as required.**

- **Services continue to routinely promote and facilitate access to wraparound supports, such as recovery cafes, peer support, mutual aid and wellbeing activities.**

Care planning and coordination: Coordinated care led by collaborative care plans should be a key part of holistic care in LAIB treatment. To achieve this, it is recommended that:

- **Services facilitate regular joint care planning and case discussion meetings between NHS and third sector providers.**

- **Care/recovery plans are created collaboratively with people in LAIB treatment and all care planning discussions should include options for longer term planning such as LAIB reduction and cessation.**

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