SCOTTISH DRUGS FORUM

EVALUATION OF LONG ACTING INJECTABLE BUPRENORPHINE PROVISION ACROSS SCOTLAND

EXECUTIVE SUMMARY

AUGUST 2025

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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. Further information and resources on the standards can be found at the SDF website: www.matstandards.co.uk.

BACKGROUND

As Scotland continues its implementation of the Medication Assisted Treatment (MAT) standards, the use of long-acting injectable buprenorphine (LAIB) has grown steadily, with 23% of people in MAT prescribed it in 2024 (Public Health Scotland, 2025)*. Despite this, limited evidence exists on how LAIB is experienced by service users and frontline staff.

To follow on from SDF's previous work about implementation of the MAT standards, this evaluation explored lived experiences of receiving and providing LAIB, to better understand what supports and what hinders provision and how LAIB impacts individuals.

AIMS

The aim of this work was to explore experiences of accessing and providing LAIB treatment and support across four health boards: Lothians, Forth Valley, Dumfries & Galloway and Highland. To achieve this, we explored:

- Individual experiences of starting LAIB, receiving treatment and reducing or stopping LAIB in community settings.
- What support is offered or provided alongside LAIB, such as mental health, psychosocial interventions and therapeutic 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 they offer.
- Participant experiences of LAIB within custodial settings.

METHODS & DEMOGRAPHICS

SDF peer researchers with lived and living experience conducted interviews with 46 people accessing LAIB in the community from across the four health boards. Approximately half (52%, n=24) were male and the other half were female (48%, n=22). Participants reported the length of time accessing LAIB treatment, ranging from less than three months to over two years.

A further nine prison residents shared their experience of LAIB in custodial and community settings, over three focus groups held at HMP Inverness and HMP Dumfries & Galloway; all nine participants were male. Eight of these were currently prescribed LAIB and one was currently prescribed Espranor but had previously received LAIB.

53 staff completed online surveys about their experiences of supporting individuals on LAIB, which included 39 NHS staff and 14 working in third sector or voluntary services.

*Public Health Scotland (2025) *National benchmarking report on the implementation of the medication assisted treatment (MAT) standards: Scotland 2024/25*. Public Health Scotland. Available at: https://publichealthscotland.scot/media/33682/final-v12-2024-25-benchmarking-report-on-mat-standard-updated-070725.pdf [Accessed 28/07/2025].

PEOPLE IN TREATMENT FINDINGS

Access

- **Initial engagement:** Most people heard about LAIB through peers (48%, n=21) or NHS workers (45%, n=20). Over half (53%, n=24) requested LAIB themselves. Before starting, 46% (n=21) were receiving methadone, 24% (n=11) buprenorphine tablets, 11% (n=5) Espranor, and 19% (n=9) had not been on any form of MAT. During initial appointments most participants discussed their levels of current drug use (87%, n=40), the service drug screening protocol (83%, n=38), daily routine and their motivations for using substances (74%, n=34) and two thirds discussed their mental health (67%, n=31), although 10 of these felt this was not talked about in enough depth.
- **Information & expectations:** Information about LAIB treatment came mainly from discussions with workers (69%, n=32) and provision of leaflets (65%, n=30). Over a third (37%, n=17) got information from their peers and 17% (n=8) did independent research online. 11% (n=5) were given little to no information, especially on potential side effects and short and long-term impacts. After the initial appointment, 61% (n=28) felt informed, but 39% (n=18) wanted more information at an earlier stage. Suggestions to improve information provided included more time to ask questions, gender-specific information and more accessible resources, such as videos.
- **Starting treatment:** Over half (59%, n=27) started LAIB within 6 days, but 22% (n=10) waited over two weeks, mostly due to tapering previous MAT or personal medical reasons, such as childbirth or surgery. At the first appointment the most commonly discussed aspects of LAIB treatment were: starting dose (96%, n=44), injection process (87%, n=40), and injection frequency (76%, n=35). Mental health support was offered to 62% (n=28), psychosocial support to 45% (n=20), and welfare/benefits support to 23% (n=10). Naloxone was offered to 56% (n=25), BBV testing to 44% (n=20) and safer drug use advice was given to 25% (n=11). Four people were offered advocacy support but half (49%, n=21) had never heard of this.

Choice

- **Injection administration:** Close to three quarters (72%, n=33) had no choice of where to attend for their injection and 22% (n=10) did. Three quarters attended local NHS services (74%, n=34), and some went to specialist clinics (15%, n=7), pharmacy (n=3), GP (n=2) or local hospital (n=1). Four people reported they could have their injection at home. 84% (n=38) had no choice of who administered their injection. 48% (n=22) had their regular worker do this and 30% (n=14) saw familiar but varying staff.
- **Dose changes:** The majority (85%, n=39) had a named worker to discuss their dose with. Three saw duty workers or were unsure who to speak to. Almost all people had choices around their dose, 93% (n=43) had dose increases offered, 85% (n=39) decreases, and 84% (n=38) had access to top-up doses. 13% (n=6) had never been offered top-ups.
- **Appointments:** Everyone was seen monthly for their injections but 28% (n=13) were also offered weekly support appointments. 67% (n=31) had some choice in frequency of contact beyond their injection appointments and 22% (n=10) did not. Choice to involve family or friends was split, 46% (n=21) were offered it, 46% (n=21) were not, and three would have liked this option.
- **Motivations for choosing LAIB:** The majority (68%, n=28) suggested being able to avoid pharmacy visits as the main reason to choose LAIB. Pharmacy visits were seen as restrictive by 24% (n=11), as they limited travel and work. Amongst the 41 participants who answered questions about pharmacy experiences, 71% (n=29) disliked the routine it required, 61% (n=25) felt stigmatised there, 49% (n=20) were neutral on the usefulness of support provided, and 29% (n=12) found pharmacists helpful. Other reasons for wanting LAIB included freedom from daily supervision, wanting more privacy not afforded by public consumption of MAT in a pharmacy, distancing from old peer groups, hearing of positive LAIB experiences from peers and four mentioned a desire to stop taking methadone.

Substance use

- **Patterns of use:** Nearly half (47%, n=21) used other substances on top of LAIB, with double the amount of men (67%, n=14) reporting this than women (33%, n=7). Cannabis was the most commonly used (n=10), often daily and used for sleep and/or anxiety. Eight people used crack cocaine, use varied from occasional to daily. Substance use was linked to managing mental health, receiving money on paydays, peer use within their social circles, or, to cope with unwanted effects of LAIB. Other substances reported were powder cocaine (n=4), alcohol (n=3), benzodiazepines (n=2), pregabalin (n=2), heroin (n=1) and gabapentin (n=1).
- **Changes since LAIB:** Over half (52%, n=11) had reduced or stopped using opiates since starting LAIB. 40% (n=8) had increased their overall substance use, often moving to other substances to manage sleep, mental health or other titration/ongoing side effects. It was common for people to feel their head was "clearer" on LAIB and for some this could make existing emotional issues more visible, leading to increased substance use. Some people mentioned LAIB was not enough to tackle the root causes of why they were using substances and only reduced the need for opiates. Over a third (35%, n=7) used fewer substances overall, with reduced cannabis and/or alcohol use specifically mentioned. A quarter (25%, n=5) changed the substances they used, including new crack cocaine or illicit benzodiazepine use and one person started injecting for the first time. Some felt in control of their substance use but others felt guilt or shame over their ongoing use.
- **Support & discussion with workers:** Most who were using substances (62%, n=13) felt comfortable disclosing this to their worker(s), especially when their relationships were strong and staff were non-judgemental. Men were slightly more likely to be comfortable discussing their substance use than women were (65%, n=9 of men compared to 57%, n=4 women). Three people feared judgement about their use, especially linked to their gender and/or role as a parent. Three others said disclosure of their substance use did not lead to real support. Crack and powder cocaine use were noted as being unsupported by three people, with one saying, "there is nothing they can offer".
- **Harm reduction:** Almost all participants using substances (95%, n=20) got some form of harm reduction, mainly naloxone (n=15) and BBV testing (n=14). 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). There were gender disparities across the whole sample, with naloxone training offered to 84% of men (n=20) compared 50% of women (n=11), and naloxone supply offered to 92% of men (n=22) versus 50% of women (n=11). Ten people would have liked the option of safer inhalation pipes and others wanted more tailored support for alcohol and mental health.

Support

- **Overall satisfaction**: Two-thirds (67%, n=31) were fairly or very happy with their support. 45% (n=10) of women said they were very happy with their support, compared to 29% (n=7) of men.
- **Contact & appointments:** Close to a third (31%, n=14) had extra appointments beyond those for their injections and 29% (n=13) only saw workers during injection visits. 16% (n=7) had no extra support but wanted this and 13% (n=6) also had no extra support but did not want this. 17% (n=8) valued being able to contact workers outside of scheduled appointments for additional support.
- **Worker allocation & relationships:** Those who saw a consistent worker or small group of workers each month felt more positively about their support. Almost a quarter (22%, n=10) engaged with third sector workers who they felt offered more time, flexibility, and better listening. 43% (n=20) described workers as kind, encouraging, and non-judgemental and 22% (n=10) felt supported in their personal goals. A few people reported issues with workers, such as distrust due to past experiences, feeling stigmatised and not taken seriously and being unable to raise personal issues when only seeing duty workers.
- **Recovery planning:** Less than half (46%, n=21) had a recovery plan they co-designed with their worker. One third (33%, n=15) had never heard of recovery plans, 13% (n=6) did not have a plan and 9% (n=4) were unsure if they had one. Four said they discussed their goals without being aware of official plans.

- **Unwanted effects:** Under a quarter (22%, n=10) experienced side effects from LAIB during titration or on an ongoing basis, including anxiety, sleep issues, nausea, exacerbation of existing medical issues and injection site problems. These effects could be intense, and a few people had not expected these and felt dismissed or unsupported when raising their concerns.
- **Referrals & external support:** Some people accessed women's groups (n=2), recovery cafés (n=2), recovery skills courses (n=4), or mental health support such as CBT (n=3). These were seen as hugely valuable, such as with helping managing anxiety, strengthening their networks and preventing relapse.
- **Comparisons to other MAT:** LAIB was said to give more consistent contact and stability for some compared to previous forms of MAT. Over one third (35%, n=14) said their mental health support improved, but others saw gaps remain with this due to things like long waiting lists. Access to third sector support was mostly unchanged in LAIB treatment.
- **Reducing treatment:** The majority, (70%, n=32) were not reducing LAIB. Of the 14 people reducing, 10 had some level of discussion with their worker about the process and some were offered extra support, such as psychosocial interventions (n=6), access to third sector organisations (n=3) or mutual aid referrals (n=2). Six people felt uncertain about the process and were concerned about things like what impact stopping LAIB would have on them. No participants had peer mentors with lived experience of LAIB but some felt this would be helpful, especially at the stage of reducing/stopping treatment.

Participant beliefs & impact of LAIB

- **Short-term impact:** Some people (15% (n=7) reported LAIB cut their cravings for opiates dramatically. Many felt more stable and clear-headed in LAIB treatment, describing empowerment and increased motivation. For example, six noted they had more free time, five valued the flexibility to go on holiday and four felt able to work. Ten people had difficulties managing physical and psychological impacts, such as increased mental clarity (highlighted by nine people). This could lead to increased substances use (n=4) or a desire to move to another form of MAT (n=2).
- **Longer-term impact:** The reduced stigma people experienced while being on LAIB was seen as a very important reason for remaining in the treatment by over half (56%, n=26) of participants. A further 39% (n=17) said this was quite important. 11% (n=5) reported LAIB improved family relationships, including restored access to children and signalling visible recovery progress.
- **Advice to others:** Every participant said they would recommend LAIB to others. Nine people emphasised the importance of having strong mental health support along with the treatment itself. Five would warn others about the feeling of their "mental fog lifting" and felt this needed upfront discussion from the start. One person flagged that LAIB can disrupt existing routines, so planning ahead is key.

PRISON FINDINGS

Access

- **Starting LAIB:** Two thirds of focus group participants (67%, n=6 of 9) accessed LAIB while in custody. Some chose it to stop "chasing" drugs and/or to avoid debts relating to substance use inside prison. Only two people knew about the MAT standards. Three people were screened for other drugs before starting LAIB.
- **Information**: Information on LAIB was said to be limited in the prison establishments. Six people had brief chats with their worker(s) and three received leaflets. Some felt they could not process the information they were given due to experiencing withdrawals at the time or they found the leaflets "too complex" to read. Those who started LAIB when it was first became available felt information was especially limited at this time, due to staff having little to no knowledge of the treatment.

Choice

- **Medication choice:** Four people felt LAIB was pushed on them, as they felt methadone was the only other option given, which they didn't want. Half (n=5) said methadone was outdated and/or stigmatised. Three people would have preferred buprenorphine tablets or wafers but these were not available, due to risk of diversion. Participants suggested LAIB offered less agency over dosing compared to other forms of MAT.
- **Dose & withdrawal:** Three people were on the maximum dose of LAIB (160mg) with no top-ups available; this led them to feel stuck and they experienced withdrawals that sometimes pushed them toward illicit substance use. Over half (56%, n=5) were on lower doses of LAIB and could access a top-up dose within a week or less if needed.
- **Injection site & frequency:** All focus group participants received monthly injections and had a choice of injection site, which was rotated monthly. Some said the injection site affected how long LAIB lasted for them during the month. One person would have preferred weekly injections but said this was not an option in the prison establishment.

Support

- **Substance use services staff:** Experiences with NHS staff were mostly positive and participants liked that there were small teams who they could build strong relationships and trust with. The participants felt addictions nurses in the establishments were responsive, generally supportive and always had time for them.
- **Barriers:** Stigma from hall staff and reliance on prison officers to pass on requests in some cases were common barriers to support, with 56% (n=5) citing officer gatekeeping and two reporting messages for NHS staff getting lost. Three people felt it was always on them to proactively seek support, rather than this being offered.
- **Mental health:** All participants had generally low trust in formal mental health services and expressed hesitancy to access this due to things like stigma, fears of looking "weak" and feeling it would not help. One person had their mental health medication stopped on entry to custody, which worsened their distress. Two said they would go to their addiction worker for mental health support and one person saw a psychiatrist quarterly but only for medication reviews. Two people felt they did not need mental health support.
- **Peer & recovery support:** Peer support in the establishments was regarded highly by all participants. This included formal support such as internal recovery spaces (mentioned by three people) and the 'Prison to Rehab' scheme (mentioned by three people), and informal things like sharing a cell with someone else also in LAIB treatment, mentioned by two people. Participants wanted more lived/living experience workers and peers in prison and community settings.
- **Managing unwanted effects:** Six people expressed a need for support to manage unwanted effects, which included, titration related effects and ongoing side effects**.** Four of these reported continued unwanted effects of LAIB, including anxiety, sweating, sleep problems, and low mood. Three of these four people were in receipt of the maximum dose of LAIB. Three felt the emotional impact of the increased mental clarity whilst on LAIB was difficult to manage, especially in the prison environment. Three felt they had been "sold the dream" of LAIB but felt unprepared and unsupported for the reality of treatment for them.
- **Long term planning:** All nine participants felt there were no clear exit plans or tapering pathways in place. Two participants expressed anxiety about their release and felt there was a lack of planning for treatment for parole or community transition.

STAFF FINDINGS

Access

- **Motivations for LAIB:** Over 92% of NHS (n=37) and third sector staff (n=13) said people were motivated to choose LAIB as they wanted less pharmacy contact. Over three quarters of staff (NHS n=29, third sector n=12) noted peer discussions influenced decisions. Approximately two thirds of staff (NHS n=26, third sector n=9) felt LAIB was the "next step" in treatment for those on other forms of MAT. Other reasons staff felt people wanted to receive LAIB included more daily flexibility and having a clearer mind.
- **Starting LAIB:** The majority of NHS staff (94%, n=33) discussed LAIB when patients showed interest in it. 86% (n=30) did so if patients wanted to engage socially or in the community, and 77% (n=27) if pharmacy attendance was difficult. Over two thirds would discuss it for people who had been in other MAT long-term (69%, n=24) or those wanting less contact (63%, n=22).
- **Timelines & delays:** Start times reported for LAIB ranged from same day (11%, n=4), next day (19%, n=7), to 2-4 days (30%, n=11), and up to 1-2 weeks or more (11%, n=4). Delays were said to be caused by staffing/capacity (35%, n=13), prescribing protocols (36%, n=14), patient readiness/health/attendance (23%, n=9), medication ordering procedures (15%, n=6), and referrals to specialists (10%, n=4).
- **Assessment process:** Most staff agreed current drug use (70%, n=37), motivation (68%, n=36), mental health (68%, n=36) and ability to access treatment (e.g. travel) (64%, n=34) were amongst the important or very important factors to discuss initially with people starting LAIB. One staff member flagged the importance of planning for disengagement and another mentioned discussing LAIB's impact on mental clarity during early stages.

Choice

- **Injection administration:** Nearly all NHS staff (94%, n=32) said injections took place at local drug and alcohol services. Over half (52%, n=17) also mentioned specialist drop-in clinics. Less common locations for injections were GP practices (44%, n=15) and pharmacies (35%, n=12), with some pilots underway to expand these options. Home visits (35%, n=12) and outreach (24%, n=8) for injection administration existed but were rarely offered, said to be usually reserved for frail or immobile patients.
- **Dose & other choices:** Almost three quarters of NHS staff (73%, n=24) said patients could request changes to their dose anytime, with dose also discussed weekly/monthly and/or at 3-6 monthly reviews. Contact frequency, dose top-ups, and injection intervals were said to be regularly discussed, but options for these were inconsistently provided. Staff hoped for expanded shared care, letting GPs and pharmacies administer injections more often to help ease capacity issues and improve choice for people in treatment.

Substance use

- **Rates of use:** Most NHS staff (81%, n=38) said people used other substances alongside LAIB, though estimates varied. NHS staff estimated an average of 48% of people they supported and third sector 28%. Most common substances reported were alcohol, powder cocaine, benzodiazepines, and pregabalin.
- **Reasons for use**: Staff felt the most common reason for use on top of LAIB was to manage mental health (72%, n=31). Other reasons included habit or enjoyment of use, peer pressure, and coping with physical pain. A few staff noted that the mental clarity offered by LAIB sometimes led people to "self-medicate" with other substances.
- **Support & harm reduction:** Staff said a broad range of support was offered, including BBV testing (83%, n=44), naloxone provision (79%, n=42), and general harm reduction advice (77%, n=41). 30% of staff made suggestions for additional harm reduction support they would like to offer. Nine mentioned safer inhalation kits, and four said sexual health advice/interventions such as contraception. Other things mentioned included vaccinations (n=3), and more psychosocial (n=2) and wound care support (n=1).

Support

- **Frequency of contact:** NHS staff mostly saw people monthly for injections plus 1:1 support (72%, n=18). 50% (n=6) of third sector staff said they could see clients as often as they wanted and could offer weekly appointments. Phone or extra face-to-face contact depended on individual needs and stability.
- **Support offered:** The most common additional supports NHS staff said they offered were harm reduction (68%, n=15), specialist mental health support (59%, n=13), and psychosocial interventions (41%, n=9). Third sector said they offered signposting to mutual aid (67%, n=8), peer mentoring (58%, n=7), and holistic support including housing, food, and rehab access.
- **MAT comparisons:** A few staff found LAIB safer (n=2), easier to manage (n=3), and saw patients as more stable or motivated (n=2) than with other forms of MAT. Three staff felt they had less interactions with people receiving LAIB and one noted people could disengage more easily from LAIB treatment due to fewer pharmacy visits, making them "less visible". Two staff felt LAIB was less desired by prison residents as unlike other forms of MAT, it cannot be diverted. They suggested people might want it nearer their release so to be on LAIB when returning to the community.
- **Reducing or stopping LAIB:** The most common reasons for someone wishing to stop LAIB were the person wanting to come off MAT altogether (88%, n=23) and changing their mind about treatment (42%, n=11). Support offered when someone was reducing/stopping included care plan reviews (88%, n=23), discussions about tapering their dose down (85%, n=22), and referrals to third sector, psychosocial support, or mutual aid. Around a quarter of NHS staff (27%, n=7) said they would like more peer mentors and structured supports like occupational therapy to offer people at these stages in their treatment.

Staff attitudes

- **Beliefs:** Some staff felt LAIB works best when people are "ready" and "motivated", with seven NHS and four third sector staff highlighting this means people are in the right physical and mental headspace to engage.
- **Effectiveness:** Around 80% of NHS (42% strongly, 39% agree; total n=21) and 83% of third sector staff (58% strongly, 25% agree; total n=10) agreed "LAIB is most effective combined with psychosocial, mental health, and holistic support".
- **Support:** 73% of NHS staff (38% strongly, 35% agree; total 73%, n=19) and 75% of third sector (33% strongly, 42% agree; total n=9) staff agreed "timely mental health support is essential alongside LAIB". 50% (n=6) of third sector staff felt LAIB should be a short-term treatment, while 58% of NHS staff (n=15) disagreed with this.

DISCUSSION

Access

Whilst LAIB is increasingly recognised as a valuable treatment option within Scotland's MAT framework, its rollout has highlighted inconsistencies in access, information provision and service delivery. Most people in treatment reported positive initial experiences of accessing LAIB, but the quality and clarity of information varied, particularly around treatment expectations, potential unwanted effects and broader supports available to them. Peer support and accessible resources were valued but not consistently available to all.

Staff perspectives and service structures sometimes limited access based on abstinence or stability, contrary to guidance promoting a person-centred approach. It is important to consider that people who present with greater complexity may have increased vulnerability to the possible emotional impacts of increased mental clarity that LAIB can provide, for example, those with existing mental health issues or experience of trauma. Therefore widening access should ensure people can make informed decisions about LAIB suitability for them and that people are prepared for titration effects to an optimal dose and are offered the necessary support around emotions returning. Delays in initiation, largely due to service capacity and clinical protocols, further hinder timely access. For LAIB to align fully with the MAT standards, services must improve consistency in early treatment conversations, broaden prescribing capacity, and ensure clear and user-friendly information is available to all people considering LAIB; this will support informed choice and equitable access.

Choice

Experiences of choice and autonomy within LAIB treatment vary significantly, with more flexibility reported in community settings than in prisons. Whilst many community participants valued LAIB for reducing pharmacy visits and experiencing less stigma around the treatment compared to other forms of MAT, some expressed limited choice around dosing frequency, treatment administration location, or engagement levels with support staff. In prison settings, individuals often felt LAIB was imposed due to a restricted range of MAT options. This highlights a tension between institutional priorities and personal choice, particularly where alternatives like buprenorphine tablets were preferred by prison residents but were not generally made available to them. Across both settings, participants linked LAIB to increased autonomy, lifestyle improvements, and reduced stigma in accessing treatment. To meet the MAT standards and deliver broader access to the most appropriate form of MAT for them, it is essential that services expand flexibility of delivery settings, ensure staff are trained to offer the full range of options, and challenge stigma across all forms of MAT.

Substance use

Experiences of substance use while on LAIB treatment were highly individual, with some participants reporting reduced opiate use due to fewer cravings, whilst others increased or continued use of other substances to manage poor mental health or unwanted effects. Although many participants felt able to discuss ongoing use with staff, follow-up support was inconsistent. This was particularly the case for stimulant use, where interventions were often limited or unavailable. Harm reduction measures such as naloxone and injecting equipment were generally available, but access to a broader range of interventions was inconsistent. There was a demand for safer inhalation equipment despite inhalation pipes being currently unavailable in Scotland.

Gender-related differences emerged, with women less likely to disclose substance use and less likely to report being offered harm reduction interventions. As drug-related harms and deaths amongst women are increasing, gender-informed approaches and dedicated services are urgently needed to ensure effective support for women.

The findings emphasise that whilst LAIB can reduce opioid use, it must be delivered alongside consistent harm reduction, psychosocial support, and trauma-informed care to address the complex reasons behind ongoing substance use. To achieve full implementation of the MAT standards and improve outcomes for specific at-risk populations, it is key that services expand their capacity to provide support to stimulant users, address gender-specific needs, and offer tailored harm reduction strategies for all individuals on LAIB.

Support

Participants' experiences of support whilst on LAIB treatment varied significantly. Support was shaped by factors such as geographic location, service provider, client needs, and individual staff practices. Many individuals valued LAIB's flexibility and the minimal contact that offered. Others desired more structured and proactive engagement from staff, including regular check-ins and continuity with keyworkers. Positive therapeutic relationships were key to effective support, both in community and custodial settings.

While many received helpful support for mental health and general wellbeing, others experienced inconsistent access, particularly with psychological interventions and recovery planning. Some individuals felt unprepared for unwanted titration related effects, more lasting side effects or the potential emotional impact of increased mental clarity brought by LAIB. As some who reported side effects were on the maximum dose, it would be important to ascertain if people may be experiencing dose-related side effects and would actually benefit from trying a reduction in dose to see if side effects subside. These experiences underline the need for clearer information at treatment inception, with regular reviews offered throughout treatment and opportunity for discussions with individuals about their ability to manage these impacts, what supports they need and what an optimal dose might be for them. Gaps in support for women and the need for clearer communication about available services e.g. advocacy and welfare support were also identified.

Concerns about stopping LAIB and navigating recovery planning reflected broader inconsistencies in care, with some receiving the help they needed, whilst others felt unsupported or unaware of available options. The findings highlight the need for flexible, person-led support models that allow people in treatment to define their own level of involvement and adjust it over time as they require. To align with the MAT standards, it is important services improve support consistency, enhance communication, actively promote wraparound supports, and ensure that all patients receive clear, realistic information about treatment and what to expect.

Impact of LAIB

Participants generally viewed LAIB positively, citing both short-term benefits e.g. rapid stabilisation and reduced cravings, and, longer-term improvements in lifestyle, autonomy, and ability to engage with their wider recovery goals. Many described LAIB as more than a clinical intervention, instead seeing it as an opportunity for an improved quality of life. Reduced stigma when in LAIB treatment was a key theme across community and custodial settings. This tended to centre around the absence of daily pharmacy visits and the perceptions of other forms of MAT, in particular, methadone. This demonstrates a need to address stigma for all forms of MAT and ensure people have access to accurate information about methadone, especially where that may be the most effective treatment for them.

Not all experiences were positive, with some participants experiencing side effects and emotional challenges linked to increased mental clarity. At times, these experiences could lead to continued substance use or returning to other MAT options. These outcomes highlight the need to address information and support for the people whom LAIB is not effective for, including: thorough pre-treatment discussions, timely mental health support, and flexible, supported exit pathways. There was a clear demand and requirement for wraparound support for LAIB to ensure its success, in particular, mental health and psychosocial supports.

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.
- **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.
- **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.

Choice

- **Choice within treatment:** All individuals - whether in the community or custody - should have access to a full range of MAT options.
- **Treatment delivery:** LAIB delivery should be expanded across a broader range of treatment settings to allow more equitable access.
- **Stigma:** Stigma surrounding all forms of MAT should be addressed to avoid treatment preferences being impacted by misinformation.

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.
- **Person-centred support:** Support offered for substance use should be person-centred, taking account of gendered issues and specific patterns of use.

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.
- **Mental health and psychosocial support:** Access to mental health and psychosocial supports should be improved, ensuring consistency and equity around what people can access across all localities and settings.
- **Care planning and coordination:** Coordinated care led by collaborative care plans should be a key part of holistic care in LAIB treatment.

SCOTTISH DRUGS FORUM

READ THE FULL REPORT

SUPPORT OUR WORK

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