Improvement Support for MAT Standards Implementation

Desk Review: Insights about the delivery of MAT standards in community pharmacies

Long Read

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Aim of this document

This report provides information about a literature scan carried out as part of a desk review which was rapidly completed in Summer/Autumn 2023 and aimed to inform HIS' Medication Assisted Treatment (MAT) Standards Pharmacy Impact report. A 'short read' summary of the desk review can be found at ihub.scot/matupdates.

The desk review was inspired by principles of 90-day cycles[2] which are a disciplined and structured form of inquiry designed to produce and test knowledge syntheses to inform quality improvement. The review had two parts 1) a rapid literature scan and 2) an analysis of strategic stakeholder interviews from Scotland. It was exploratory rather than exhaustive by design and was not intended to provide a comprehensive review of literature or a full thematic analysis of interview data.

Note on language

We have used the term MAT or MAT-related for ease of reading, but we recognise much of the published literature focuses on Opioid Substitution Therapy (OST) alone in the community pharmacy context. We recognise that MAT combines pharmacotherapy with psychological and social support.

What we did

Inspired by 90-day cycle principles, we carried out a rapid, non-systematic, scan of selected UK and international published literature. We did not analyse the quality of the literature found.

Although owing to time constraints we were not able to follow the 2:2:1 approach suggested in guidance[4] for 90-day cycles, we aimed to carry out a broad scan in line with 90-day principles. We met regularly with the whole programme team to discuss what we had found and asked for additional references, ahead of the key stakeholder interviews. We used an existing internal information search checklist to explore documents published on various organisational websites related to community pharmacy and substance use experiences. We used a *Google Scholar*[3] title keyword search for reviews and then for primary research articles related to experiences or implementation of MAT-related services in community pharmacy. We considered the first five pages of results of each search. We looked at the titles of publications and tended towards including them for further consideration unless they were clearly very dated or not specifically relevant to the topic of experiences or implementation of MAT-related services in community pharmacy.

What we found

The scan approach was rapidly employed to align with the 90-day process. Whilst this exploratory scan resulted in finding 23 insightful papers/documents, it was not designed to be comprehensive and will have missed relevant literature.

We found research about perspectives of people using services, and people providing services. We found some examples of quality improvement and implementation research relating to collaborative treatment models with community pharmacists from other countries. There was less information available from the scan about the perspective of families or peer support or recovery workers in treatment models.

We organised interpreted overarching insights from the literature into three areas: Relationships and engagement, Knowledge and confidence, and System support and structures. These were adapted and renamed from themes identified by a systematic review of factors influencing community pharmacy national innovation implementation[5].

Relationships and Engagement

- People using services in pharmacy have described that positive and constructive relationships with friendly staff they see regularly are important to them.
- The experiences and perspectives of families did not appear to be well represented in research literature.
- Inspiring, hopeful, and positive communications around MAT as evidence-based and recovery-focused in community pharmacy may be helpful. Using case studies and positive images of people has been suggested.
- There was some evidence that people in the USA reacted more positively to the term's 'pharmacotherapy' or 'medication assisted recovery' or 'long-term recovery' than the term 'medication assisted treatment'.
- People accessing MAT may face stigma on a variety of levels including from self, others, and society. Stigma may exist in relation to people using MAT, but this may also be related to the MAT intervention itself and/or be operating on other levels. People accessing a prescription for MAT may be thought about or treated differently in comparison to other patients in community pharmacy, such as people prescribed diabetes or blood pressure medication.
- Stigma may discourage access of MAT by people who need it or affect ongoing engagement and retention, and hamper efforts to provide recovery-focused services.

Knowledge and Confidence

- Pharmacists and prescribers have described a lack of confidence in providing some aspects of MAT in community pharmacy.

- There is variation in undergraduate education about MAT and no related mandatory professional training once qualified. Involvement of people who are now in recovery in the development and/or delivery of staff training related to providing MAT services may be particularly meaningful.
- Trauma informed environment training has been shown to be successful in community pharmacy in Scotland. It has been suggested that trauma informed training is more effective if whole teams are involved.
- Pharmacists may not be aware of all available services in the wider system. The enhanced role that community pharmacists can play in supporting MAT may not be well understood by other professional fields.
- There may be different interpretations of recovery, including an assumption that recovery equals abstinence.

System support and structures

- Community pharmacies in Scotland have a history of working with people with substance use issues including alcohol.
- The maturity of working relationships between prescribers and dispensers can be variable. Issues with conflict resolution and timely communication between pharmacists and prescribers have been reported.
- Studies have identified issues with collaborative processes across different roles and have suggested that clear protocols, guidance, tools and agreed communication and information sharing mechanisms are required.
- Considerations about privacy and dignity of spaces and environment design for people accessing MAT have been raised.
- Pharmacists must balance their legal responsibilities with patient-centred care.

We continued to update the programme team with emerging themes throughout the scan process. Insights about stigma, pharmacist confidence and training, system communication and agreed pathways remained strong themes from the beginning.

Summaries of papers by country

A summary of the 23 papers we explored during the scan is set out below by country.

Scotland

Perspectives of people using or providing services

A 2017 study[1] of experiences of service users attending a community pharmacy to receive opiate replacement therapy in Scotland reported that participants had examples of poor experiences including stigma and discrimination but valued positive relationships with their pharmacy. The authors suggested that such stigma contributed to social inequality and

worked against delivery of recovery-focused treatment. Where pharmacy staff had constructive attitudes and could form positive relationships this improved experiences.

In 2014 Matheson and colleagues invited Lead Pharmacists in each community pharmacy in Scotland to complete a postal questionnaire covering attitudes towards people with drug problems, service provision and level of involvement in services (needle exchange, dispensing for (people with a drug problem) PWDP and methadone supervision)[2]. The authors concluded that the Scottish community pharmacy workforce had:

- positively embraced their expanded role with this group of clients over the past two decades, so that working with people with drug problems was now considered a core part of practice;
- taking part in training had been key to this change, and
- identified better integration and communication with existing services would need to be in place to support ambitions for continued development of community pharmacy in this area.

A 2023 study[3] of the feasibility of training pharmacy staff on the psychologically informed environments (PIE) approach to improve the delivery of care in Scotland found that it was positively evaluated and justified further research. Staff attitudes towards clients were generally positive, but there were some aspects of pharmacy practice that were potentially stigmatising, and development and extension of the PIE training was recommended.

Quality improvement and implementation research

A 2021 non-randomised feasibility study[4] in Scotland of a Pharmacist-led homeless outreach engagement and non-medical independent prescribing intervention for people experiencing homelessness (which included assessment of physical/mental health, addictions, housing, benefits, and social activities followed by pharmacist prescribing with referral to other health service specialities if necessary) was reported by Lowrie and colleagues. The authors found the intervention was feasible and called for further research into its clinical and economic effectiveness.

During this desk review the 2022/23 National benchmarking report[5] on implementation of the MAT standards was released by Public Health Scotland. This reported that MAT implementation priorities over 2023/24 should benefit all people affected by problematic drug use including women, young people, people living in remote and rural areas and people who use benzodiazepines and stimulants. In the foreword a representative from SFAD called for greater involvement of families as key partners in supporting the delivery of MAT.

Policy and position papers

In 2021 the Royal Pharmaceutical Society produced a paper[6] focused on pharmacies' role in Scotland in reducing harm and preventing drug deaths which made 14 detailed recommendations. The 'headline' recommendations are reproduced below:

Harm reduction

1. Naloxone must be available from every community pharmacy and staff trained to use it.
2. Pharmacy teams in all settings should have the tools to prevent and identify possible dependence on prescribed or over the counter (OTC) medicines and carry out brief interventions where appropriate.
3. Community pharmacy teams should have a method of recording OTC medication purchases to help identify overuse or misuse and enable action to prevent harm.
4. The expansion of the existing new medication/high risk medication tools in community pharmacy should include medicines with a risk of dependence to encourage and enable education to start at the point of prescribing and dispensing.
5. Community pharmacies are ideally placed to host targeted public health campaigns around dependence on prescribed, illicit, and over the counter meds. Pharmacy teams in any setting can highlight and reinforce these messages.

Improved multidisciplinary working

6. All pharmacists should have access to shared patient records and clear communication pathways with other health care professionals involved in the care of people who use drugs.
7. Some community pharmacies could be set up to act as hubs where patients could access services from other agencies, available for all but particularly to reach those patients not currently engaged with services.
8. As part of the multidisciplinary team (MDT) and when appropriate for patients, pharmacists could undertake polypharmacy reviews and carry out health checks to improve the health and wellbeing of people who are dependent on drugs.
9. Pharmacists and pharmacy teams in all settings could be used to widen patient treatment options and location of treatment supply e.g., Depot buprenorphine injection clinics, independent prescribing and deprescribing.
10. A new structured service with clear referral pathways should be established to enable prisons and hospitals to refer people who are at risk and require medication at a time when addiction services are not available to an appropriately trained and resourced community or primary care-based pharmacist.

Education and training

11. Pharmacy teams should be trained in psychologically informed care and should identify and change areas of their practice to reduce the stigma on this patient group.
12. All pharmacy teams involved in caring for people who use drugs should undertake mandatory basic training on addiction and harm reduction, plus further training if offering enhanced services in response to local need.
13. Undergraduate courses should have learning and teaching about addiction that is comparable in scope and depth to other clinical areas, teaching the basics of addiction, harm reduction and extensive training on treatment options, pharmacological and non-pharmacological.

Future development

14. Regulated Supervised Drug Consumption Rooms should be introduced, and use of Heroin Assisted Treatment should be expanded as treatment options with pharmacy input from the start.

The Drugs Death Taskforce developed a stigma charter that all organisations, including businesses and community groups, can use. This shows a commitment to creating a Scotland that is free from stigma[7].

By signing up to the stigma charter, people commit to:

- treat people with dignity and respect when using any services and in line with a trauma informed approach,
- support people in recovery and their families to create a culture of mutual respect and support in their local community, wider area and nationally,
- promote the use of positive language when speaking with, or about people in active substance use or recovery and their families,
- challenge the image and attitude portrayed of people who use or have used substances, or their families, through work with media partners to develop policies and proactive campaigns.

Scottish Families affected by Alcohol and Drugs (SFAD) have made a toolkit[8] freely available to journalists and editors which aims to ensure reporting on alcohol and drugs is done with dignity and respect. There are five key recommendations about imagery, language, case studies, support information and education and stigma. Whilst not specific to community pharmacy this may relate to any communication campaigns via posters/information in community pharmacy windows/noticeboards.

England

Perspectives of people using or providing services

In 2019 a qualitative investigation[9] into current UK practice and community pharmacists' role in preventing Opioid Substitution Therapy (OST) related deaths was published. Three key themes were interpreted by researchers from the analysis of interview data:

- organisational challenges of providing OST service
- managing risk in practice, and
- behavioural and environmental impact on patient care.

Some examples of specific barriers and potential implications suggested by the authors are shown below.

Table 1: Selected implications and barriers described by Yadav and colleagues.

Example barriers (from Yadav and colleagues, 2019)	Example implications (from Yadav and colleagues, 2019)
Lack of standardised communication and feedback mechanisms between the treatment teams and community pharmacists	Current information sharing is patchy, with different working practices locally
Lack of mandatory professional training, and undergraduate teaching about OST varies in UK universities	A service may be provided by pharmacists with little or no exposure and understanding of the service
Pharmacist professional decision-making may be influenced by workload, safety concerns, stigma, patient behaviour	Practice urgently needs appropriate guidance and education to enable change
Lack of training and confidence in dealing with OST-related issues, misinformation, training gaps and lack of guidance e.g., take home naloxone for patients and their families	Professionals may not intervene in situations where a patient could be at risk of harm if they have a lack of knowledge or low confidence

Australia

Perspectives of people using or providing services

A 2010 research report[10] explored problems experienced by community pharmacists delivering opioid substitution treatment in two states of Australia (Victoria and New South Wales) via a cross-sectional survey of 669 pharmacists (68 % response rate). There were a range of problems, and in general these were more evident in Victoria. The authors noted there were differences in medication and dose provision, service delivery and availability of resources between the two states. The two most common problems community pharmacists experienced with prescribers were the provision of takeaways to clients identified as unstable and difficulties in contacting the prescriber. The authors concluded that particular attention should be paid to the numbers of clients per pharmacy and inter-professional communication between pharmacists and prescribers. Suggested innovations included online 'Patient Journey Kits' such as those developed by the New South Wales Department of Health, that use enhanced care plans with GPs and pharmacy review proformas. Training for staff to identify identifying opioid withdrawal or toxicity in OST clients was also suggested.

A 2021 qualitative evaluation[11] from Australia interviewed 10 participants 6-8 weeks after they had taken part in two 2 hour professional training workshops in pharmacies on the social determinants of health for pharmacy assistants and pharmacy dispensary technicians on medically assisted treatment of opioid dependence. The authors reflected that a lack of understanding of MAT (and lack of specific guidance for these staff groups) coupled with stigmatising social discourse around addiction risked stigma playing out in the pharmacy environment.

Quality improvement and implementation research

Researchers in Australia designed a protocol[12] for a prospective, multisite implementation-efficacy trial of a collaborative prescriber-pharmacist model of care for Medication Assisted Treatment for Opioid Dependence (MATOD).

This model of care design was informed by barriers and enablers which had been identified in local needs assessment drawing on prescriber and pharmacist perceptions:

Table 2: Selected enablers and barriers described by Nielsen and colleagues.

Barriers	Enablers
• Patient preference for prescriber involvement/oversight • Patients felt prescriber involvement essential, and may not want pharmacists to control some aspects of care • Debt for dosing fees seen to impact the therapeutic relationship for pharmacists	• Preference for established relationships between prescriber and pharmacist (and pharmacist and patient) • Pharmacists regularly seeing patients provides greater opportunity for ongoing monitoring
• Prescribers only comfortable delegating certain tasks/to certain pharmacists • Prescriber concerns about pharmacist skills and training • Pharmacist lack of confidence in some domains	• Clear protocols and processes that define scope of activities for pharmacists would engender confidence
• Time (lack of capacity/impact on pharmacist workload) • Remuneration for services • Poor communication between prescriber and pharmacist • Perceived lack of infrastructure (lack of private and confidential space) • Lack of software or clinical standard for record keeping	• Clear protocols would mitigate concerns about medicolegal risks for pharmacists

Key MATOD implementation strategies were planned to overcome barriers around adaptability, educational materials, relay of clinical data to providers, using payment schemes and physical structure and equipment.

Specific strategies included:

- Individualised treatment agreements developed by the prescriber, in conjunction with the patient, including the ability to delegate (or not delegate) individual clinical tasks

- Comprehensive training and competency assessments for pharmacists (to address prescriber concerns as well as pharmacist lack of confidence in some domains)
- Care guided by extensively reviewed Clinical Practice Guidelines that include standardised review processes, validated assessment tools, clear points for contacting the prescriber, and a structured re-induction protocol (to facilitate confidence for both pharmacists and prescribers, and mitigate concerns around medico-legal risks for pharmacists)
- Clearly specified requirements for documentation and communication (including timeframes, pre-agreed upon methods, and standardised forms for clinical records)
- Remuneration of pharmacists to mitigate barriers caused by workload/time pressures and allow for the scheduling of an additional pharmacist, if necessary
- A requirement that pharmacists have a confidential space for patient review

Canada

Perspectives of people using or providing services

A 2021 qualitative assessment[13] of patients' perspectives and needs from community pharmacists in substance use disorder management was carried out in Canada. Four focus groups (n=20) with people who had experienced substance use and accessed community pharmacy services were analysed by two researchers. The researchers reported four emerging themes from across the focus groups: 1) conflicted experiences with community pharmacists, 2) lack of knowledge concerning community pharmacists' extended services, 3) negative experiences in Opioid Agonist Therapy (OAT) programme, and 4) needs from community pharmacists. The authors concluded that there was 'significant potential for the patient-pharmacist relationship to address the varying needs of patients who use substances and improve their overall health care experience.' They identified respectful communication, provision of drug-related information, and patient counselling as demand areas.

A 2016 qualitative focus group and interview study[14] of Canadian community pharmacists' experiences in mental illness and addictions care reported barriers to enhanced scope of practice because of work environment limitations including a lack of structures and processes in place for engagement as a full member of the community mental health care team. The authors identified five key themes: 1) competing interests, demands, and time; 2) relationships, rapport, and trust; 3) stigma; 4) collaboration and triage; and 5) role expectations and clarity.

Quality improvement and implementation research

A 2019 narrative review[15] undertaken in North America considered evidence around leveraging the role of community pharmacists in the prevention, surveillance, and treatment of opioid use disorders. The authors noted studies had established the feasibility and acceptability of delivering brief alcohol interventions in community pharmacies in the UK. They noted that pharmacists faced tension between their need to balance their legal role to monitor for diversion and other behaviour with their caregiving role to provide safe, effective, timely access to treatment. They concluded that increasing access to screening for opioid use

disorder, sterile syringe and naloxone distribution were the most easily achievable targets for this professional group.

USA

Perspectives of people using or providing services

A 2023 qualitative study[16] involving focus groups in the USA explored perceived stigma, barriers, and facilitators experienced by members of the opioid use disorder community when seeking healthcare. Authors concluded that people are challenged by both internal and external stigma when seeking healthcare and reported that negative attitudes impacted support for allocation of resources to opioid use disorder treatment. Tackling stigma was essential to support effective treatment and prevent barriers to care.

A 2021 systematic literature review[17] of 21 studies of patient perspectives of barriers and facilitators to access, adherence, stigma, and persistence to treatment for substance use disorder in the USA found stigma and feeling unvalued in society was a dominant theme, even where this was not the original focus of research. The authors also noted a mismatch in the treatment goals of healthcare providers and patients and suggested that better understanding of why those patients who persist with medication assisted treatment (despite the known barriers) might inform improved care and access. This could include convenient treatment locations, expanding pharmacy provision, providing training and education and the use of public awareness campaigns that demonstrate lived experiences and stories.

A 2019 scoping review[18] of US pharmacists' attitudes toward dispensing naloxone and medications for opioid use disorder reported that pharmacists were positive in their attitudes toward such increased practice responsibilities both for patients at risk of an opioid overdose or with an opioid use disorder. The authors recommended that pharmacists must receive education, training, and support to provide effective care for these patients. Pharmacists' stated needs around building confidence and competence included: building collaboration with prescribers, more education and training, more time available to spend with patients, management support, and workflow integration for patient counselling and dispensing naloxone and buprenorphine.

A 2018 qualitative analysis[19] of five focus groups (two pharmacist, two prescriber and one inter-professional) in the USA of inter-professional communication among prescribers and pharmacists about non-prescribed use of prescription opioid medications identified the following influential factors: trust, role perception, a history of communication conflict, personal relationships, and use of a prescription monitoring programme. Potential intervention tools for further research were suggested: enhancing inter-professional trust, understanding roles and responsibilities, conflict resolution related to prescribed opioids, and using prescription monitoring programmes to enhance inter-professional communication. The authors suggested that reliance on default communication behaviour may not drive person-centred care and that the potential dangers of leaving inter-professional communication to the patient should be explored.

Quality improvement and implementation research

A 2020 report[20] of an evidence-based quality improvement strategy described in detail how an initiative aimed to expand the use of MAT and complementary and integrated health across two primary care facilities in the USA. Before implementation, the authors suggested that access to MAT was inconsistent in primary care because of stigma, logistical challenges, and lack of knowledge regarding medication for opioid use disorder.

Various action plans were proposed by the two facilities, but both used an adapted collaborative treatment model with primary care providing a maintenance role once patients were started and stabilised on buprenorphine in the addiction psychiatry or pain clinic, with clinical pharmacist support. Strategies included establishing regular (monthly) meetings across professions to solve problems in a collaborative way. One facility also focused efforts on media and information campaigns to support people prescribed long-term opioids and benzodiazepines to become active participants. Participants reported an attitude shift where people with a 'mild to moderate opiate use disorder' was viewed as something that could be managed within a primary care setting or primary psychiatry setting, with triage of more complex support requirements to specialists.

Researchers in the USA (Wyse, 2022) have documented[21] how a self-appointed local team developed, established broad support for, and successfully implemented a Primary Care-based Buprenorphine Clinic and remote consultation service to expand access to medication for opioid use disorder for patients across the health care system. The researchers concluded this approach had built processes which were both tailored to local need and would be sustainable in future. They also noted this model had precedent in the healthcare provider's system, where pharmacists and primary care providers often collaborated on treatment plans for patients with chronic conditions such as diabetes, high blood pressure or chronic pain.

A 2018 study[22] in the USA recruited 1,200 participants to rate terms associated with substance use disorder which they hypothesised to be stigmatising or non-stigmatising including the terms 'medication assisted treatment', 'pharmacotherapy' and 'medication assisted recovery'. The authors found that though the term "medication assisted treatment" was not likely to elicit stronger negative biases from participants, replacing MAT with "pharmacotherapy" elicited stronger positive implicit biases and therefore the term 'pharmacotherapy' might better serve clients. Both "medication assisted recovery" and "long-term recovery" elicited strong positive implicit associations and the authors concluded either of these terms can likely be used without promoting stigma in that context.

International

Perspectives of people using or providing services

A 2020 scoping review[23] of the attitudes and practice strategies of community pharmacists towards drug misuse management included 19 studies, 5 from the UK, and found that it was important to consider the role of early career pharmacists and the training and resources

required to promote high-quality care. Pharmacists reported gaps in knowledge and training on substance use and barriers included lack of staff training and time. The authors suggested that there were opportunities for development of approaches to harm reduction led by pharmacists.

Conclusion

We considered 23 papers in total in this broad literature scan, a combination of literature from Scotland and beyond including reviews of literature, primary research, organisational reports, policy documents and campaign toolkits. We did not formally assess literature quality.

We found research about perspectives on services and about service models. We found less about the perspective of families or peer support or recovery workers in treatment models. We adapted an existing framework[5] to loosely group insights related to enablers and barriers around relationships and engagement, knowledge and confidence, and system support and structures. Recurring themes throughout the scan process related to stigma and hope, pharmacist confidence and training, system communication breakdown and agreed care pathways.

Glossary

ADP - Alcohol and Drug Partnership

IEP - Injecting equipment provision

HIS - Healthcare Improvement Scotland

MAT - Medication Assisted Treatment. Public Health Scotland describe as the use of medication alongside psychological and social support in the treatment of people who are experiencing issues with their drug use.

NEO – NEO 360 is a web-based recording tool used to record harm reduction interventions, most commonly supply of injecting equipment.

OST - Opioid Substitution Therapy

PIE - Psychologically informed environments

SFAD - Scottish Families affected by Alcohol and Drugs

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