National benchmarking report on implementation of the Medication Assisted Treatment (MAT) standards. 2021/22

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MAT standards summary

Medication assisted treatment (MAT) is used to refer to the use of medication, such as opioids, together with psychological and social support, in the treatment and care of individuals who experience problems with their drug use.

The standards aim to improve access, choice and care and to ensure that MAT is safe and effective.

1. All people accessing services have the option to start MAT from the same day of presentation.
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.
3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.
4. All people are offered evidence-based harm reduction at the point of MAT delivery.
5. All people will receive support to remain in treatment for as long as requested.
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.
7. All people have the option of MAT shared with primary care.
8. All people have access to independent advocacy and support for housing, welfare and income needs.
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.
10. All people receive trauma-informed care.

Foreword from Angela Constance, MSP, Minister for Drugs Policy

The Medication Assisted Treatment (MAT) Standards, published in May 2021, provide a clear summary of criteria and principles to help care providers and those who will benefit from services understand what must be on offer to support people in their MAT treatment and in recovery. The standards are a demonstration of our commitment to a whole-system approach to care and are fundamental to our rights-based approach in Scotland.

Through our national mission, the Scottish Government has committed to providing more than £10 million additional funding per year for local areas to implement the standards and has established a MAT Implementation Support Team to provide consistent support across the country.

Implementing the standards is a central platform of our national mission which focuses on delivering change on the ground – getting more people, more quickly into protective treatment, and ensuring that it's the right treatment for them and available where they are. But the standards rely on the joins being made to mental health, primary care, psychosocial care, as well as to housing and benefits through advocacy.

While the standards are designed to be simple, implementing them fully will not be. We have set ambitious targets on the pace of change required. This benchmarking report provides the first thorough evidence of the changes being made – focusing mainly on what was achieved locally in the first 10 months of implementation particularly for MAT standards one to five.

This report shows progress to April 2022 has been made in all local areas, largely thanks to the hard work of the people commissioning and delivering services, and shows that change can be delivered with the commitment and leadership to back it.

Having a report that pulls no punches and provides this level of details is very welcome in terms of giving everyone a much clearer picture of the challenges faced. We cannot make improvements together without transparent data and reporting. It shows us that, on average, implementation is only partial across most standards. So we need more progress, more quickly to fully embed all standards in all areas.

We acknowledged that April 2022 does not mark the end of a process, but rather gives us a realistic picture of what has been achieved and what more is needed.

The report will help set the agenda for what will happen next in local areas to ensure the standards are fully embedded, improved and made sustainable as part of our national mission.

I would like to thank the MAT Implementation Support Team, and particularly the lived experience colleagues working on the experiential data collection, for the work it has done both in providing support to local areas tasked with implementing the standards, but also for the work done to bring this benchmarking report together. This team's efforts on the road ahead will be just as vital.

Angela Constance, MSP
Minister for Drugs Policy

Foreword from people with lived and living experience of substance use

Over this past year, the Alcohol and Drug Partnerships (ADP areas) and the MAT programme have worked hard in Scotland to improve options for people in addiction and reduce drug deaths. Using a rights-based approach, an innovative and transparent way of working has allowed teams to start to hear the voices of people seeking help, their loved ones and the staff providing care. This offers an opportunity to encourage change in a 'quality improvement' way.

One difference noted has been an increase in people's knowledge of their rights and the ability to challenge organisations. Other changes are the many initiatives springing up over the country: assertive outreach, dedicated non-fatal overdose workers, long-acting injectable buprenorphine and same-day prescribing programmes. Many of these are connected in to share good practice and find imaginative ways to provide care for our most vulnerable citizens.

The teams are beginning to adopt this new way of working and to see changes embedded into our treatment services, especially around same-day prescribing. It is refreshing to see more accountability in people's treatment; some staff appear to give people informed choices and discuss recovery options while others are taking a bit longer to embrace this new way of working. For example, there are concerns regarding over prescribing in certain areas and that some staff do not understand the move away from a medicalised approach and the need to use the ten standards as a rounded and complete approach to treatment.

While families welcome the new standards, some are disappointed by the pace of implementation and are not yet seeing the expected impact of change in their area. They also feel frustrated and disrespected by some ADP areas lack of transparency and engagement with families. Service providers need to explain to families why they are not able to implement changes at the desired pace and start to build those vital relationships.

For sustained change in the delivery of MAT, a Recovery Orientated Systems of Care should be at the heart of everything we do and there needs to be – at all levels from frontline providers to national leaders – a commitment to change, to be accountable and to evidence any changes. Services across the country need to be more consistent so that

people and their families using services in rural and urban areas have access to the same treatment choices (including medication and dose) and options for recovery support.

There are advances that are truly welcomed: voices of lived experience are being heard and ensuring this is more than a tokenistic gesture allows for a change in the weight given to lived experience. This offers a direct voice to the Scottish Government. Further discussions around recovery and addiction can be achieved through ADP area reference groups and better links with lived experience recovery officers and lived experience panels.

The MAT standards are pushing change, offering hope to individuals, families and communities, and empowering people to demand the treatment they deserve. Hopefully it becomes a natural way of treating all individuals: trauma-informed, psychosocial support, and immediate access so that people truly feel involved in their own treatment and can access the most appropriate supports they need at a time they need them.

Becky Wood, Allan Houston, Colin Hutcheon

- Becky Wood, National MIST Quality Officer, Scottish Recovery Consortium and the MAT Implementation Support Team (MIST), and Lived Experience Representative on the Drugs Death Task Force.
- Allan Houston, Senior Addictions Worker, ADRS Glasgow and Lived Experience Representative on the Drugs Death Task Force.
- Colin Hutcheon, Families Lived Experience Representative on Drugs Death Task Force and Chair of Scottish Families Affected by Alcohol and Drugs.

Contents

MAT standards summary 4

Foreword from Angela Constance, MSP, Minister for Drugs Policy 5

Foreword from people with lived and living experience of substance use 7

List of charts and tables 10

List of abbreviations 12

Executive summary 13

1. Introduction 19

2. Scope 22

3. Methods 23

4. Findings 24

5. Progress with MAT standards 6–10 in the community 48

6. Progress with the MAT standards in justice and custodial settings 51

7. The MAT standards for specific populations 52

8. Conclusions 54

9. Recommendations 57

10. Implementation 63

Appendix 1: Allocation of RAG for progress against the MAT standards 64

Appendix 2: Evidence collection challenges and plans 67

Appendix 3: Risks 74

Appendix 4: Maps 80

List of charts and tables

- Chart 1: RAG score for all ADP areas for each MAT standard.
- Chart 2: Three questions on whether the evidence provided by 29 ADP areas demonstrates implementation of a given standard. Combined for standards 1–5.
- Chart 3: Responses to question two (process) on whether the evidence provided by 29 ADP areas demonstrates implementation of a given standard. Summarised for each standard.
- Chart 4: Responses to question four (numerical) on whether the evidence provided by 29 ADP areas demonstrates implementation of a given standard. Summarised for each standard.
- Chart 5: Responses to question five (experiential) on whether the evidence provided by 29 ADP areas demonstrates implementation of a given standard. Summarised for each standard.
- Chart 6: Total RAG score for all ADP areas for all 5 MAT standards.
- Table 1: Breakdown of implementation status (RAG score) by Health Board and ADP area for each of the standards 1 to 5.
- Chart 7: Median number of days by which 50% of people have achieved access to opioid substitution therapy per ADP area.
- Chart 8: Median number of days by which 50% of people have achieved access to opioid substitution therapy per ADP area.
- Chart 9: Percentage of people prescribed different opioid substitution therapies.
- Chart 10: Percentage of people prescribed long-acting injectable buprenorphine.
- Chart 11: Median days between identification and initial assessment by the multi-agency team per ADP area.

- Chart 12: Percentage of locations delivering MAT that provide harm-reduction measures at the same time and place as initial and follow-up MAT appointments.
- Chart 13: Percentage of planned and unplanned discharges per ADP area.
- Chart 14: Percentage of planned and unplanned discharges per ADP area by months on treatment.
- Table 2: Phases of implementation of the MAT standards.
- Chart A1: The main challenges to collecting experiential evidence.
- Table A1: Partnerships
- Table A2: Funding and sustainability
- Table A3: Workforce
- Table A4: Intelligence
- Table A5: Effectiveness of care
- Table A6: Communication and wider environment

List of abbreviations

Abbreviation	Full description
ADP	Alcohol and Drug Partnership
COVID-19	Coronavirus disease
DAISy	Drug and Alcohol Information System
EMIS	Educational Management Information System
HIS	Healthcare Improvement Scotland
HMP	Her Majesty's Prison
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
LPASS	Lead Psychologists in Addiction Services Scotland
MAT	Medication Assisted Treatment
MATSIN	MAT Standards Implementation Network
MIST	MAT Implementation Support Team
RAG	Red, amber, green status
TRAK	TrakCare® Patient Management System

Executive summary

Background

The term medication assisted treatment (MAT) is used to refer to the use of medication, such as opioids, together with psychological and social support, in the treatment and care of individuals who experience problems with their drug use. The Drug Deaths Taskforce published ten standards of care for medication assisted treatment in May 2021. The MAT standards aim to improve access, choice and care across Scotland.

The purpose of this document is to provide:

- a baseline assessment of the implementation of MAT standards 1–5 across Scotland as of April 2022
- information that alcohol and drug partnerships (ADP) areas can use for benchmarking and inter-organisational support.

The full report provides an update on plans for the implementation of standards 6–10 in the community, of plans to map and implement the standards in justice and custodial settings, and of work to ensure that the standards are met for specific populations such as women, young people and people who use benzodiazepines, stimulants and other drugs.

Methods

Note that in this report, Midlothian and East Lothian are separate Integration Joint Boards (IJBs) but a single ADP. Falkirk ADP and Clackmannanshire and Stirling ADP have a history of working closely together, as do their respective IJBs, so their progress is reported jointly in this report.

For each of the 29 ADP areas, and each of the MAT standards 1–5, process, numerical and experiential (from people using and providing services) evidence was combined with information from local narrative and strategic plans to allocate a RAG score: red (not implemented), amber (partially implemented), green (fully implemented), blue (sustained).

Each component of evidence was considered necessary for a balanced assessment with no single component sufficient on its own.

This report focuses on the progress that ADPs are making to meet the MAT standards, and the recommended actions to address gaps. There is an enormous amount of good will, good practice and commitment to change across all ADPs that is not fully represented in this report. A lot of this information is provided in the supplementary information that will be published in August, and the improvement plans agreed by ADPs will rely on these assets for change.

Key findings

There is unwarranted variation in the implementation.

The models of care to deliver the MAT standards need to be flexible and adapted to local circumstances, such as small caseloads in rural areas and large caseloads in urban areas. There are good models in place and developing.

Of 145 standards of care assessed, 17% (25/145) are fully implemented, 65% (94/145) are partially implemented and 18% (26/145) are not implemented. This suggests that work has started or is well established in most places, but that there is still a lot to do for full, consistent and sustained implementation of the standards in all areas.

Chart 1: RAG score for all ADP areas for each MAT standard

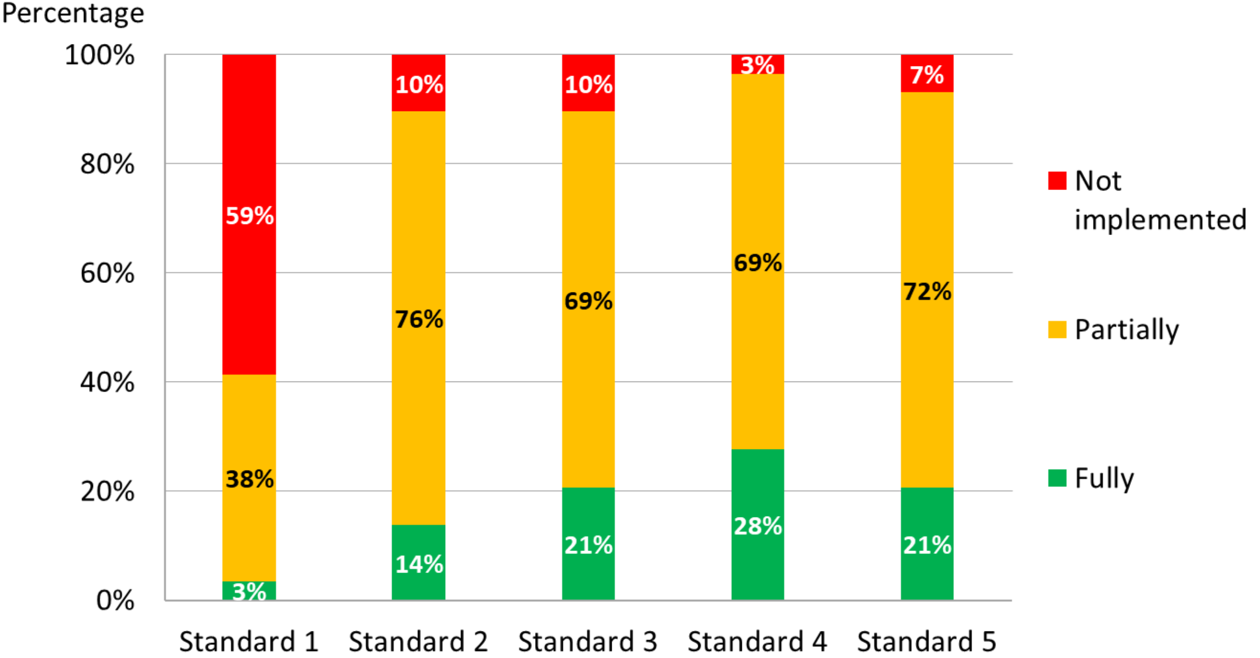


Chart description: Of 29 ADP areas by MAT standard:

- MAT standard 1: The standard is fully implemented in 1 ADP area (3%), partially implemented in 11 ADP areas (38%) and not implemented in 17 ADP areas (59%).
- MAT standard 2: The standard is fully implemented in 4 ADP areas (14%), partially implemented in 22 ADP areas (76%) and not implemented in 3 ADP areas (10%).
- MAT standard 3: The standard is fully implemented in 6 ADP areas (21%), partially implemented in 20 ADP areas (69%) and not implemented in 3 ADP areas (10%).
- MAT standard 4: The standard is fully implemented in 8 ADP areas (28%), partially implemented in 20 ADP areas (69%) and not implemented in 1 ADP area (3%).
- MAT standard 5: The standard is fully implemented in 6 ADP areas (21%), partially implemented in 21 ADP areas (72%) and not implemented in 2 ADP areas (7%).

The RAG score of blue (there is evidence of sustained implementation and ongoing monitoring of the standard across all MAT services) was not allocated to any standard.

Systems are not sufficiently intelligence led.

The national and local systems for the collection of numerical data are frequently unable to provide the person-centred data that is required for the effective implementation of the MAT standards.

- Process documentation was submitted by ADP areas for 98% of standards. For 27% the documentation was sufficient, 32% partially sufficient and for 39% insufficient to demonstrate full implementation of a given standard. There was no data for 2% of standards.

- Numerical data was submitted for 86% of standards. For 21% the data was sufficient, 33% partially sufficient and for 32% insufficient to demonstrate full implementation of a given standard. There was no data for 14% of standards.

- Experiential data was submitted for 57% of standards. For 16% the data was sufficient, 22% partially sufficient and for 19% insufficient to demonstrate full implementation of a given standard. There was no data for 43% of standards.

Funding commitments to fully implement the standards have not been realised.

In many ADP areas plans have not yet been implemented because of delays in recruitment, conflicting priorities due to COVID-19, and challenges with leadership and financial planning. Over 2021–22, all ADP areas specified improvement projects and funds were agreed with the Scottish Government. It is notable that initial analysis of funding requirements demonstrates that around 60% of funds will be allocated to clinical staff to build capacity for service delivery (see supplementary information to be published in August 2022).

Risks include:

- Partial implementation leading to the standards not contributing to a reduction in drug-related deaths.

- Systems being unable to collect the evidence required for intelligence-led improvement work to take place.

- Uncertainties about continued funding beyond the initial project term.

Recommendations

1. Fully implement MAT standards 1–5 in the community by April 2023.

- The MAT programme will agree improvement plans with ADP areas and provide assistance to implement them.
- Commitment and senior leadership from Health and Social Care Partnerships will be necessary to allocate the resource that is required for successful implementation.

2. Partially implement MAT standards 6–10 in the community by April 2023.

- The MAT programme will provide practical assistance to do this, including the establishment of thematic clusters so that ADP areas can collaborate on mapping, tests of change, benchmarking, spread of good practice and inter-organisational support.

3. Map and implement the MAT standards in early adopter sites in justice and custodial settings by April 2023.

- This will include a local network approach and aim to map out and strengthen pathways between prison, police custody and community care so that consistent care can be offered as people move between locations.

4. Ensure the MAT standards provide improved access, choice and care for specific populations.

- This will include women, migrants and people who use benzodiazepines, stimulants, gabapentinoids and other drugs.

5. Build sustainable numerical data systems to monitor and improve implementation of the standards.

- This will include strengthening national data systems, using to greater advantage local systems and the use of audit for reporting and targeted improvement work.

6. Build sustainable experiential data systems to monitor and improve implementation of the standards.

- Establish in all ADP areas systems that ensure ongoing dialogue with people using and providing services and that feedback is incorporated into the local improvement cycles.

7. Conduct targeted national investigations.

- Conduct audits that track a person's journey through care and include the collection of process and clinical information as well as experiential data with people using services, their families and people providing services.

8. Strengthen the improvement and benchmarking programme for the MAT standards.

- Establish benchmarking across ADP areas and justice settings by the systematic collection, collation, analysis and sharing of learning from local programmes.

1. Introduction

Scotland has a high level of drug-related deaths. The annual figure for 2020 increased by 5% from the previous year to 1,339. This is the highest number recorded for the seventh year in a row.

The Drug Deaths Taskforce was established in September 2019 and prioritised the introduction of standards for medication assisted treatment (MAT). During 2019 and 2020, ten evidence-based measurable standards of care were developed, consulted on and tested in early adopter sites. The standards provide a framework to help increase the number of people receiving effective treatment through improved access and choice, while also ensuring that care is safe, and that it enables people to benefit from treatment and support for as long as they need it. The standards were published by the Drugs Death Task Force in May 2021: **www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support**

In January 2021, the First Minister announced a new national mission to reduce drug-related deaths and harms. This led to the establishment by Public Health Scotland and the Scottish Government of a national MAT programme with multi-agency partners. The programme will run for five years and provides direct assistance to improve coverage, quality and consistency of MAT. The leadership, experiences and knowledge of people with lived and living experience of problematic drug use, and their families and named persons, are integrated across the MAT programme workstreams.

Implementing all ten MAT standards in community, justice and custodial settings across Scotland is a hugely ambitious task. It requires a step change in the understanding, support and contribution of all partners across the health, social care, justice and third sectors, as well as the communities at risk.

The Health and Social Care Partnership (HSCP) Chief Officers are accountable for implementation. ADP areas provide the forum for partners to come together to plan, develop and deliver alcohol and drug services. The MAT programme provides support to build local capacity for improvement and national capacity for systems strengthening. The Public Health Scotland drugs team leads on strategic development.

Ways in which the MAT programme will contribute to the national mission include:

- Building local and national capacity with treatment and rehabilitation services in community and justice settings to implement the standards, and to provide evidence that implementation is safe and effective.
- Supporting the national target for opioid substitution therapy by helping to improve access and choice, and by monitoring the quality and safety of care including any unintended consequences of increased treatment coverage.
- Supporting people with multiple and complex needs – the implementation of the standards will inevitably uncover challenges and needs specific to population groups such as women, young people, and people using drugs such as benzodiazepines and stimulants. The MAT programme will work with partners to help improve access, choice and care for these people.
- Enabling, through a programme of capacity building, people with lived and living experience of problematic drug use, and their families and named persons, to make ongoing and substantive contributions to the improvement of services.
- Providing a supportive and non-stigmatising learning environment for local teams to develop new models of care and share these across the country through benchmarking and inter-organisational support.

The purpose of this document is to provide:

- a baseline assessment of the implementation of the MAT standards across Scotland as of April 2022
- information that alcohol and drug partnerships can use for benchmarking and inter-organisational support.

Timeline of activities

- In March 2021, the MAT programme was established.
- In May 2021, the MAT standards were published with the evidence base, and the process, numerical and experiential evidence required to verify success.
- In June 2021, a baseline mapping template was sent to all ADP areas so that they could conduct a self-assessment of their current status with respect to MAT standards 1–10. The mapping template requested ADP areas to provide background to their self-assessment, and to identify any specific areas of support required from MIST. A thematic analysis of the mapping information was conducted to help identify gaps for local improvement and national escalation (published in supporting documentation, August 2022).
- In August 2021, interim guidance titled 'MAT Standards Informed Response for Benzodiazepine Harm Reduction' was published by the Drug Deaths Taskforce: **mat-standards-informed-response-for-benzodiazepine-harm-reduction_interim-guidance_august-2021.pdf (drugdeathstaskforce.scot)**
- From August 2021, the initial mapping was followed up jointly with ADP areas and the MAT Implementation Support Team (MIST) to determine what progress could be expected with implementation of the MAT standards by April 2022. It was agreed that a joint (MIST and ADP areas) evidence-based assessment of progress would be conducted in April 2022.
- Between winter 2021 and spring 2022, local strategic plans ('project specification documents') for the implementation of MAT standards 1–5 were developed with each ADP area and funding was agreed with the Scottish Government. A thematic analysis of the plans was conducted and will be published in the supporting documentation, August 2022. The themes are embedded throughout this report and the risks identified can be found in **Appendix 3: Risks**.
- During this time, a national network, the MAT Standards Implementation Network (MATSIN), was started with ADP areas to coordinate improvement work. This

network has since been supplemented by networks for numerical and experiential data gathering and by an information governance network.

- From January 2022, MIST worked with ADP areas to collect, collate and report the process, numerical and experiential evidence required to assess progress with implementation of MAT standards 1–5 as of April 2022.

2. Scope

This report provides an evidence-based assessment of progress with the implementation of MAT standards 1–5 across all 29 ADP areas in Scotland, as of April 2022.

Note that in this report, Midlothian and East Lothian are separate Integration Joint Boards (IJBs) but a single ADP. Falkirk ADP and Clackmannanshire and Stirling ADP have a history of working closely together, as do their respective IJBs, so their progress is reported jointly in this report.

The results presented will be used for benchmarking across ADP areas as part of the national improvement process. A detailed summary of the evidence and an improvement plan for each individual ADP area will be published in the supplementary information in August 2022.

The report also summarises some of the actions and plans underway to implement MAT standard 6–10 in the community, to map and implement the standards in justice and custodial settings and to ensure that the standards are met for specific populations such as women, and people using benzodiazepines. The MAT programme did not request detailed evidence of progress in these areas and for this reason does not present results for benchmarking.

This report focuses on the progress that ADPs are making to meet the MAT standards, and the recommended actions to address gaps. There is an enormous amount of good will, good practice and commitment to change across all ADPs that is not fully represented in this report. A lot of this information is provided in the supplementary information that will be published in August, and the improvement plans agreed by ADPs will rely on these assets for change.

The document does not report on the wider work ADP areas are doing such as providing care for people with problematic alcohol use.

3. Methods

For each ADP area and each of MAT standards 1–5, the following evidence was used:

- Process evidence – formularies, clinical guidelines, care pathways, standard operating procedures, policies and other supporting documentation.
- Numerical evidence – the measures and analyses set out in the MAT standard document were simplified to enable ADP areas to provide the core data in the time available.
- Experiential evidence – all documented feedback obtained in the previous year through interviews, focus groups and surveys with people using services, and their families, and people providing services.
- Project specification documents (local plans for MAT implementation developed jointly with ADP areas and the MAT programme).
- Local narrative elicited through discussions with ADP area teams.

The process, numerical and experiential evidence was analysed and summarised in templates. It was then combined with information from the project specification document and local narrative to assess progress. All components were considered necessary for a balanced assessment, with no single component sufficient on its own.

To ensure that this ‘pentangulation’ process produced a consistent approach to allocation of RAG status, a checklist of eight questions on the evidence provided was used for each standard. The RAG status was allocated according to the extent to which the process, numerical and experiential evidence was sufficient to demonstrate the stage of implementation (further details in **Appendix 1: Allocation of RAG for progress against the MAT standards**).

All eight questions were used to assess RAG status. The allocation of RAG status was agreed, checked within the MIST team by three senior clinicians, and then shared by email or through Teams meetings for clarification and agreement with each ADP area. Results for the assessment of progress are presented as a red, amber, green or blue (RAG) score.

Questions two, four and five were used to analyse the completeness of the data returns and the extent to which the process, numerical and experiential evidence demonstrates implementation of a given standard. Results for data completeness and the contribution of process, numerical and experiential data to the assessment are presented as stacked bar charts.

4. Findings

4.1. Evidence collection

At this point in the MAT programme, systems for the collection of evidence are still under development. As most of the information has not been routinely collected before, there is frequently limited capacity to do this, and ADP areas use different data sources and methods to collect data. For this reason, some information is presented with caveats, may be incomplete, and may not fully reflect local or national circumstances. For more detail on the challenges of data collection and analysis, see **Appendix 2: Evidence**.

Chart 2: Three questions on whether the evidence provided by 29 ADP areas demonstrates implementation of a given standard. Combined for standards 1–5.

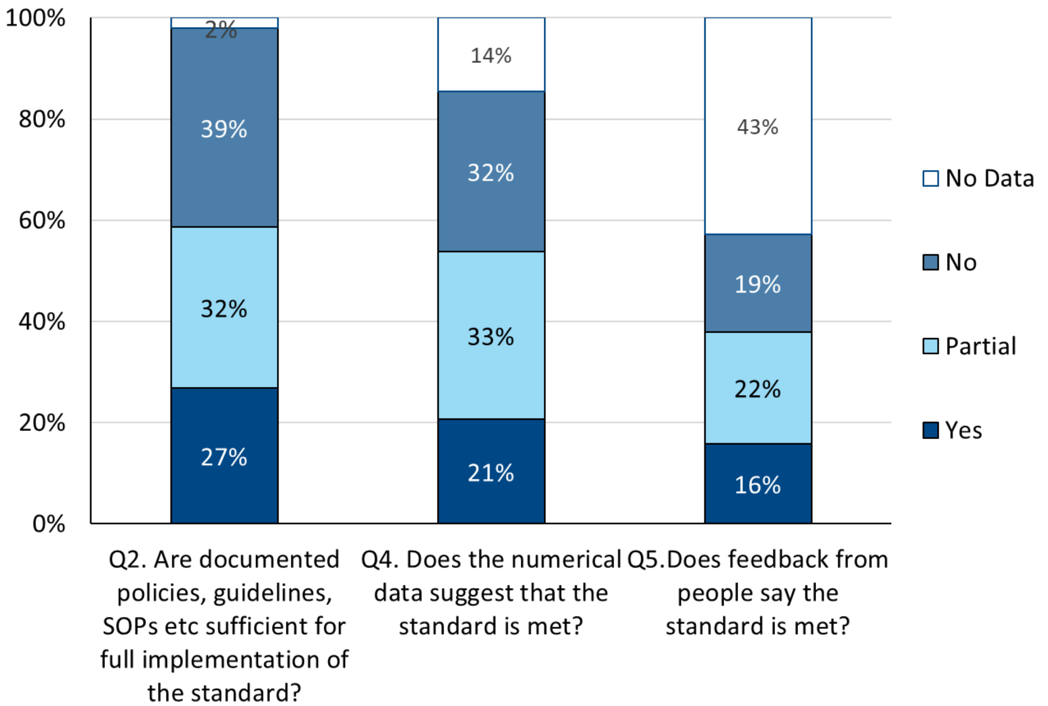


Chart description: This chart shows a combination of all answers from 29 ADP areas to all of MAT standards 1–5 (i.e. a total of 145 responses per question). The data shows that:

- for question two, process documentation was submitted for 98% of standards. For 27% the documentation was sufficient, 32% partially sufficient and for 39% insufficient to demonstrate full implementation. There was no data for 2% of standards.
- for question four, numerical data was submitted for 86% of standards. For 21% the data was sufficient, 33% partially sufficient and for 32% the data was insufficient to demonstrate full implementation. There was no data for 14% of standards.
- for question five, experiential data was submitted for 57% of standards. For 16% the data was sufficient, 22% partially sufficient and for 19% the data was insufficient to demonstrate full implementation. There was no data for 43% of standards.

Chart 3: Responses to question two (process) on whether the evidence provided by 29 ADP areas demonstrates implementation of a given standard. Summarised for each standard.

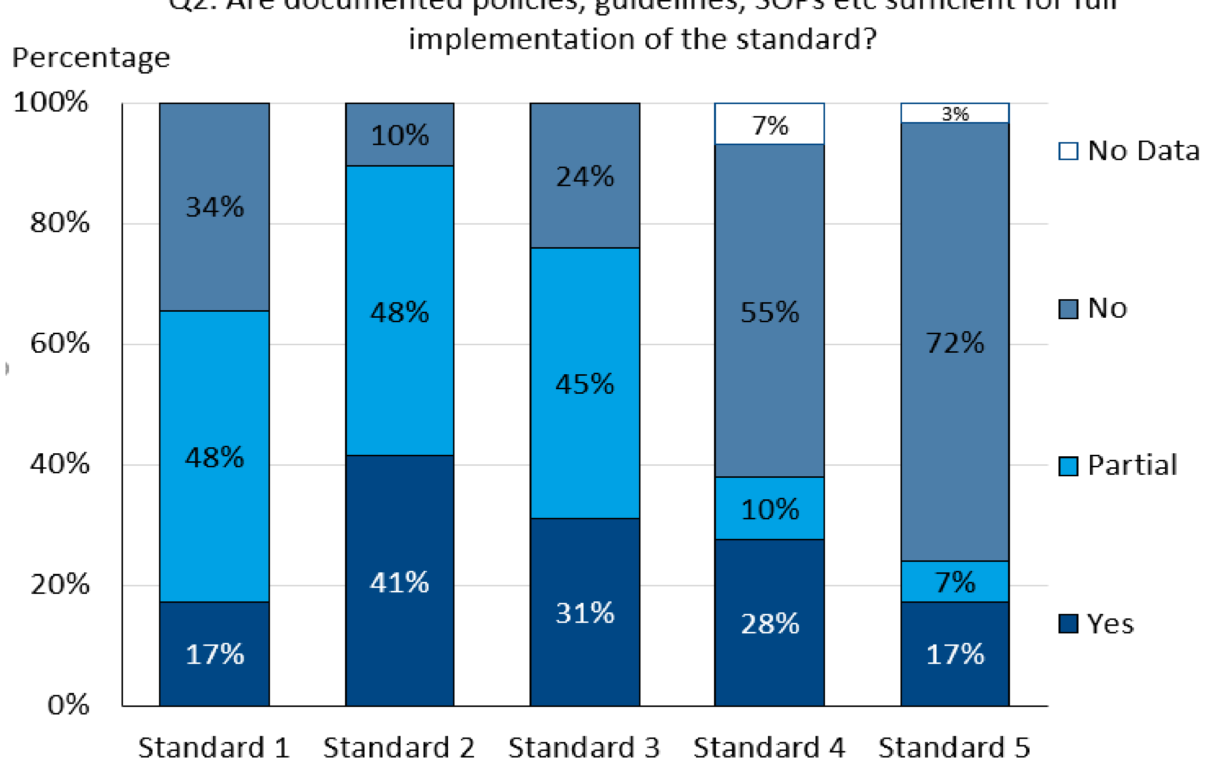


Chart description: The data shows that for question two (process), standards 4 and 5 were least likely to have process documentation sufficient to demonstrate implementation (55% and 72% respectively).

Chart 4: Responses to question four (numerical) on whether the evidence provided by 29 ADP areas demonstrates implementation of a given standard. Summarised for each standard.

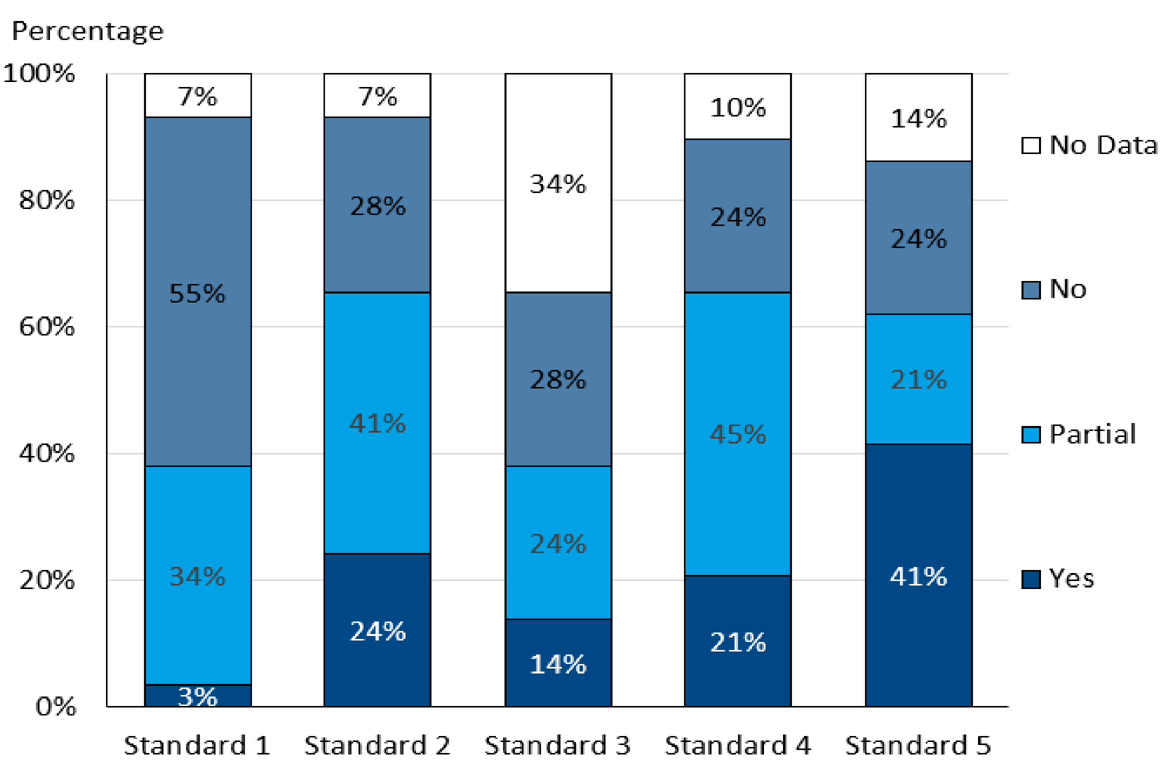


Chart description: For question four (numerical), standard 1 was least likely to have numerical data to support full implementation (3%) and most likely to have numerical data that the standard was not met (55%). Standard 3 was most likely to have no data (34%).

Chart 5: Responses to question five (experiential) on whether the evidence provided by 29 ADP areas demonstrates implementation of a given standard. Summarised for each standard.

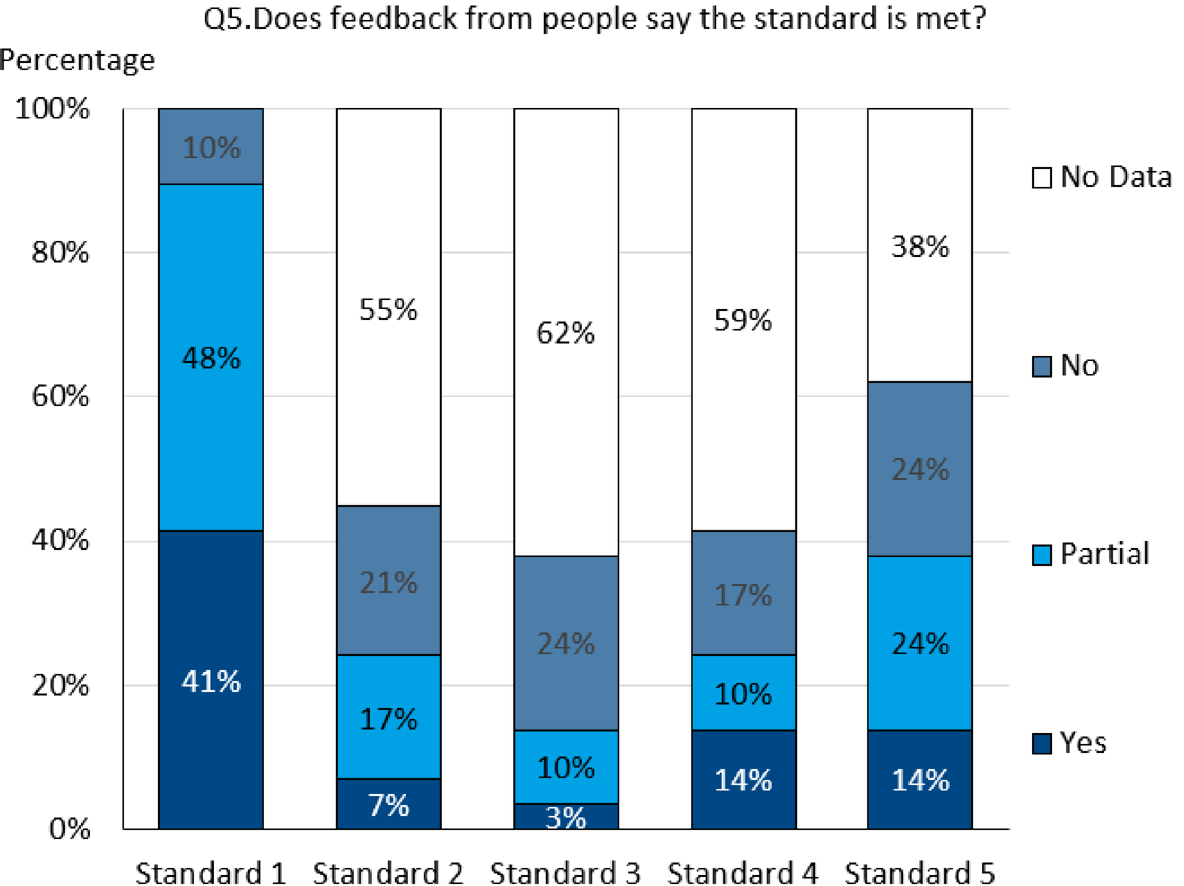


Chart description: Experiential data for standard one was provided by all ADP areas and in 41% it suggested that the standard is being met. For standards 2, 3, 4 and 5 there was no experiential data from 55%, 62%, 59% and 38% of ADP areas respectively. Note that the experiential data is often from small samples and not necessarily representative. This may account for the discrepancy between process, numerical and experiential evidence for MAT standard 1.

There is variation in the data provided for each standard, but experiential data showed the biggest gap with no data provided for 43% of standards overall. Experiential evidence (from people using services, people who could benefit from them, and their families and friends) is the closest measure used in this report to an outcome because it describes the interaction of people and families with the services, and any benefit or detriment experienced.

Interpretation of the numerical data must take account of the following caveats:

- The sources and methods used for data collection vary and this means that reports may over- or underestimate values. For example, for MAT standard 1 some ADP areas include the whole of a person's journey from presentation to prescription while others include a part of the journey such as the time from receipt of referral.
- There is variation in some of the definitions used. For example, the definition of planned or unplanned discharge can include transfers to prisons.
- There is variation between ADP areas in the caseload and the proportion of people on MAT. This can mean for example that high percentages shown on long-acting injectable buprenorphine may reflect small numbers on the caseload overall, rather than large numbers of people on this treatment. Conversely, low percentages on a large caseload can actually reflect a large number of people on long-acting injectable buprenorphine.
- There is variation in the time periods for which data was provided and this can make comparison and identifying trends difficult.

While the methods remain more or less stable, the data can be used to demonstrate a positive trend in a given ADP area over time. Also, when considered together with other factors such as rurality and caseload, the data can be used for benchmarking across ADP areas, to identify good practice, to identify where the variation is unwarranted and where additional support is required for improvement.

The detailed caveats for measurements in each ADP area will be published with the supplementary information in August 2022.

4.2. Assessment of MAT standards 1–5 overall

Chart 6: Total RAG score for all ADP areas for all 5 MAT standards

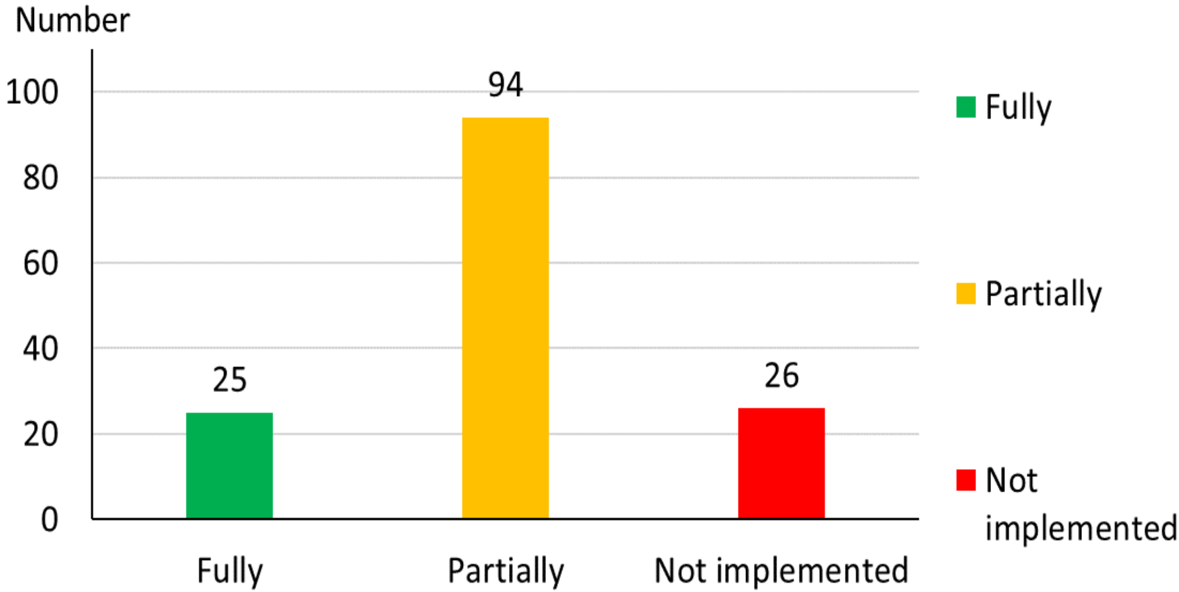


Chart description: Of five standards of care assessed in each of 29 ADP areas, 17% (25/145) are fully implemented, 65% (94/145) are partially implemented and 18% (26/145) are not implemented. The RAG score blue (there is evidence of sustained implementation and ongoing monitoring of the standard across all MAT services) was not allocated to any standard.

Chart 1: RAG score for all ADP areas for each MAT standard

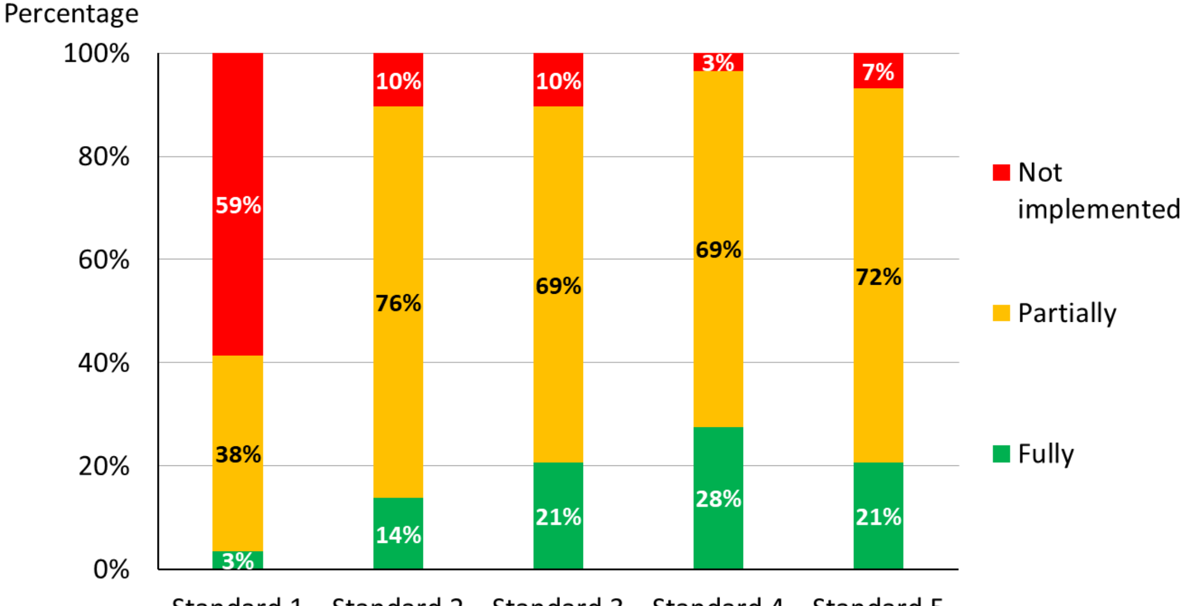


Chart description: Of 29 ADP areas by MAT standard:

- MAT standard 1: The standard is fully implemented in 1 ADP area (3%), partially implemented in 11 ADP areas (38%) and not implemented in 17 ADP areas (59%).
- MAT standard 2: The standard is fully implemented in 4 ADP areas (14%), partially implemented in 22 ADP areas (76%) and not implemented in 3 ADP areas (10%).
- MAT standard 3: The standard is fully implemented in 6 ADP areas (21%), partially implemented in 20 ADP areas (69%) and not implemented in 3 ADP areas (10%).
- MAT standard 4: The standard is fully implemented in 8 ADP areas (28%), partially implemented in 20 ADP areas (69%) and not implemented in 1 ADP area (3%).
- MAT standard 5: The standard is fully implemented in 6 ADP areas (21%), partially implemented in 21 ADP areas (72%) and not implemented in 2 ADP areas (7%).
- The RAG score blue (there is evidence of sustained implementation and ongoing monitoring of the standard across all MAT services) was not allocated to any standard.

Table 1: Breakdown of implementation status (RAG score) by Health Board and ADP area for each of the standards 1–5

NHS Board	ADP area	MAT 1 evidence, April 2022	MAT 2 evidence, April 2022	MAT 3 evidence, April 2022	MAT 4 evidence, April 2022	MAT 5 evidence, April 2022
Ayrshire & Arran	East Ayrshire	Amber	Green	Green	Green	Green
Ayrshire & Arran	North Ayrshire	Amber	Green	Green	Green	Green
Ayrshire & Arran	South Ayrshire	Amber	Green	Green	Green	Green
Borders	Borders	Green	Green	Green	Green	Green
Dumfries & Galloway	Dumfries & Galloway	Amber	Amber	Green	Green	Amber
Fife	Fife	Amber	Amber	Amber	Amber	Amber
Forth Valley	Clackmannanshire, Stirling, Falkirk	Red	Amber	Amber	Amber	Amber
Grampian	Aberdeen	Red	Amber	Amber	Green	Green
Grampian	Aberdeenshire	Amber	Amber	Green	Green	Green
Grampian	Moray	Red	Amber	Red	Red	Amber
Greater Glasgow & Clyde	Glasgow	Amber	Amber	Amber	Amber	Amber
Greater Glasgow & Clyde	East Dunbartonshire	Red	Amber	Amber	Amber	Amber
Greater Glasgow & Clyde	East Renfrewshire	Amber	Amber	Amber	Amber	Amber
Greater Glasgow & Clyde	Inverclyde	Red	Red	Amber	Amber	Amber
Greater Glasgow & Clyde	Renfrewshire	Amber	Red	Amber	Green	Amber

NHS Board	ADP area	MAT 1 evidence, April 2022	MAT 2 evidence, April 2022	MAT 3 evidence, April 2022	MAT 4 evidence, April 2022	MAT 5 evidence, April 2022
Greater Glasgow & Clyde	West Dunbartonshire	Red	Amber	Amber	Amber	Amber
Highland	Argyll & Bute	Red	Red	Red	Amber	Amber
Highland	Highland	Red	Amber	Amber	Amber	Amber
Lanarkshire	North Lanarkshire	Red	Amber	Amber	Amber	Red
Lanarkshire	South Lanarkshire	Red	Amber	Amber	Amber	Amber
Lothian	Edinburgh	Amber	Amber	Amber	Amber	Amber
Lothian	Mid & East Lothian	Red	Amber	Amber	Amber	Amber
Lothian	West Lothian	Amber	Amber	Amber	Amber	Amber
Orkney	Orkney	Red	Amber	Amber	Amber	Red
Shetland	Shetland	Red	Amber	Red	Amber	Amber
Tayside	Angus	Red	Amber	Amber	Amber	Amber
Tayside	Dundee	Red	Amber	Amber	Amber	Amber
Tayside	Perth & Kinross	Red	Amber	Amber	Amber	Amber
Western Isles	Western Isles	Red	Amber	Amber	Amber	Amber

Table description: This table provides the detail of RAG status for each of MAT standards 1–5 for each ADP area. This information is presented visually in **Appendix 4: Maps**.

4.3. Assessment of MAT standard 1: Same-day access

ADP areas that have achieved or are close to achieving full implementation of the standard demonstrate, or plan to implement:

- collaborative working to release prescribing capacity
- inclusive multidisciplinary teams
- multiple delivery approaches such as drop-ins, mobile units, telehealth

- open referral including from self, family, third sector
- extended opening hours
- non-medical prescribers embedded in outreach teams
- access through community pharmacy in remote locations
- documented pathways linking to non-fatal overdose
- families and nominated person included in care planning.

Case study: Borders ADP area has overcome rural challenges to offer rapid access to MAT through multiple and flexible models of care. Services are delivered through a multi-agency team comprising Borders Addiction Service, the Engagement Team and We Are With You. Interventions are available through one-to-one assessment at static sites, drop-in clinics at Eyemouth, Galashiels and Hawick, or at people’s own homes. Some consultations are delivered through telemedicine and prescribers have access to laptops and portable printers. This means that prescriptions can be emailed to pharmacies in rural areas for local dispensing. This arrangement was put in place during the COVID-19 pandemic and is still being used.

In total, 93% of ADP areas provided numerical evidence for standard 1 with 3% supporting implementation and 34% partially supporting implementation. The charts below show median values for 19 ADP areas where full data was submitted and the number of people on MAT is greater than ten.

Chart 7: Median number of days by which 50% of people have achieved access to opioid substitution therapy per ADP area.

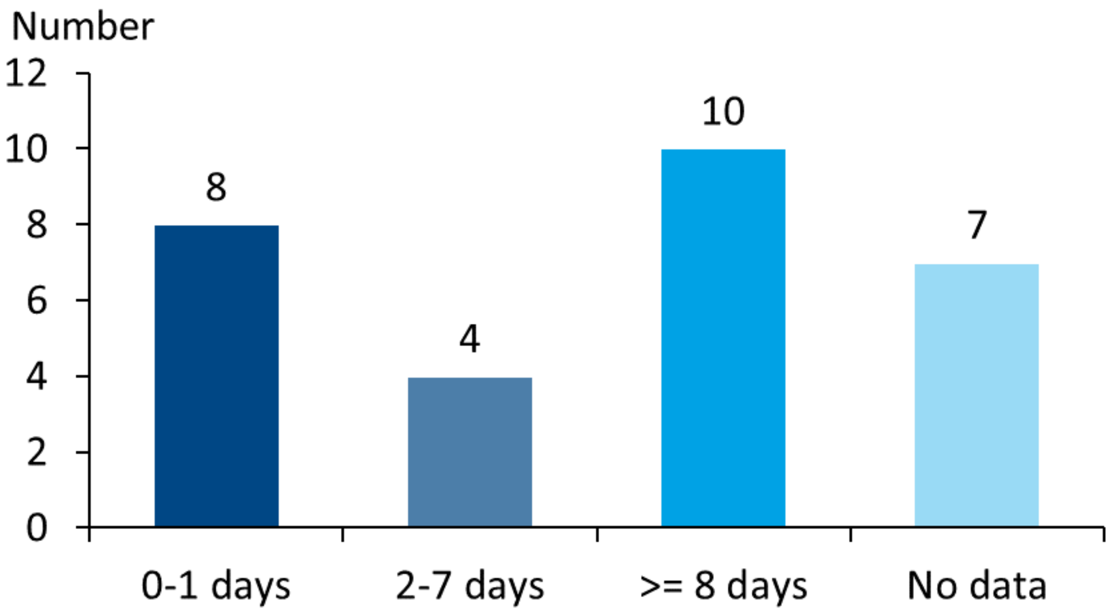


Chart description: The chart indicates that in 8 ADP areas (28%), 50% of people have access to opioid substitution therapy on the same day, in 2 to 7 days in 4 ADP areas (14%), and eight days or more in 10 ADP areas (34%). Seven ADP areas (24%) did not submit data.

Chart 8: Median number of days by which 50% of people have achieved access to opioid substitution therapy per ADP area.

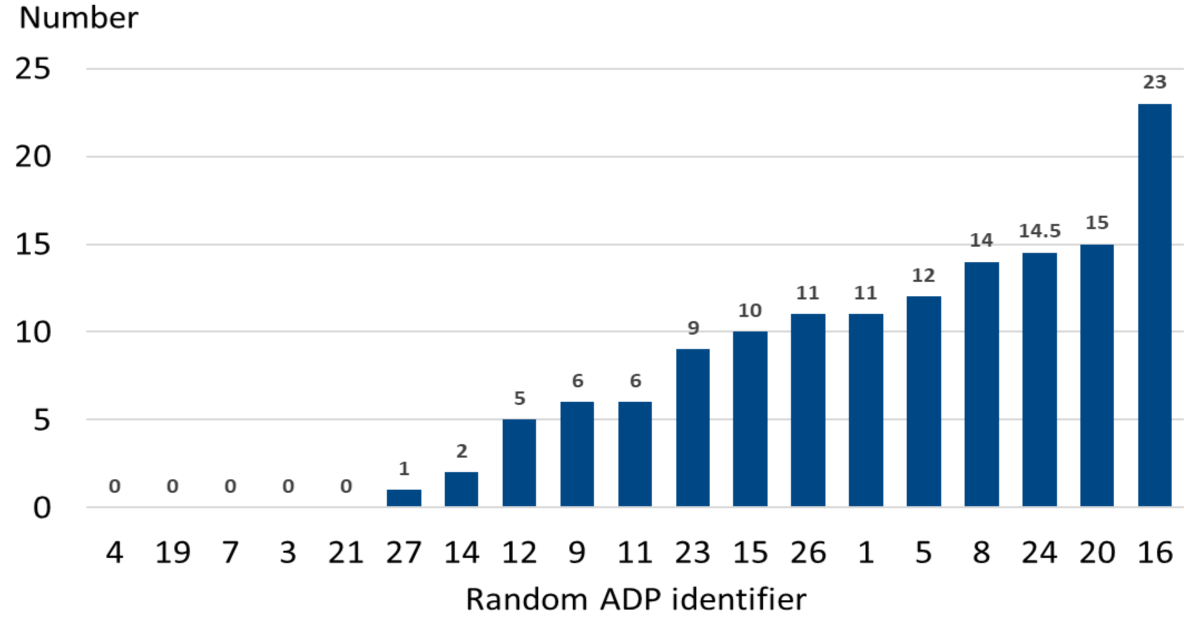


Chart description: 19 ADP areas submitted data suitable for analysis. The chart demonstrates the variation across these ADP areas with the median time to a prescription for opioid substitution therapy ranging from zero days to more than 20 days.

Note that much of the data for this standard records the time from referral received to prescription, rather than first presentation to any member of the multi-agency team, as set out in the MAT standards. Some data also excludes the time where people are not able to attend appointments.

Of the ADP areas providing access to same-day prescribing, four provided evidence of feedback from people using services. For example, evaluation of the South and North Ayrshire pilot reported that people appreciated rapid access to MAT and that they had the opportunity to engage with other services for support at the same time.

Overall, this standard is not implemented across Scotland. Of 29 ADP areas, the standard is fully implemented in one, partially implemented in 11 and not implemented in 17. To move this standard to full implementation, Health and Social Care Partnerships and ADP areas need to commit to rapidly establishing tests of change, and where change has been tried and tested, scale up locally and share the learning nationally.

Assessment of MAT standard 2: Choice

The process of ensuring consistent informed choice of opioid substitution therapy is complex and this means that innovative models are required.

There are specific challenges with long-acting injectable buprenorphine. Storage in community locations other than NHS hospitals and community pharmacies requires a United Kingdom Home Office licence. Administration of the product by the practitioner that prescribes is not permitted, nor does the product licence allow take-home use or self-administration. This means that MAT locations that cannot store medication (such as small rural community sites) or where there is limited staff capacity, require models that enable staff to prescribe, collect, transport and administer medication in the local clinics, pharmacies or in patients' homes.

ADP areas that have achieved or are close to achieving full implementation of the standard demonstrate, or plan to implement:

- documented formularies
- clinical guidance and standard operating procedures that support the full range of options
- patient information provided about products and pathways
- recovery workers to support informed choice
- workforce development plans and a family-inclusive approach to care planning.

Challenges include appropriate buildings and licences for the delivery of long-acting injectable buprenorphine and a lack of specific guidance and formal care planning for all options. There can also be a challenge to accurately record and report the number of people prescribed long-acting injectable buprenorphine. This a recently introduced treatment with specific requirements that have led to different dispensing and recording systems between ADP areas, not all of which have been easily accessible.

Case study: A pilot with five community pharmacies in Aberdeenshire is an example of a model that aims to overcome rural challenges. Prescriptions are provided by the specialist substance use services and taken to one of the participating pharmacies by the people given the prescription. Dispensing and administration is carried out by the pharmacist. The process is led by specialist services and governed by an agreed pathway and information-sharing agreements. The community pharmacy staff are already trained and experienced in delivering opioid substitution therapies and in the administration of vaccinations. The pilot has been running for six months and once the evaluation is complete it will be shared nationally. West Lothian is now adopting this model. There is an opportunity to combine learning from this pilot with the system of electronic prescribing used in Borders ADP area where the consultation is done by telemedicine and the prescription is transferred electronically to the community pharmacist.

Chart 9: Percentage of people prescribed different opioid substitution therapies.

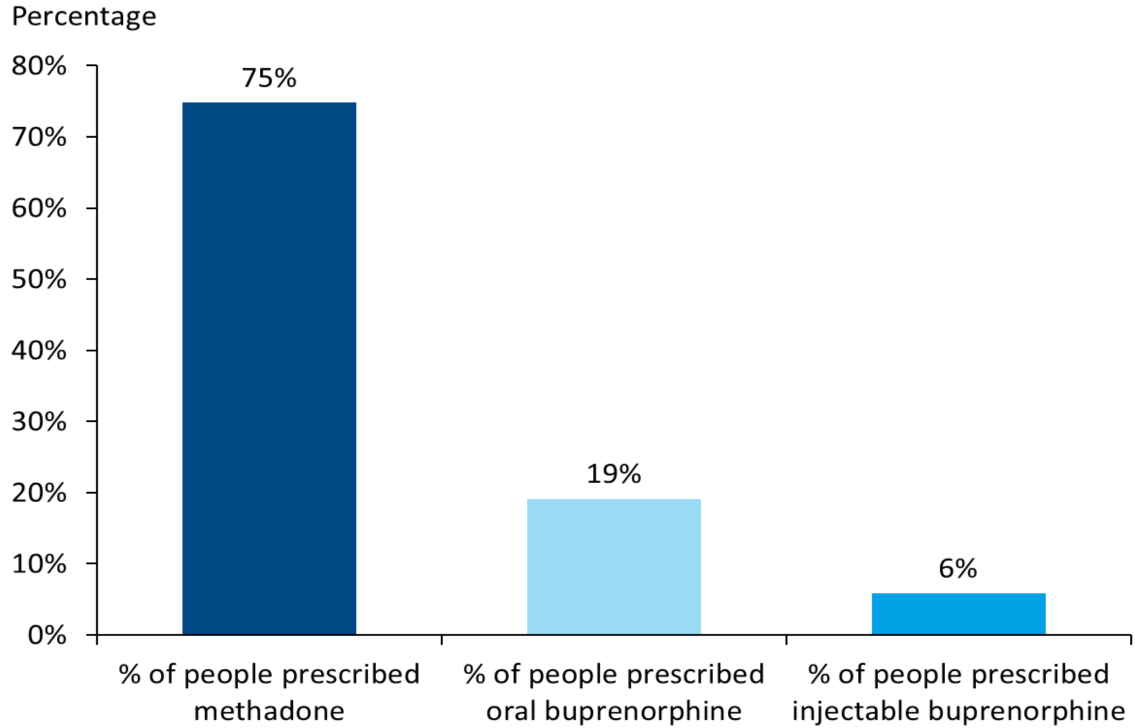


Chart description: 26 ADP areas submitted data suitable for analysis. The proportion of people prescribed different opioid substitution therapy options was 75% (n=19,022) of people prescribed methadone, 19% (n=4,859) oral buprenorphine, 6% (n=1,474) long-acting injectable buprenorphine and 11 people in one ADP area were prescribed heroin-assisted treatment (0.04%).

Chart 10: Percentage of people prescribed long-acting injectable buprenorphine.

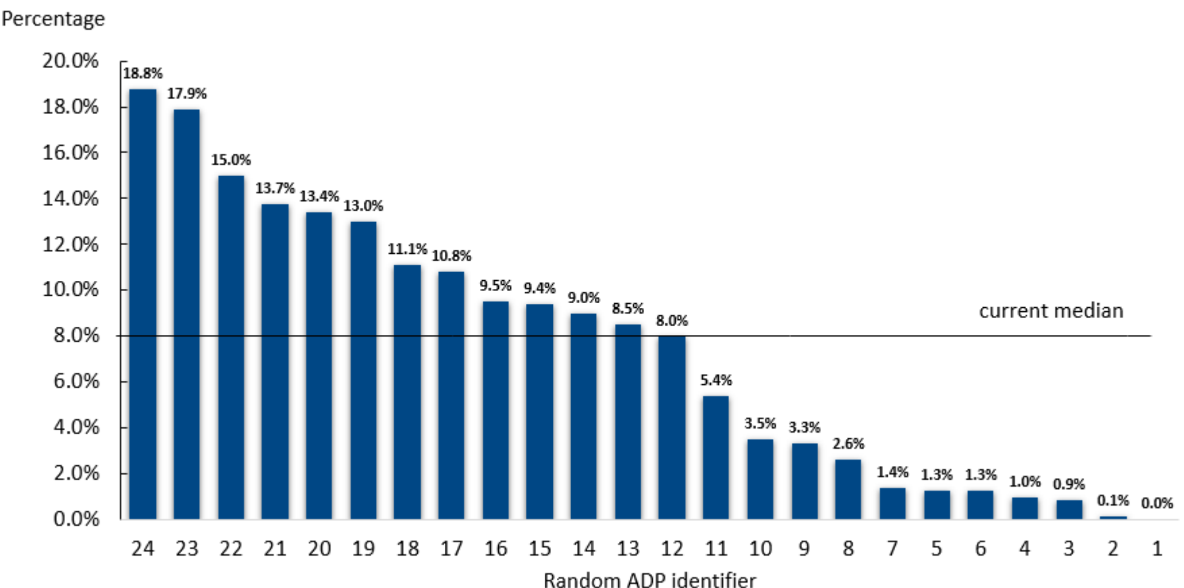


Chart description: 26 ADP areas submitted data suitable for analysis. The proportion of people prescribed different opioid substitution therapy options indicates that there is considerable variation in the prescription of long-acting injectable buprenorphine ranging from 18% of the caseload to zero.

The purpose of this standard is to empower people to make informed choices and not to meet targets for specific medications. Choice is best represented through experiential evidence. Thirteen ADP areas provided evidence from people using services on whether they felt they had been supported to make an informed choice of what medication to use for MAT, and the appropriate dose. There were limitations to some of this evidence due to the small number of people consulted.

Experiential evidence from an evaluation of the Glasgow Drugs and Alcohol service suggests that some people may not make choices when formulating their recovery plan, and that more peer support could help this issue. There are indications that optimal dosing has reduced people topping up their opioid substitution therapy with other substances, and people commented on being able to return to 'normality'. Feedback from the Dumfries and Galloway evaluation reported stability and an improved quality of life.

Although ADP areas are starting to offer choice, and to develop models of care to support this, long-acting injectable buprenorphine is not yet widely available. It is mainly provided through tests of change as demonstrated in the Glasgow City and Aberdeen pharmacy

pilots, or on a case-by-case basis where logistics, funding and capacity allow. This could partially account for the variation across ADP areas.

Overall, this standard is partially implemented. Of the 29 ADP areas, the standard is fully implemented in four ADP areas, partially implemented in 22 and not implemented in three. To move this standard to full implementation it is a priority to ensure that formularies and funding enable a choice of all options, and that ADP areas collaborate to share models of care that can help to overcome challenges such as logistics, rurality and limited capacity.

Assessment of MAT standard 3: Assertive outreach and anticipatory care

ADP areas that have achieved or are close to achieving full implementation of the standard demonstrate, or plan to implement:

- pathways and procedures that are documented
- a dedicated multi-agency team and third sector leadership
- the inclusion of general and specialist clinicians
- notification data provided daily
- data-sharing agreements with a wide range of partners
- documented links to justice settings
- rapid access to opioid substitution therapy (MAT 1 at least partially implemented)
- access to wider health and social support
- numerical data that demonstrates the time from notification to assessment and support
- programmes that cover the whole health board area.

Challenges include a focus on reactive approaches to re-engage with less emphasis on proactive engagement and planning to reduce risk. Although on the other hand some places report less intervention with people who are already in services. Few ADP areas describe systems to support young people or women, or the transition through justice settings.

Case study: Dumfries and Galloway ADP area established an assertive outreach service in October 2020. This service is delivered jointly by specialist drug and alcohol services and We Are With You and comprises two full-time specialist addiction nurses, a team leader and two full-time community navigators. There are clearly documented referral pathways in place with specialist drug and alcohol services, the accident and emergency department, Police Scotland, the Scottish Ambulance Service and the Scottish Prison Service. Numerical data provided indicate that from 7 March 2022 to 22 March 2022, all incidents were responded to on the same day the multi-agency team were notified, and all received a joint community and health services response. Experiential evidence from an evaluation found that people supported by the assertive outreach service appreciated the proactive approach and that staff felt that regular outreach support had allowed them to build relationships with people.

Chart 11: Median days between identification and initial assessment by the multi-agency team per ADP area.

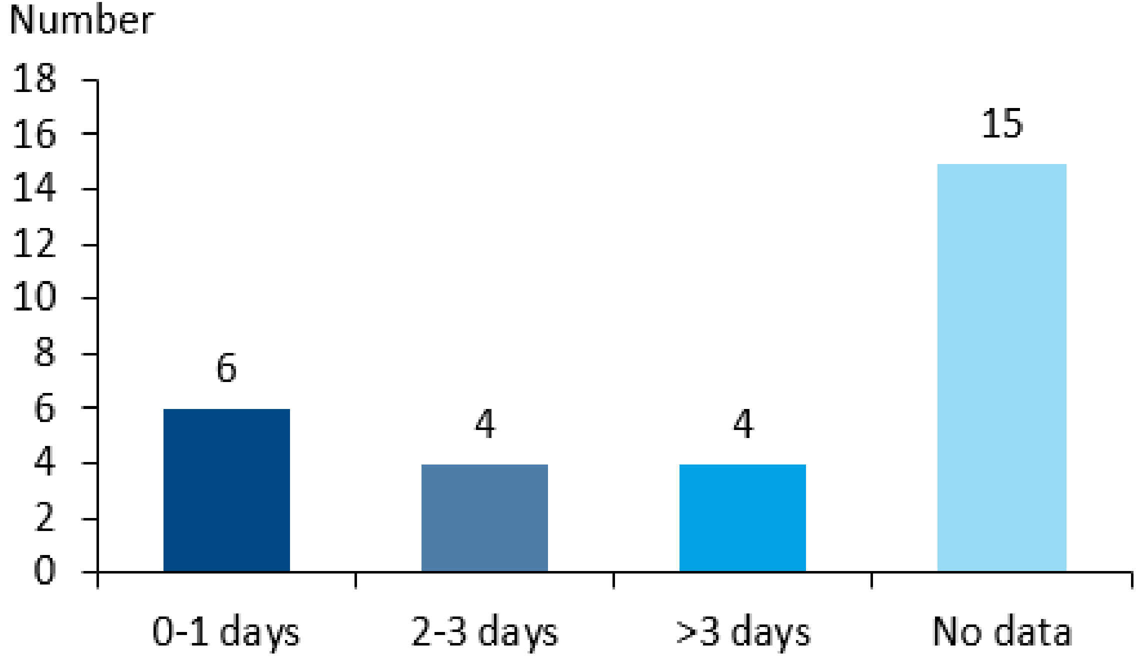


Chart description: Evidence on time from notification to initial assessment (MAT standard three requires 24–72 hrs) demonstrates that six ADP areas (21%) recorded initial assessment within one day of identification for at least 50% of referred people, four ADP areas (14%) recorded two to three days and four ADP areas (14%) an initial assessment in more than three days from notification for at least 50% of identified people. Fifteen ADP areas (52%) did not provide data. The provision of accurate numerical data for this standard is very challenging. In some cases it was not clear that the time to assessment includes all steps from the incident to initial assessment because there can be delays before notification to the team.

Experiential evidence was provided by 19 ADP areas. For six the evidence showed that the standard was not met, for three partially met and one fully implemented. Evidence was from people contacted by assertive outreach teams and participants small in number.

Overall, this standard is partially implemented. Of 29 ADP areas, the standard is fully implemented in six, partially implemented in 20 and not implemented in three.

Challenges of not fully implementing this standard include that:

- not all people at risk are identified, and identification, rather than support to improve life experience, may be seen as an end in itself
- when people are identified they do not have immediate access to care. e.g. rapid access to opioid substitution therapy, welfare, housing, social work support, child protection, primary care – this is often not in place.
- the systems to collect evidence are not able to provide data for improvement work so the improvement work cannot take place.

To fully implement MAT standard three the systems in ADP areas should be more consistent, particularly with respect to justice settings. A periodic audit is required to collect data for improvement and to establish the extent to which the systems are meeting the needs of the populations at risk. The data from audit will identify groups with specific characteristics that need to be addressed, for example women, young people, people on benzodiazepines or stimulants, and people with no recourse to public funds.

Assessment of MAT standard 4: Harm reduction

ADP areas that have achieved or are close to achieving full implementation of the standard demonstrate, or plan to implement:

- documented guidance
- availability of equipment at the MAT locations or in boxes for outreach
- local champions to enable change in practice
- mobile services
- partnership with MAT delivery
- workforce development and checklists to ensure that all staff are confident to provide the core interventions at all contacts
- embedded nursing staff in third sector teams
- documented referral pathways for interventions like wound care and sexual health
- systems for documentation and data sharing (such as for injection equipment provision)
- specific experiential feedback on services
- firm commitments to extend interventions to primary care and justice settings.

A challenge is the tendency to view the delivery of core harm-reduction interventions as the role of specialised practitioners. This role is required, but tools such as checklists, outreach bags with blood-borne virus testing equipment and ‘one-hit kits’ (including needles and syringes) enable all practitioners to offer interventions opportunistically.

Case study: North Ayrshire Drug and Alcohol Recovery Service offers injecting equipment, take-home naloxone and blood-borne virus testing at every patient contact location in the community, with checklists and outreach kits to ensure staff are trained and equipped.

The numerical data provided was based on a self-reported questionnaire on whether the three core interventions (naloxone, injection equipment provision, blood-borne virus testing) are provided at the same time and place as all MAT appointments. Nationally it is reported that approximately 60% of sites that offer MAT provide this service. However, reported custom and practice indicates that while Scotland has good access to core harm reduction at fixed sites and through specialist teams, the core interventions are not consistently provided at the time and place of all MAT appointments, especially where these involve outreach.

Chart 12: Percentage of locations delivering MAT that provide harm-reduction measures at the same time and place as initial and follow-up MAT appointments.

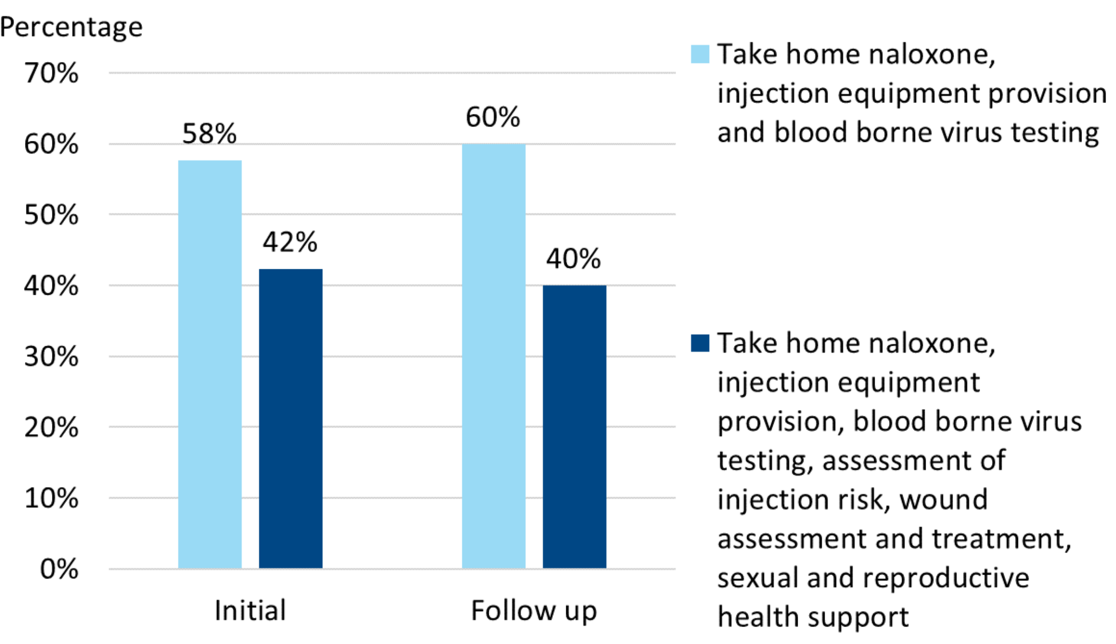


Chart description: There are 85 locations where initial MAT appointments are offered. Out of those, 49 (58%) offered the three core harm-reduction interventions (take home naloxone, injection equipment provision and blood-borne virus testing) and 36 (42%) offered all six harm-reduction services at the same time and place as the appointment. For follow-up assessments there are 95 centres, of which 57 (60%) provide the three core harm-reduction interventions and 38 (40%) offer all six at the same time and place.

Key to full implementation of this standard is that people using services and their families are aware and empowered to request harm-reduction interventions, such as needles,

irrespective of other aspects of their treatment. Very few ADP areas presented experiential evidence and these did not include that specific element.

Overall, this standard is partially implemented. It is fully implemented in eight ADP areas, partially implemented in 20 and not implemented in one. Although harm-reduction interventions are widely available, there is a lack of documented procedures or evidence to confirm that the three core interventions are consistently available in all community settings at the same time and place as MAT initiation appointments and follow up. Many ADP areas are strengthening systems and to move this standard to full implementation, local audit and specific experiential evidence is required to confirm practice and progress.

Assessment of MAT standard 5: Retention as long as needed

ADP areas that have achieved or are close to achieving full implementation of the standard demonstrate, or plan to implement:

- proactive identification of people who miss pharmacy appointments
- weekly multidisciplinary team case discussions
- expanded third sector and primary care partnership
- resource to increase psychologically informed interventions
- open-access and drop-in sessions plus cafe clinics with prescribing and psychosocial support
- documented disengagement policies
- inclusion of patients and families in care planning
- support for harm reduction and prescribing if circumstances change.

Case study: In Glasgow city there is a commitment to invest in increased numbers of front-facing staff in each of the three ADP areas. Dedicated staff will take a more assertive approach to improving access, choice, harm reduction and retention (standards 1–5) outwith the office base. This will free up capacity in the core service to meet standards 6–10. The increased capacity will also allow space and time for the development of

therapeutic relationships, including trauma-informed care, psychosocial support and effective handovers of care at treatment episode transitions, and will create capacity to train, maintain and grow the required workforce.

The numerical data provided for ten ADP areas is presented in Charts 14 and 15. Caveats to this data include the variation in the definition of planned versus unplanned discharge (for example some discharges are incarcerations where people may continue MAT) and the link to the number on treatment, because higher caseloads can lead to reduced retention where service capacity is not sufficient.

Chart 13: Percentage of planned and unplanned discharges per ADP area.

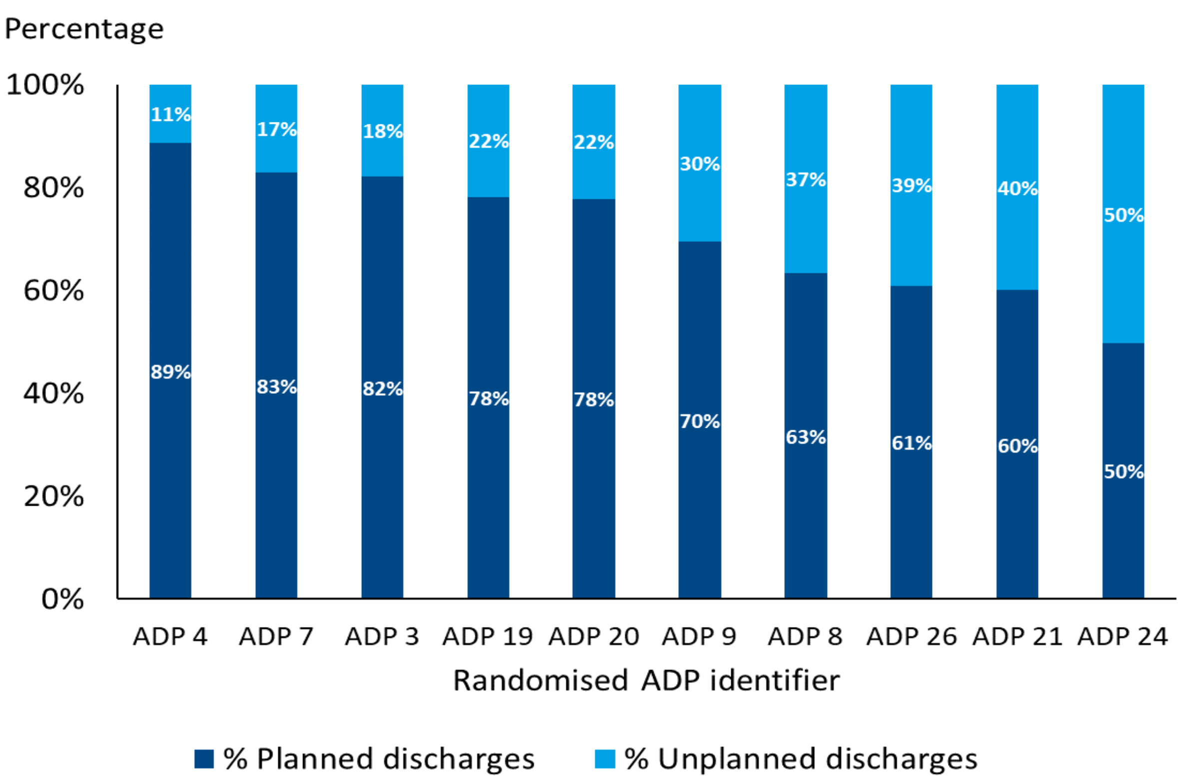


Chart description: Ten ADP areas submitted data suitable for analysis. There were 10 ADP areas without submitted data and a further 9 where the number of discharges was too low for inclusion. Of the 10 ADP areas analysed, this chart demonstrates that the proportion of unplanned discharge ranges from 11% to 50% and planned discharge ranges from 89% to 50%. This is an indication of unwarranted variation and the need for targeted improvement in some areas.

Chart 14: Percentage of planned and unplanned discharges per ADP area by months on treatment.

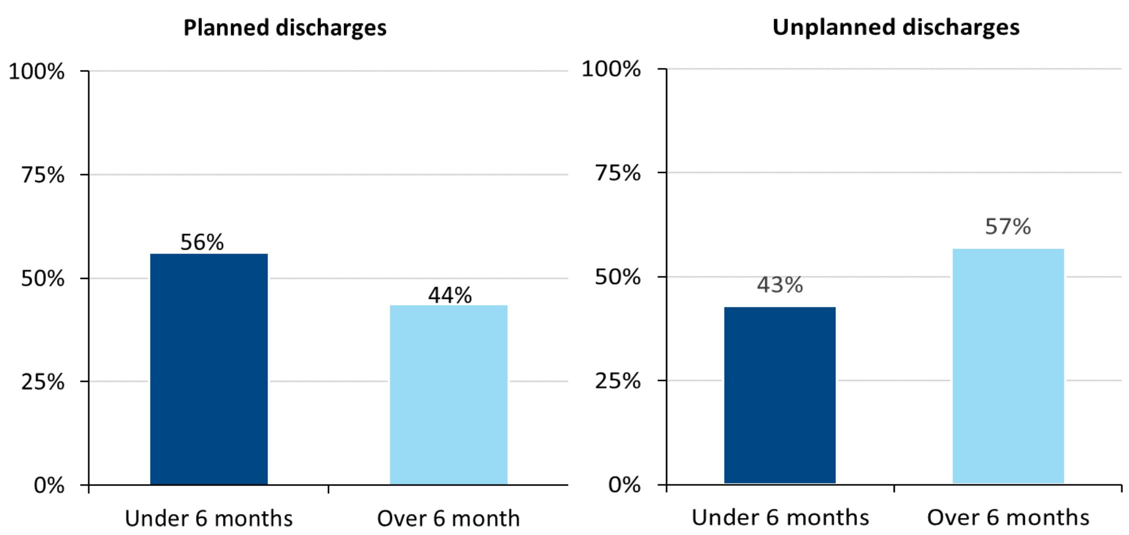


Chart description: Sixteen ADP areas submitted data suitable for analysis. There are 10 ADP areas without completed data and three had fewer than 10 discharges recorded. For those ADP areas included, 43% (n=117) of unplanned and 44% (n=240) of planned discharges occur less than six months into treatment. This may suggest poor support for retention and planned exit from care. The evidence is that at least six months in treatment reduces drug-related death if followed by a coordinated discharge when a person is ready.

Experiential evidence relating to support to remain in treatment was submitted by 22 ADP areas. Evidence gathered illustrates that the support offered by recovery communities, cafes and hubs is valued by people who use them. This includes activities such as walks, peer support groups and volunteering opportunities. Support from people with lived experience is especially valued. Where ADP areas have submitted evidence on the experience of families and nominated persons, it indicates they need and want support to help them care for a family member or friend who is in treatment, but frequently struggle to achieve this. There is limited, if any, experiential evidence from ADP areas on moving on from services.

Overall, this standard is partially implemented. It is fully implemented in six ADP areas, partially implemented in 21 and not implemented in two. There are considerable gaps in documentation and in the numerical and experiential data needed to assess and improve the service. To move this standard to full implementation, clinical audit and structured

dialogue with people using services, and their families and nominated persons, is required to fully understand the reasons for the variation in rates of planned and unplanned discharge, and the high proportions of people in care for fewer than six months.

5. Progress with MAT standards 6–10 in the community

The key actions being taken at national and local level are summarised below.

MAT standards 6 and 10: Psychological support and trauma-informed care

National work

- Training for staff in trauma-informed care and psychological support is underway in ADP areas and aligned with the NHS Education Scotland Transforming Psychological Trauma Knowledge and Skills Framework.
- The Lead Psychologists in Addiction Services Scotland (LPASS) group is leading the development of a national competency framework that will include defining minimum national standards across all tiers for psychological and trauma-informed care.

Examples of current and planned work

- Aberdeenshire is using a workforce development model to build capacity across the multi-agency teams so that psychological interventions can be delivered consistently. Coaching, supervision and reflective groups are being developed with an increased focus on staff wellbeing. This model will also be implemented in Fife and Borders.
- East Dunbartonshire and West Dunbartonshire have cognitive behaviour therapists as part of the multidisciplinary team.

- In both Lanarkshire ADP areas, psychology staff are delivering psychological interventions to people using services, and providing training, support and supervision to staff.
- Pathfinder projects led by the National Trauma Training Programme and supported by NHS Education for Scotland, will be working with NHS Dumfries and Galloway and NHS Orkney. The pathfinder projects will explore the challenges and enablers to embedding sustainable models of trauma-informed care.

MAT standard 7: Primary care

National work

The Scottish Government, with support from the MAT programme, will establish a short-life working group in June 2022 to identify options for the delivery of drug treatment in primary care. The scope of this work will include expert review of models of care, and synthesis of literature and learning from other sources.

Examples of current and planned work

- NHS Lothian has a Primary Care Facilitation Team that provides professional support to general practices signed up to the substance use national enhanced service. The enhanced services include the offer of opioid substitution therapy. A high proportion of people on MAT in Lothian (around 70%) have the option of shared care with general practice.
- Moray and East Lothian have a model of care where an advanced nurse prescriber works within a primary care setting to offer opioid substitution therapy prescribing and improved pathways for holistic health care needs through general practice and the third sector. This model will be adapted for local implementation in Aberdeenshire, Midlothian, Borders and Inverclyde.
- There are three tests of change funded, and due to start shortly, with primary care in Dundee to find ways of working that can support implementation of MAT standards 5 and 7. Plans include opioid substitution therapy prescribed by GPs and

supported by specialist services, and GP-led multidisciplinary review with a focus on wider health needs. Further work is planned to provide more care options through increased partnership working with third sector colleagues.

MAT standard 8: Independent advocacy and social support

National work

- REACH Advocacy, a grassroots third sector organisation, delivers education and training to raise awareness and understanding of the MAT standards and their underpinning principles for a human-rights-based approach. The aim is to deliver training across all ADP areas and to have champions accredited with the REACH Advocacy Practice Award (SCQF 7).

Examples of current and planned work

- The REACH training has been delivered to 15 ADP areas through a series of one-day workshops, a Scottish Qualification Authority-approved 12–14-week course and a REACH Advocacy Practice Award. There are plans to take this training into justice settings in 2023.

MAT standard 9: Mental health

National work

- The Integrated Mental Health and Substance Use Pathfinder Programme is working to redesign care pathways to improve health outcomes for people with mental health and substance use support needs. This work is led by Healthcare Improvement Scotland and jointly funded by Scottish Government mental health and drug policy divisions.

Examples of current and planned work

- The Pathfinder Project began working across NHS Tayside in February 2021 with the ‘Working Better Together’ project. This work is ongoing and is being expanded to NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lanarkshire and NHS Lothian.

- Borders ADP area will recruit an advanced nurse practitioner to offer mental health assessments through third sector services to people who do not meet the criteria for the community mental health team or addictions services. There will be joint assessment and care for people with multiple and complex needs, including prescribing of opioid substitution therapy or benzodiazepine detoxification where indicated.

6. Progress with the MAT standards in justice and custodial settings

The MAT programme team have started work with the Scottish Prison Service, National Care Networks (prison and police custody) and specific prisons to raise awareness of the MAT standards and to scope out plans. A scoping exercise is also underway to include the United Kingdom Government immigration removal centre, Dungavel House, and the three UK Government Border Force immigration offices in Glasgow, Edinburgh and Aberdeen.

The MAT programme will deliver a programme of support for justice and custodial settings with the following components:

- Mapping with individual justice and custodial settings to identify areas of good practice and gaps for improvement.

- Identification of areas of focus. This will be achieved through mapping and will identify a combination of specific settings and specific standards for targeted improvement work.

- In some areas a local network approach will be proposed. This will aim to map out and strengthen pathways between prison, police custody and community services so that consistent care can be offered as people move between locations.
- In all settings the MAT programme will offer support to collect process, numerical and experiential evidence of success and use this for benchmarking across settings.

Examples of current work and planned work

- In April 2022 the MAT programme team met with senior management and the multi-agency staff teams at Her Majesty's Prison (HMP) Perth to discuss implementation of the MAT standards. There is agreement with the Scottish Prison Service and NHS Tayside that HMP Perth will be an early adopter site for implementation of the standards.
- The MAT programme proposes to work with HMP Perth, local police custody suites and with Dundee, Perth and Kinross, Angus and Fife ADP areas to identify models of care that can ensure the standards are met across the pathways between all settings. The learning from this will be shared nationally to assist scaling up.

7. The MAT standards for specific populations

The MAT standards need to improve access, choice and care for all people affected by problematic substance use. This includes:

- women
- people who use multiple drugs, such as benzodiazepines, stimulants and gabapentinoids
- migrants
- young people
- people engaged with drug rehabilitation services.

Further work is required in all these areas. Below are examples of action in some.

Benzodiazepines

In January 2022, an expert group met to discuss how to ensure that the MAT standards are applied for people who use benzodiazepines. The main areas noted for action:

- A clear route for rapid access to benzodiazepine care within MAT standard 1 is required, even where this does not necessarily include prescribing.
- Local and national leadership is required for prescribing, psychology, third sector support and training.
- Prescribing advice is required within current British National Formulary and licensing parameters, for example for long detoxification.
- Greater involvement in services of people with lived and living experience of harmful benzodiazepine use is required, including young people and families.
- National training needs assessment is required across all MAT standards work, and needs to include requirements for benzodiazepine care (this is underway to an extent as part of the Scottish Government workforce survey).
- There is a need to work with academic institutions to obtain and disseminate evidence for maintenance prescribing and psychological care.
- Coordination is required between the benzodiazepine work and the Scottish Government work on safer prescribing of ‘Z drugs’ (sleeping tablets with effects similar to benzodiazepines).

Young people

In spring 2022 an expert group was established by the Scottish Government to develop a set of minimum standards of care for young people with problematic substance use. These standards will be developed in consultation with young people and supported by the MAT programme team.

Women

The Scottish Drug Deaths Taskforce published a report on 1 December 2021 on the subject of women and drug-related deaths. The MAT programme team will use the recommendations in this report to support ADP areas with the development of gender-specific services for women who use drugs, and their families or nominated persons.

Stimulants

There has been a large increase in cocaine deaths, from 93 in 2015, to 459 in 2020. The Scottish Drugs Forum is developing a cocaine toolkit with NHS Greater Glasgow and Clyde. A report will be published in summer 2022 and will provide guidance for service providers working with people using cocaine and crack cocaine. There is a need for mapping of current service provision for stimulants across Scotland, and a clear route for rapid access to care in line with MAT standards 1 and 3.

8. Conclusions

There is unwarranted variation in the implementation

The models of care to deliver the MAT standards need to be flexible and adapted to the local circumstances, such as small caseloads in rural areas and large caseloads in urban areas. There are good models in place and developing.

Of 145 standards of care assessed, 17% (25/145) are fully implemented, 65% (94/145) are partially implemented and 18% (26/145) are not implemented. This suggests that work has started or is well established in most places, but that there is still a lot to do for full, consistent and sustained implementation of the standards in all areas.

There is variation between ADP areas. This is demonstrated where benchmarking and RAG assessment indicates that access, choice and retention is much lower in some ADP areas than the majority. For example the median time to a prescription for opioid substitution therapy ranges from the same day to more than 20 days. In 17 ADP areas there is at least one of MAT standards 1–5 that is RAG status red, and in seven ADP areas two or more standards are RAG status red. MAT standard 1 is most frequently not implemented (17 ADP areas; 59%). This means that in these ADP areas there is no evidence of ongoing service provision or a current test of change to implement the standard. In other ADP areas, although the standard is allocated RAG status amber, the evidence indicates that the ADP area is only just starting implementation.

There is variation within ADP areas. This is demonstrated by the RAG score amber which indicates that although the standard is partially implemented it is not consistent across the area for all people. Overall 11 ADP areas are at amber for MAT standard 1; 22 for standard 2; 20 for standard 3; 20 for standard 4 and 21 for standard 5.

There is insufficient documentation in many ADP areas of the policies, processes and pathways required for safe, effective and consistent delivery of services. Overall, across all the standards, including all ADP areas, approximately 27% of ADP areas were able to provide documented policies, guidelines, and standard operating procedures sufficient to demonstrate full and consistent implementation of a given standard.

Systems are not sufficiently intelligence led

The national and local systems for the collection of numerical data are frequently unable to provide the person-centred data that is required for the effective implementation of the MAT standards. This is because most were designed and implemented before the MAT standards were published.

The most commonly used system was DAISy (39 times), followed by local databases (29 times), and EMIS (17 times). For each MAT standard, over 20 specified data sources were

used. The variety of methods, reporting periods and populations included make comparison of data difficult across Scotland. For example, some ADP areas conduct manual audit and others use data linkage to report on the same indicator. Overall, the numerical data provided was insufficient to demonstrate implementation for 46% of standards and there was no data provided for 14% of standards.

Of the evidence collected to demonstrate progress, experiential (from people who use services, people who could benefit from them and their families and nominated persons) is the closest of the measures used in this report to an outcome because it describes the interaction of people with the services and any benefit of detriment experienced. It is not possible to assess progress or effect change without experiential evidence. However, there was no data provided for 43% of standards; 19% of data indicated the standard was not met; 22% partially met and for 16% of standards fully met.

The variation in completeness and quality of numerical, experiential and process data emphasises the need to collect all three types of evidence and to combine this with local narrative and expert opinion to obtain as true a picture of implementation as possible.

The variability and gaps in the systems for evidence collection mean that it can be difficult to identify exactly what the systems of care are, the experiences of the people involved, and the things that need to improve.

Further details on the methods and challenges for numerical and experiential evidence collection are in **Appendix 2: Evidence**.

Funded commitments to fully implement the standards have not been realised

In many ADP areas, plans have not yet been implemented because of delays in recruitment, conflicting priorities due to COVID-19, and challenges with leadership and financial planning. Over 2021–22, all ADP areas specified improvement projects and funds were agreed with the Scottish Government. It is notable that initial analysis of funding requirements demonstrates that around 60% of funds will be allocated to clinical staff to build capacity for service delivery (see supplementary information to be published in August 2022).

Risks

There is a risk that partially implemented strategies to improve access, choice and care will fail because without full implementation, the system will be unable to meet the requirements of people that are identified, and improvement will not be sustained. As a result the standards will not meet their aim of reducing drug-related harm.

There is a risk that, as a result of systems to collect numerical and experiential information not being set up, data for improvement work is not available and the improvement cannot take place.

As a result of uncertainties about continued funding beyond the initial project term, there is a risk that the discontinuation of part, or all, of the funding could lead to a decrease in the quality and quantity of care that can be provided. This is particularly an issue for areas that have sought funding to strengthen existing ways of working (as opposed to creating separate service structures for parts of the standard delivery).

A detailed analysis of risks based on feedback from ADP areas is in **Appendix 3: Risks**.

9. Recommendations

1. **Fully implement MAT standards 1–5 in the community by April 2023**

   The MAT programme will agree improvement plans with ADP areas and these will be published in August 2022.

   - MAT improvement plans will be agreed for ADP areas with standards that have a red or only just amber RAG status. To support the MAT improvement plans the MAT programme will:
     - provide practical assistance and tools for quality improvement, data collection and project management
     - establish cluster groups to support ADP areas with MAT improvement plans.

- Scale-up plans will be agreed with ADP areas for standards that are further advanced. To support the scale-up plans, the MAT programme will:
    - provide practical support through the establishment (in collaboration with partners) of thematic ADP area clusters
    - enable benchmarking, information sharing, spread of good practice, development and dissemination of tools (such as audits, template documents) and inter-organisational support.
- Commitment and senior leadership from health and social care partnerships will be necessary to allocate the resource that is required for successful implementation.

2. **Partially implement MAT standard 6–10 in the community by April 2023**

The MAT programme will work with partners to complete the following actions:

- Provide practical support to implement the standards and this will include the establishment of thematic ADP area clusters for individual or groups of standards so that ADP areas can collaborate on mapping, tests of change, benchmarking, spread of good practice and inter-organisational support
- Work with ADP areas to define the measures of success that will be used for the evidence-based assessment of progress against MAT standards 6–10 in April 2023.

3. **Map and implement the MAT standards in early adopter sites in justice and custodial settings by April 2023**

The MAT programme will work with partners to complete the following actions:

- Mapping with individual justice and custodial settings to identify areas of good practice and gaps for improvement.
- Identification of areas of focus. This will be achieved through mapping and will identify a combination of specific settings and specific standards for targeted improvement work.

- In some areas a local network approach will be proposed. This will aim to map out and strengthen pathways between prison, police custody and community services so that consistent care can be offered as people move between locations.

- In all settings, the MAT programme will offer support to collect process, numerical and experiential evidence of success, and use this for benchmarking across settings.

- Thematic clusters will be established to support implementation and inter-organisational support.

4. Ensure the MAT standards provide improved access, choice and care for specific populations

The MAT programme will work with partners to complete the following actions:

- People who use benzodiazepines, stimulants and other drugs:

  - Agree prescribing and psychological approaches to enable practitioners to provide harm-reduction support for people using benzodiazepines in line with the interim guidance published in August 2021.

  - Ensure that implementation of the MAT standards explicitly includes access, choice and care for people using benzodiazepines, stimulants and other drugs such as gabapentinoids.

  - Establish (in collaboration with partners) a thematic cluster to share learning and practical approaches to implementation of the MAT standards for people who use benzodiazepines, stimulants and other drugs such as gabapentinoids.

- Women, young people and migrants:

  - Establish (in collaboration with partners) thematic clusters to share learning and practical approaches to implementation of the MAT standards for women, young people and migrants.

- People engaged with drug rehabilitation services:

- Establish (in collaboration with partners) stronger links with rehabilitation services to ensure that pathways into rehabilitation care are accessible through MAT, and to share learning and practical approaches to implementation of the MAT standards in these settings.

5. **Build sustainable numerical data systems to monitor and improve implementation of the standards**

The MAT programme will work with partners to complete the following actions:

- Strengthen the national data systems for substance use (such as DAISy, Needle Exchange Online) and data linkage across the systems. The MAT programme will work with Public Health Scotland, ADP areas, the Scottish Government and others to do this.
- Use to greater advantage the existing local capacity and systems during the transition to national reporting systems. This includes funding and support for local analysts, investigating development of the most commonly used databases (for example EMIS, TRAK), and assessing whether local databases can be shared.
- Extend the use of local audits for reporting and targeted improvement work. The MAT programme will facilitate sharing of good practice (for example the Glasgow MAT audit) and will provide assistance for ADP areas to develop local audits.

6. **Build sustainable experiential data systems to monitor and improve implementation of the standards**

The MAT programme will work with partners to complete the following actions:

- Establish in all ADP areas systems that ensure there is ongoing dialogue with people using and providing services, and that feedback is incorporated into the local improvement cycles.
- Standardise systems to enable collection, collation and reporting of raw and aggregate data from ADP areas for national analysis to enable

benchmarking, and to identify common themes that require further investigation and action.

- Provide practical assistance to ensure there is dedicated local capacity, tools, training and partnerships (for example with local lived experience panels) in place to enable the actions above to take place.

7. Conduct targeted national investigations

The MAT programme will work with partners to complete the following actions:

- Identify standards and topic areas that require national audit. The evidence provided as part of the April 2022 assessment can be used and the priorities need to be agreed with partners. These should include the experiences of women and people using multiple drugs such as benzodiazepines, stimulants and gabapentinoids.

- Conduct audits that track a patient's journey through the care pathway and include the collection of process and clinical information as well as experiential data with people using services, their families and people providing services.

8. Strengthen the improvement and benchmarking programme for the MAT standards

The MAT programme will work with Healthcare Improvement Scotland, the Scottish Government Drugs Mission, and other partners to deliver the following actions:

- Build capacity in ADP areas for practical quality improvement expertise.

- Establish and develop national networks including with:
  - senior clinicians to provide expertise and clinical leadership
  - ADP areas' lead officers, analysts, experiential leads and information governance leads

    - thematic clusters to support MAT improvement and scale up plans for specific standards or groups of standards.

- Establish benchmarking across ADP areas and justice settings by the systematic collection, collation, analysis and sharing of learning from local programmes. This will be enhanced through:

    - the spread of knowledge and good practice through inter-organisational visits and face-to-face learning events

    - a digital learning zone that will be established in partnership with Healthcare Improvement Scotland.

    - regular sharing of reports, results and innovations relating to models of care to meet the MAT standards.

10. Implementation

Table 2: Phases of implementation of the MAT standards

Phase	April 2022	April 2023	April 2024	April 2025	April 2026
Phase 1: Partially implement MATs 1–5 in community services	✓				
Phase 2: Fully implement MATs 1–5, partially implement MATs 6–10 in community services	✓	✓			
Phase 3: Fully implement MATs 1–10 in community and justice settings	✓	✓	✓	✓	
Phase 4: Sustained implementation of MATs 1–10 in community and justice settings, including for women, young people and people who use other drugs (benzodiazepines, stimulants)	✓	✓	✓	✓	✓
Evidence collection capacity building	✓	✓	✓	✓	✓

Appendix 1: Allocation of RAG for progress against the MAT standards

Eight questions posed on whether the evidence provided by an ADP area confirms implementation of a given standard

1. Are the necessary services offered?
2. Are documented policies, operating procedures, guidelines and so on sufficient to support full implementation?
3. Does reported custom and practice indicate full implementation?
4. Does the numerical data provided indicate that the standard is met?
5. Does feedback from people using the service and their families and people providing the service indicate that the standard is met?
6. Is implementation of the standard consistent across the ADP area and all community locations that provide MAT?
7. Are resources, plans and commitments in place to address the gaps?
8. What is the clinical and public health assessment of the MAT Implementation Support Team?

For full implementation, all or most of questions one to seven are required to be answered yes.

For partial implementation, all or most of questions one to five are required to be answered yes or partial.

No or limited implementation is allocated where most answers are ‘no’, ‘partial’ or ‘no data’.

Example of allocation of RAG status for MAT standard 1

Red: There is no or limited evidence of implementation of the standard in MAT services.

For example:

- there are no documented tests of change for standard 1
- there are no or insufficiently documented procedures
- reported custom and practice is not clear
- the numerical data systems in use are unable to demonstrate time from first presentation to prescription to accurately assess if people have same-day access to prescribing
- there is no documented systematic feedback that access is improving.

Amber: There is evidence of partial implementation of the standard in MAT services.

For example:

- a single service test of change for standard 1 is in progress or has been completed
- there is evidence of documented clinical procedures in place
- there is evidence that reported custom and practice includes access to same-day prescribing for people presenting to any member of the multi-agency team
- positive trends in time from first presentation to prescription have been observed in the numerical data available, or there is evidence that a significant proportion of people start on the same day of presentation
- there is documented systematic feedback from people using services that access is improving

- there are documented plans and commitments in place to fully implement the standard.

Green: There is evidence of full implementation of the standard across all MAT services.

For example:

- the processes established in an initial test of change for standard 1 (such as standard operating procedures and prescribing guidelines for same-day assessment and treatment) have been formalised through local governance agreements and implementation is being rolled out across all MAT services in the ADP area

- there are systems in place, to document the time from first presentation to any member of the multi-agency team to prescription, and there is ongoing evidence of a positive trend in access

- there are documented systems in place to enable systematic input from people about their experiences of services and plans to demonstrate that feedback is incorporated into service evaluation and improvement.

Blue: There is evidence of sustained implementation and ongoing monitoring of the standard across all MAT services.

For example:

- all the criteria in place for green are established as usual business across the ADP area. These include procedures for service delivery, numerical and experiential data collection and systems to ensure that learning informs continuous quality improvement

- key staff delivering services are permanently funded and there is clear corporate ownership and forward planning of services

- there are systems in place to enable sustained input from people, and their family or nominated persons about their experiences of services.

Appendix 2: Evidence collection challenges and plans

Numerical evidence

Overall, 11 different database systems are listed as having been used by the ADP areas to produce the numerical data requested for MAT standards 1–5. It should be noted that this includes the class of 'local database' that will contain several different local systems. The most commonly used system was DAISy (39 times), followed by local databases (29 times) and EMIS (17 times). For each MAT standard, over 20 specified data sources were used with a further five to ten unspecified. This indicates that data sources were sometimes used in combination to produce the required MAT data, with the commonest combination being DAISy and EMIS (15 times).

DAISy was most commonly used for MAT standard 1. However, DAISy does not currently record the required measure of time from first presentation to any partner in the multi-disciplinary team and would require altering to do so. This is true of all the national systems currently in use as they were designed and implemented before the MAT standards were developed and published. As such, they are often unable to provide the required person-centred data that the monitoring of MAT implementation requires. Development and amendment of these national databases cannot be done quickly and therefore use of local databases represents one way to achieve calculation of key measures until key developments of DAISy can be completed. Another approach is to use a local audit system, in effect a local manual data collection, storage and analysis process.

The main challenges to collecting numerical evidence

- It was found that the data definitions require to be tightened internally.
- Clinical decision points (did not attend, could not attend, continuation of care) were needed from experienced clinical staff.
- The variety of data sources used means that the MAT standard data definitions were often not fully matched by the data that was submitted.

- There was use of different definitions, for example, start and stop point for waiting times, and different definitions for discharge.
- The variety of reporting periods (annual, quarterly, test of change) and populations included (all people on the caseload, pilots) made comparison of data difficult across Scotland.

The main steps in the collection and collation of data

- Data definitions were developed as far as possible, combining the description in the MAT standards and clinical decisions on the range of defining factors.
- It was decided to use the median and quartiles to summarise data, for example the number of days. This avoided data being skewed by the low number of outliers.
- Two versions of the numerical data collection format, known as Form 2, were developed. One with gender and age breakdowns of data, and one with summary data (population totals). This was done to accommodate the different local capacity to collect and report data.
- The MAT team supported data collection by the ADP areas through online meetings to explain what was required, and to provide support on what data could be used. The approach of the team was to acknowledge that data quality would be variable in terms of data sources available, what was used, completeness and accuracy.
- Each of the 29 Form 2s returned was analysed separately for each MAT standard, and an overall summary was also produced.
- A MAT 'numerical network' was set up with ADP areas to support the work.

How to build capacity

Below is a list of actions that will be followed up by the MAT programme team:

- Improve the quantity of available analytical capacity, or share analysts between ADP areas. This is an action for ADP areas but has been supported by the MAT

programme through funding and discussion of the Project Specification Documents. Several ADP areas are in the process of recruiting analysts.

- Identify the training needs and opportunities for ADP area analytic staff, for example in R, or database design.
- Clarify and set definitions, both data descriptions and clinical decision points.
- Define and standardise the data required to match actual MAT standard definitions including start and stop points and the reporting periods.
- Move to more detailed age and gender data structure, but perhaps less detailed than the original structure to avoid low number issues.
- Provide advice on data sources and how to use them (both the MAT team and ADP areas will contribute to this through an information-sharing and workshop process).
- Develop the use of the most commonly used databases (DAISy, EMIS, and TRAK etc.).
- Evaluate the use of local databases and whether sharing these is a possible route to improving data quality.
- Investigate wider use of the audit system developed in Glasgow City and Edinburgh to record the details of the patient journey.
- Develop DAISy to enter and extract the data required. This is likely to be a medium-term project and be part of a larger DAISy updating project. This could potentially create competition for programming resources, and prioritisation will be required.
- Collect information from each ADP area to capture the key issues and possible solutions relating to evidence gathering. Collate these and use a workshop approach to develop practical solutions.
- Facilitate the exchange of methods that have been found to be both practical and that produce the required data. One such method identified is an audit system that

looks at a limited period of data in greater detail, for example, one month's data every three to four months.

Experiential evidence

Experiential evidence has been gathered from people who use services and their families, through methods that include: questionnaires and surveys as part of service evaluation and feedback; focus groups (for example, for seeking the views of the families of people who use services); and one-to-one qualitative interviews as part of research and evaluation by third sector organisations such as the Scottish Drugs Forum and Scottish Families Affected by Alcohol & Drugs.

While much of the evidence submitted to MIST has been collected by staff, peer researchers have been involved in research conducted by the Scottish Drugs Forum. MIST has begun training people with lived experience and staff to enable them to carry out qualitative interviews with people who use services.

The evidence presented by ADP areas has been collected for a specific time-limited purpose; for example service evaluation, needs assessment or service redesign, and not as part of an ongoing systematic process of collecting user experience to inform quality improvement work. A considerable amount of feedback is by surveys with predominately closed questions.

Examples of recent evidence gathering of the views of service users:

- The South and North Ayrshire Medication Access Service questionnaires asked service users to give their views on their experience with care and support when accessing same-day prescribing. While predominantly a closed-question survey, open questions were asked.

- A telephone questionnaire evaluation of a pilot of long-acting injectable buprenorphine prescribing by Glasgow Alcohol and Drug Recovery Services seeking the views of people who had accessed, and received treatment, from the service.

- Qualitative research gathering the views of people using services and their families, for example:
    - the Scottish Drug Forum report: 'Medication Assisted Treatment: Service Evaluation of People's Experience of Accessing MAT in Six Health Board Areas Across Scotland (2021)'. Data collection was facilitated by peer researchers
    - the Scottish Families Affected by Alcohol & Drugs and North Lanarkshire ADP area report: 'Hidden in plain sight? The experiences of families affected by substance use in North Lanarkshire (2021)'. This was mixed-methods research focusing on support for adult family members affected by a loved one's alcohol and drug use
    - the Scottish Drug Forum and Action on Drugs & Alcohol Dumfries & Galloway report: 'Understanding the treatment and care needs of pregnant women who use substances in Dumfries and Galloway (2021)'. This was an evaluation of the needs of pregnant women who use substances. It was qualitative research with women and staff, and included women's experience of services.
- An example of a planned process of collecting user experience is the North Ayrshire Drug and Alcohol Recovery Service, and Ward 5 Service User Satisfaction Audit Programme 2022. These are ongoing audit processes including the collection of experiential data with clients who have accessed the MAT pathway.

How to build capacity

It is recognised that ADP areas are all at different stages of readiness to start gathering experiential data. In May 2022 a survey was sent round all ADP areas to assess the extent to which key components are in place. For example trained capacity to collect data, plans to use data for improvement and systems to ensure that appropriate support and governance is in place for people collecting and sharing information (see Chart A1).

Chart A1: The main challenges to collecting experiential evidence

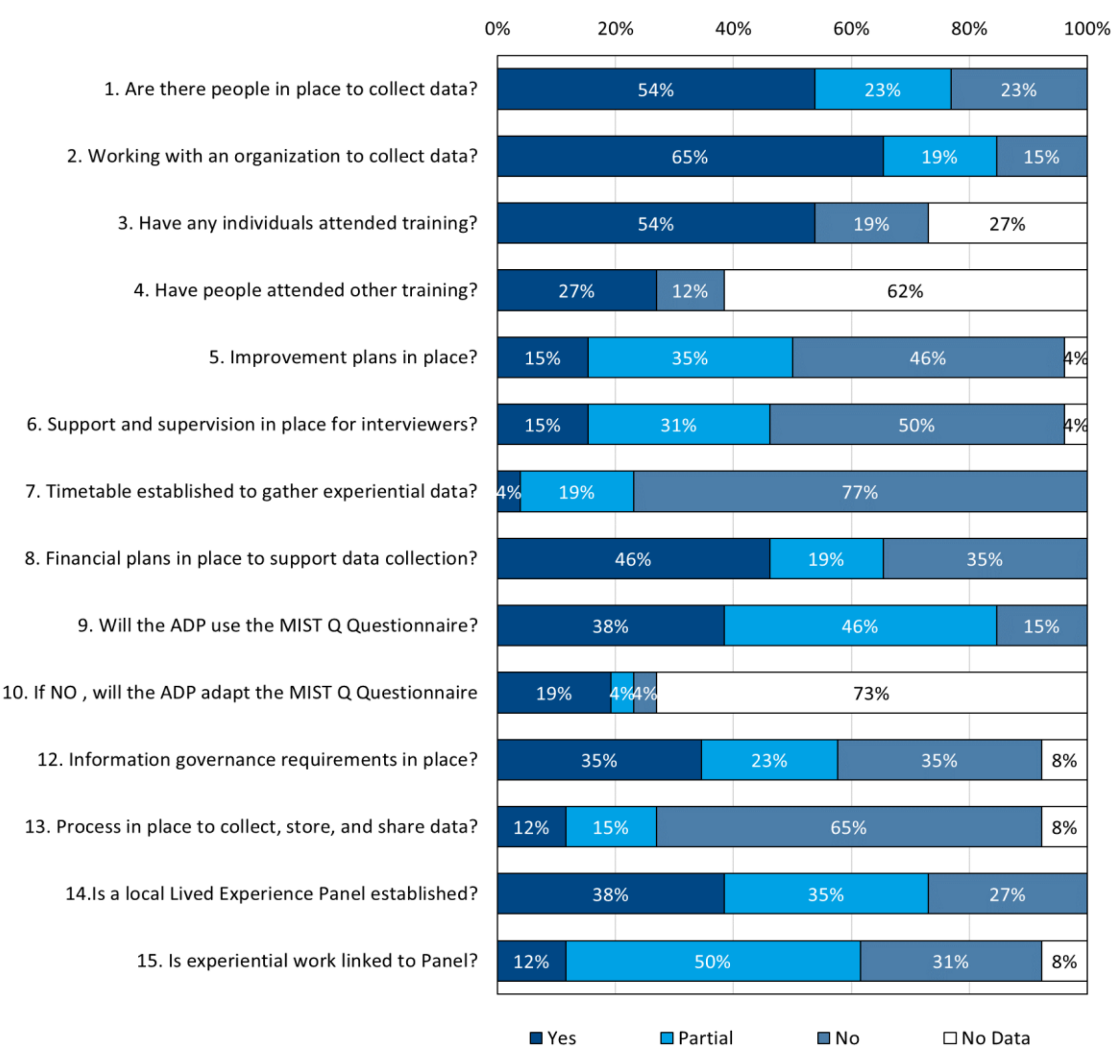


Chart description: Of 29 ADP areas, 26 returned completed questionnaires. Data from the questionnaires show that roughly 54% of ADP areas currently have individuals or groups in place to conduct interviews to gather experiential data. Similarly, 54% of ADP areas reported that their interviewers have had the necessary training to conduct interviews. When asked about whether the ADP area had an improvement plan in place to use experiential data for programme evaluation and quality improvement, 15% of ADP areas reported that they had this system in place and 4% of ADP areas reported that they had a timetable established for future gathering of experiential data. Thirty-eight per cent of ADP areas reported that there is a local Lived Experience Panel established, but only 12% reported that the experiential work is being linked to the panels. Thirty-five per cent of ADP areas reported that they have local information governance requirements agreed and

in place to ensure that the experiential data collected can be shared and used for improvement.

Below is a list of actions that will be followed up by the MAT programme team (Team Q) with ADP areas and other partners:

- Establish a team of trained locality interviewers with local administrative support.
- Ensure local information governance requirements are in place.
- Make links and agree ways of working with lived experience groups and the local Lived Experience Panel.
- Identify the initial services to focus on as a ‘test of change’ (linking in with the local ADP area action plan and national priorities).
- Establish procedures for recruitment of service users, family members, nominated persons and service providers to be interviewed.
- Establish local plans and schedules to gather evidence from people recruited.
- Identify appropriate mechanisms to offer emotional support to interviewees and interviewers if necessary.
- Establish local capacity and systems to analyse the experiential data and use this to inform quality improvement of services.
- Establish local and national procedures to report the raw and analysed data to the MAT programme team for analysis and feedback.

Appendix 3: Risks

This appendix summarises the risks and issues identified by the ADP areas in their project specification documents that were returned in February 2022. The mitigation of these risks and issues varies between ADP areas and are considered as part of the ongoing improvement processes.

Table A1: Partnerships

These are risks that emerge because local plans have been made with a number of partners and have a series of external dependencies that are outwith the control of the Chief Officer or ADP area coordinator.

Partnership point number	Partnership's risk	MAT standard	Notable features
P1	As a result of funding pressures and required efficiencies within external organisations, there is a risk that improvement projects which require contributions from external partners (not benefiting from additional Scottish Government investment) to strengthen multi-agency approaches cannot be delivered. This would result in siloes in service provision and increased or unsustainable demand on the partners who do have additional funds.	This risk is dependent on the type of model proposed but is particularly an issue for standards 7, 8, 9	n/a
P2	As a result of high service entry thresholds and exclusion criteria, there is a risk that services created to improve support for people with substance use and mental health difficulties are unable to access specialist services, and people are not given the care that they require.	Third sector commissioned support services to deliver standard 9	n/a
P3	As a result of competing priorities and no additional resource, there is a risk that partners withdraw participation from care arrangements that leads to increased	Standard 7	n/a

Partnership point number	Partnership’s risk	MAT standard	Notable features
	pressure and demand on the remaining parts of the service.		

Table A2: Funding and sustainability

These are risks that emerge that are directly related to the provision and access of funding in the short, medium and long term to provide the required service.

Funding point number	Funding and sustainability risk	MAT standard	Notable features
F1	As a result of uncertainties about funding during and beyond the initial project term, there is a risk that the discontinuation of part, or all, of the funding could lead to a decrease in the quality and quantity of care that can be provided.	All	This is particularly an issue for areas who have sought funding to strengthen existing way of working
F2	As a result of cost of equipment, or training, not being included in project planning, there is a risk that costs associated with expanding blood-borne virus testing (testing, staff training) will not be covered by partner agencies and these services will not be delivered.	Standard 4	n/a
F3	As a result of uncertainty in local financial processes, there is a risk that financial savings generated by improvement projects are not reinvested in the service leading to lack of motivation and commitment among staff to engage in improvement work.	All	n/a

Table A3: Workforce

These are risks that relate to the workforce, actual or intended, professional or peer, who will provide the care and support required to meet the standards.

Workforce point number	Workforce risk	MAT standard	Notable features
W1	As a result of a limited available eligible workforce that is unevenly spread across the country, there is a risk that the posts identified to create additional capacity to deliver improvement actions will not be filled. This will result in planned work not being delivered because existing staff cannot take on additional workload. This will also lead to financial slippage that will need to be recognised and managed.	Standards 1–5	This is an issue across Scotland but a particular challenge for rural areas
W2	As a result of limited available training opportunities and capacity there is a risk that staff recruited to new posts are unable to take on the roles that have been identified for them.	All, but particularly specialist skills such as standard 1, 2, 3	Particular issue for prescribing and complex social work assessment
W3	As a result of not having a large number of patients requiring drug treatment, there is a risk GPs providing care as part of MAT standard 7 may have difficulty in maintaining clinical competencies and the resources required to provide care for a small number of patients seen as unsustainable. This could result in a loss of primary care capacity.	Standard 7	Rural areas and areas of low prevalence of problematic drug use
W4	As a result of more than one ADP area being associated with an NHS Board and ADP area-level differences in information systems, there is a risk that each area will require a bespoke data solution and support. This could disadvantage other	All	This might relate to specialist skills provided on a limited basis across a health board (such as specialist

Workforce point number	Workforce risk	MAT standard	Notable features
	ADP areas associated with the same health board.		pharmacist, public health)
W5	As a result of an increasing workload and uncertainty in creating additional capacity, there is a risk that staff wellbeing will be negatively affected, leading to an increase in sickness absence, create a cycle of limited capacity, and poor workplace wellbeing.	All	n/a

Table A4: Intelligence

These are risks that relate to the collection of data that can be used as intelligence that informs improvement activity.

Intelligence point number	Intelligence risk	MAT standard	Notable features
I1	As a result of information systems and patient management systems not being set up to inform improvement, there is a risk that data for improvement work is not available and improvement work cannot take place.	All	n/a
I2	As a result of a lack of qualitative intelligence on the reasons why people do not access or remain in treatment services, strategies to improve access and quality fail, and harms related to drugs continues to rise.	All	This would particularly impact the ability to know how to respond to needs of population sub-groups such as women, people in justice system and so on
I3	As a result of limited intelligence about the target population, service planning	All	A particular issue for MAT standard

Intelligence point number	Intelligence risk	MAT standard	Notable features
	and unclear justification for resource allocation, there is a risk that allocation is inadequate for demand. As a result, the quality of care experienced by people may not improve.		3 and 7-day service provision

Table A5: Effectiveness of care

These are risks that directly contribute to care that is less effective/safe.

Effectiveness point number	Effectiveness risk	MAT standard	Notable features
E1	As a result of a limited available workforce, there is a risk that increasing the number of people in treatment services leads to an increase in caseload size and a reduction in the quality or quantity of care each patient is offered during contact.	Standards 1–5	n/a
E2	As a result of entry into treatment being prioritised, there is a risk that care, and care planning, are compromised and the quality of care for people who leave or discontinue treatment is inadequate.	n/a	n/a
E3	As a result of focusing on treatment and deprioritising social needs (housing and welfare) or needs in relation to support (e.g. with child protection or removal), there is a risk that people's underlying needs are not met at the earliest stage.	n/a	n/a
E4	As a result of focus on implementation of drug treatment standards in services that provide both alcohol and drug services, there is a risk that the quality and availability of care for people with alcohol problems will decrease.	n/a	n/a

Table A6: Communication and wider environment

These risks relate to the physical and interpersonal conditions required for optimal team working to deliver the standards.

Wider environment point number	Wider environment conditions risk	MAT standard	Notable features
WE1	As a result of real and perceived barriers to information sharing, there is a risk that people who are at the highest risk of drug-related death experience delays in accessing support.	Standard 3	n/a
WE2	As a result of a limited number of suitable premises, there is a risk that care cannot be delivered in the place where it is most needed, and that people continue to experience barriers in access to care.	Standard 1, 2	Theme – licences for provision of long-acting injectable buprenorphine, and geographic dimension of rurality
WE3	As a result of a limited number of suitable premises, there is a risk that care is compromised by the physical environment. For example, it exacerbates trauma when there are no private spaces for confidential conversations, and no public transport to the chosen premises.	All	Rural areas with high cost and limited number of accommodation options available
WE4	As a result of poor connectivity and digital exclusion, people cannot access care provided by remote care apps and virtual consultations.	n/a	n/a

Appendix 4: Maps

MAT 1 Evidenced RAG

NHS Health Boards and Alcohol & Drug Partnerships:

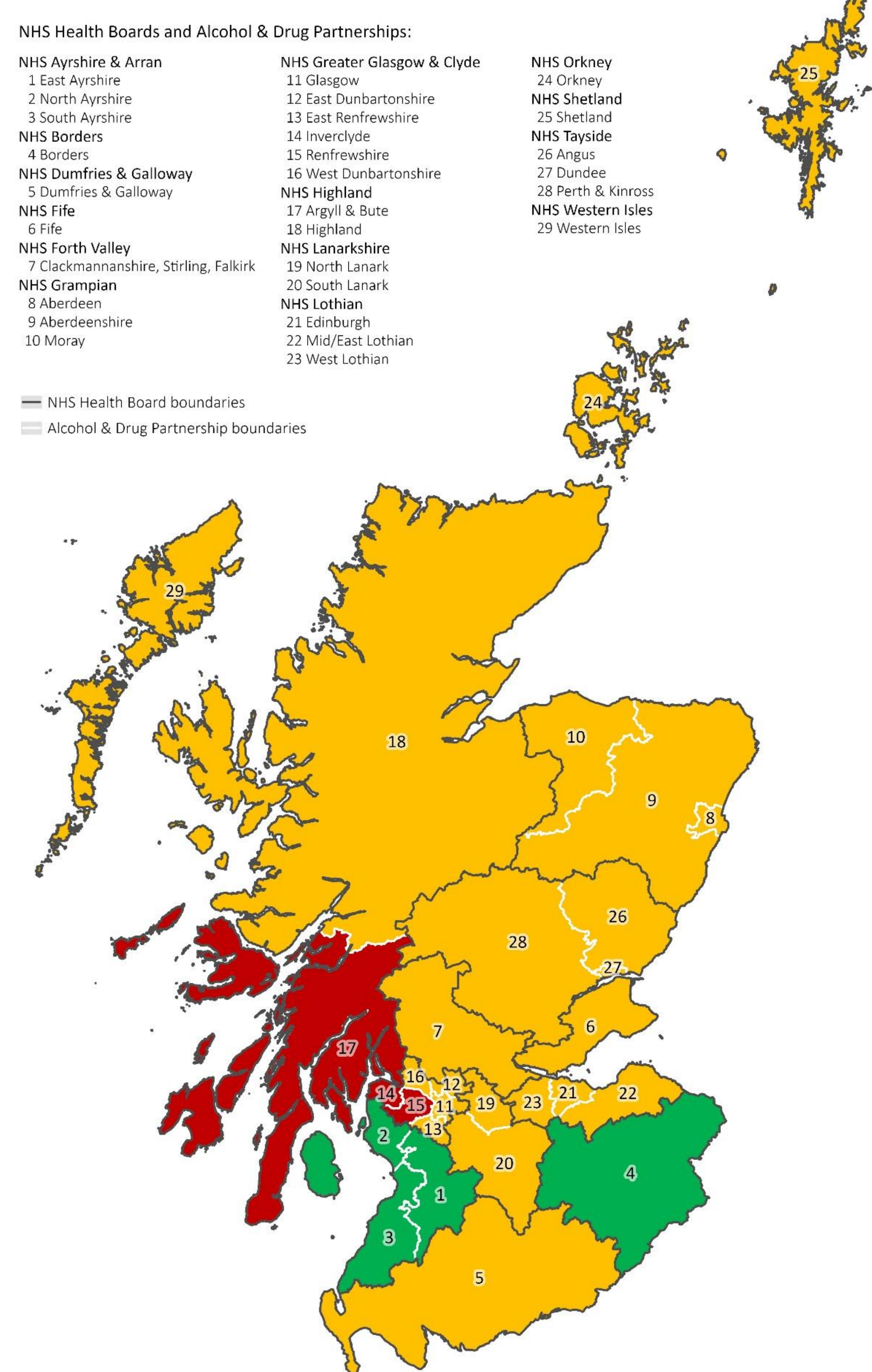
NHS Ayrshire & Arran
1 East Ayrshire
2 North Ayrshire
3 South Ayrshire
NHS Borders
4 Borders
NHS Dumfries & Galloway
5 Dumfries & Galloway
NHS Fife
6 Fife
NHS Forth Valley
7 Clackmannanshire, Stirling, Falkirk
NHS Grampian
8 Aberdeen
9 Aberdeenshire
10 Moray

NHS Greater Glasgow & Clyde
11 Glasgow
12 East Dunbartonshire
13 East Renfrewshire
14 Inverclyde
15 Renfrewshire
16 West Dunbartonshire
NHS Highland
17 Argyll & Bute
18 Highland
NHS Lanarkshire
19 North Lanark
20 South Lanark
NHS Lothian
21 Edinburgh
22 Mid/East Lothian
23 West Lothian

NHS Orkney
24 Orkney
NHS Shetland
25 Shetland
NHS Tayside
26 Angus
27 Dundee
28 Perth & Kinross
NHS Western Isles
29 Western Isles

NHS Health Board boundaries
Alcohol & Drug Partnership boundaries

MAT 2 Evidenced RAG



MAT 3 Evidenced RAG

NHS Health Boards and Alcohol & Drug Partnerships:

NHS Ayrshire & Arran
- 1 East Ayrshire
- 2 North Ayrshire
- 3 South Ayrshire

NHS Borders
- 4 Borders

NHS Dumfries & Galloway
- 5 Dumfries & Galloway

NHS Fife
- 6 Fife

NHS Forth Valley
- 7 Clackmannanshire, Stirling, Falkirk

NHS Grampian
- 8 Aberdeen
- 9 Aberdeenshire
- 10 Moray

NHS Greater Glasgow & Clyde
- 11 Glasgow
- 12 East Dunbartonshire
- 13 East Renfrewshire
- 14 Inverclyde
- 15 Renfrewshire
- 16 West Dunbartonshire

NHS Highland
- 17 Argyll & Bute
- 18 Highland

NHS Lanarkshire
- 19 North Lanark
- 20 South Lanark

NHS Lothian
- 21 Edinburgh
- 22 Mid/East Lothian
- 23 West Lothian

NHS Orkney
- 24 Orkney

NHS Shetland
- 25 Shetland

NHS Tayside
- 26 Angus
- 27 Dundee
- 28 Perth & Kinross

NHS Western Isles
- 29 Western Isles

NHS Health Board boundaries

Alcohol & Drug Partnership boundaries

MAT 4 Evidenced RAG

NHS Health Boards and Alcohol & Drug Partnerships:

NHS Ayrshire & Arran
1 East Ayrshire
2 North Ayrshire
3 South Ayrshire
NHS Borders
4 Borders
NHS Dumfries & Galloway
5 Dumfries & Galloway
NHS Fife
6 Fife
NHS Forth Valley
7 Clackmannanshire, Stirling, Falkirk
NHS Grampian
8 Aberdeen
9 Aberdeenshire
10 Moray

NHS Greater Glasgow & Clyde
11 Glasgow
12 East Dunbartonshire
13 East Renfrewshire
14 Inverclyde
15 Renfrewshire
16 West Dunbartonshire
NHS Highland
17 Argyll & Bute
18 Highland
NHS Lanarkshire
19 North Lanark
20 South Lanark
NHS Lothian
21 Edinburgh
22 Mid/East Lothian
23 West Lothian

NHS Orkney
24 Orkney
NHS Shetland
25 Shetland
NHS Tayside
26 Angus
27 Dundee
28 Perth & Kinross
NHS Western Isles
29 Western Isles

NHS Health Board boundaries
Alcohol & Drug Partnership boundaries

MAT 5 Evidenced RAG

NHS Health Boards and Alcohol & Drug Partnerships:

NHS Ayrshire & Arran
- 1 East Ayrshire
- 2 North Ayrshire
- 3 South Ayrshire

NHS Borders
- 4 Borders

NHS Dumfries & Galloway
- 5 Dumfries & Galloway

NHS Fife
- 6 Fife

NHS Forth Valley
- 7 Clackmannanshire, Stirling, Falkirk

NHS Grampian
- 8 Aberdeen
- 9 Aberdeenshire
- 10 Moray

NHS Greater Glasgow & Clyde
- 11 Glasgow
- 12 East Dunbartonshire
- 13 East Renfrewshire
- 14 Inverclyde
- 15 Renfrewshire
- 16 West Dunbartonshire

NHS Highland
- 17 Argyll & Bute
- 18 Highland

NHS Lanarkshire
- 19 North Lanark
- 20 South Lanark

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- 21 Edinburgh
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NHS Orkney
- 24 Orkney

NHS Shetland
- 25 Shetland

NHS Tayside
- 26 Angus
- 27 Dundee
- 28 Perth & Kinross

NHS Western Isles
- 29 Western Isles

NHS Health Board boundaries

Alcohol & Drug Partnership boundaries