Healthcare Improvement Scotland

MAT Standards National Improvement Programme

Stakeholder Insights, Barriers and Recommendations for Improvement

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Contents

Introduction

Scotland has the highest numbers of drug related deaths per capita in Europe, a rate that is almost triple compared with the UK average. The number of people dying due to opioid use alongside other substances rose by 152% from 527 in 2013 to a peak of 1339 in 2021, with a reduction in deaths evident in 2021 and 2022 to 1,330 and 1,051 respectively. The causes of this phenomenon are felt to be a complex interplay of 1980's de-industrialisation and the resultant economic and social impact in the subsequent decades, resulting in a higher population involvement in problematic opioid use alongside other substances like alcohol and benzodiazepines.

Due to this high level of drug-related deaths the introduction of standards was prioritised with the aim of reducing drug related harm and deaths. The MAT Standards define what is needed for the consistent delivery of safe and accessible drug treatment and support in Scotland. The Standards apply to all services and organisations responsible for the delivery of care in a recovery orientated and person- centred system. The purpose of the Standards is to not only improve access to medically assisted treatment, but also ensure people have access to treatment on the same day as support is requested, together with mental health support and support for associated needs such as money advice and housing. The smooth interplay of all these services facilitates a safe recovery journey.

Background

In 2022, Healthcare Improvement Scotland (HIS) was commissioned by the Scottish Government Drug Policy Unit to deliver the Improvement Support for Medication Assisted Treatment (MAT) Standards Implementation programme by March 2025.

The overall aim of the programme is to support national progress towards timely access to effective care and treatment for people at risk of harm from drug or alcohol related harms.

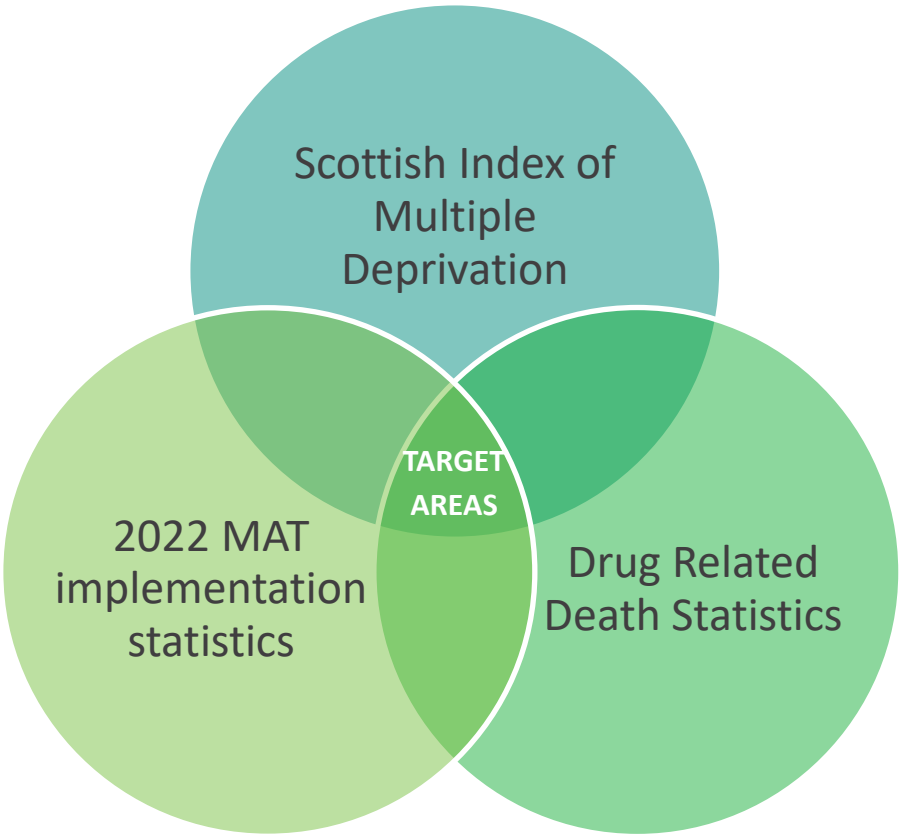
This report is a summary of findings from initial scoping conversations with areas across Scotland to understand the challenges, barriers, and facilitators to the successful implementation of the MAT Standards. This is part of the discovery phase to support the design of the national improvement programme for the MAT Standards.

Plan for Engagement

It is well understood that certain communities are disproportionately affected by substance use or addiction issues, with people in the most deprived areas almost 16 times more likely to die of a drug related death than those in the least deprived areas of Scotland. People with substance use issues are often vulnerable individuals with complex needs and it is not unreasonable to assume that most of these individuals will reside in vulnerable communities. Understanding where individuals with the highest rates of unmet need in relation to substance use, or highest rate of need allows improvement efforts to be more focused.

Knowing this, and to build a plan for engagement, a mapping exercise was undertaken, bringing together the Scottish Index of Multiple Deprivation (SIMD) statistics, drug related deaths (DRDs) statistics and initial MAT implementation statistics from 2022 to establish priority areas to begin engagement work for the discovery phase of the design of the national improvement programme for MAT Standards (Figure 2). In addition, two other key areas of interest were identified, rural areas and prisons, due to the difficulties and differences that may be evident in the implementation of the Standards in these settings.

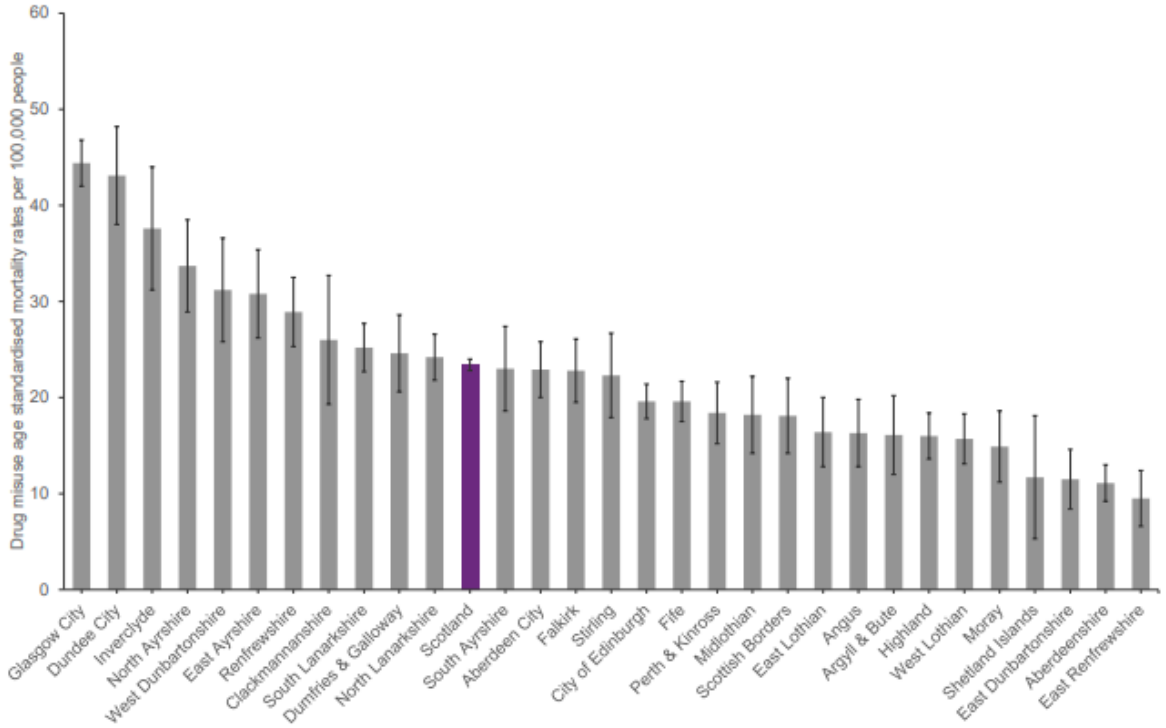
Figure 1: Triangulation of data to inform engagement plans for discovery phase of the national improvement programme.



Targeted Areas

During this scoping exercise, it was considered appropriate to identify and engage with council areas where drug related harm is more prevalent. At the time the 2021 drug related death statistics were taken into consideration as figures for 2022 had not yet been published although it is worth noting that this triangulation was carried out to identify target areas and we acknowledge the ever-changing landscape of the statistics.

Figure 2: Drug misuse deaths for selected council areas, age standardised death rate 2018 – 2022 (National Records of Scotland Drug-related Deaths in Scotland 2022 report)



Using this methodology, and including areas where we had established contacts, we focussed our attention on the following areas to help us gain insights into the local and national implementation of the MAT Standards, and drug and alcohol treatment as whole:

- Inverclyde
- City of Edinburgh (specifically Niddrie, Craigmiller and Muirhouse).
- Dundee City
- North and East Ayrshire
- Forth Valley

Additional areas of interest (rural areas and prisons) were identified due to the potential added complexities of implementation of certain elements of the MAT Standards in these areas:

- Argyll & Bute

- Prison Estate.

Methodology

Discussions were held both online and in person; in person was preferred when deemed to be more beneficial due to group attendance.

Interviews were sought to include insights from a range of people, from those with Lived and Living Experience (LLE), family members and workers on the frontline and from as wide a demographic as possible. Questions were intentionally set to be simple, exploratory, and standardised to enable ease when theming the findings.

The interview discussion prompts were:

1. What do you know about the MAT Standards?
2. What is working locally with MAT?
3. What isn't working?
4. What needs to be done to make them work?
5. What does good and bad drug treatment look like to you?
6. What does better look like to you?

Due to current updates in relation to suspected drug type and usage nationally, the following questions were added:

7. What drugs are we seeing being used locally, are there any treatment issues?
8. New drugs on scene, are there any new issues due to them?

It was decided to initially engage with a maximum of 20 professionals and 20 people with lived or living experience of addiction across approximately 10 organisations to set the scene for the initial insights' engagement, acknowledging that insights gathered would set the required theme within this number.

Due to this being an initial scoping activity, engagement was undertaken with an existing network of stakeholders rather than a more formal wide-ranging group of stakeholders. The purpose of the engagement was to hear what the situation was like "on the ground" for those within the identified stage 1 areas, to ensure we had heard the information correctly at a secondary community engagement stage and to use this information, and identify recommendations for improvement, to design a national improvement plan.

Contact and identification of frontline organisations and those with lived and living experience (LLE) within the identified areas was made by cross referencing Corra funded projects, accessible information online and an existing list of contacts.

Engagement

The following insights and recommendations have been sense checked with those working in the sector and those with lived and living experience of using services, through a series of small-scale engagement meetings, to ensure the information we heard, and translated, resonates with them and that they had the opportunity to tell us what better looked like, forming their recommendations for improvement.

Table 1 provides the cumulative numbers of people spoken to during refinement of the insights, barriers, and recommendations. There were, and continue to be, additional indirect participants engaged with that have not been recorded due to the ad hoc nature of the conversations.

Table 1: Stakeholder engagement by number and type

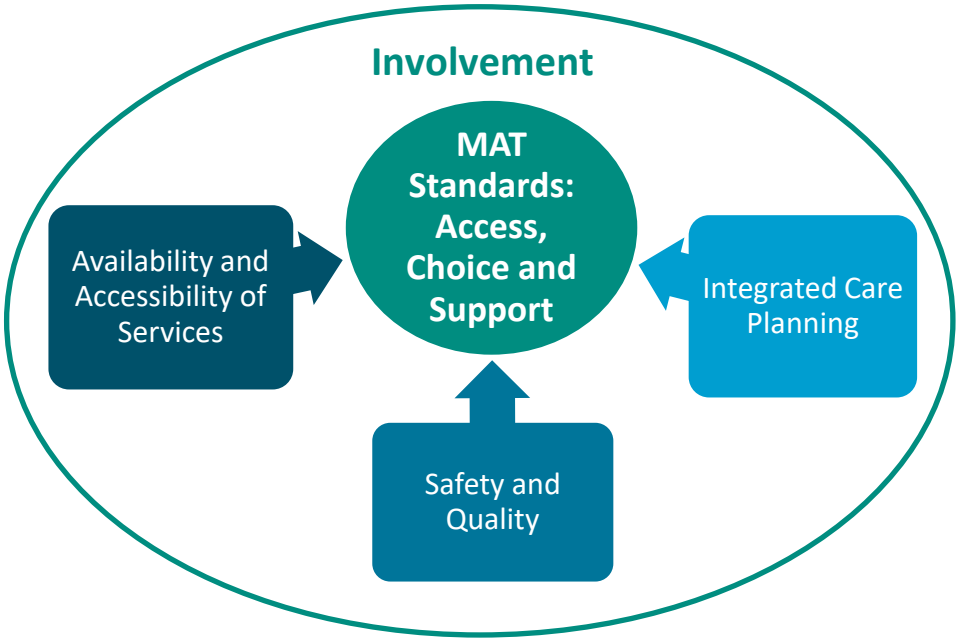
DESCRIPTION	STAGE 1	SENSE CHECKING	TOTAL
Professionals	20	13	**33**
Lived/Living Experience	19	23	**42**
TOTAL	39	36	**75**
Organisations	18	5	23

Insights Analysis

Analysis of the Stage 1: Stakeholder Insights discussions formed a number of insights that can be described either within the national context (all areas reporting); for example, homeless pathways, data sharing and learning/training, to those that were local (specific to one area); such as prescribing for stimulant use, provision of recovery communities, psychosocial services or availability of harm reduction equipment.

To aid the development and design of the national improvement programme for the MAT Standards, these insights have been aligned with the overarching principles of the MAT Standards; Access, Choice, and Support (Figure 3), while recognising the need for continual and meaningful involvement with those accessing and delivering services. The necessity for community level engagement across the design, implementation, and review of drug and alcohol treatment services was also raised during every discussion.

Figure 3: Themed recommendation headings aligned to the principles of the MAT Standards



The overarching thematic principles have come from The Charter of Human Rights and Essentials of Safe Care: availability and accessibility, safety and quality and integrated care planning, are further broken down into sub-groups (Table 2) to aid the design of a national improvement programme to support the implementation of the MAT Standards. The below subgroups inform key areas relating to the delivery of MAT Standards and the national mission to improve care for those who are seeking support for their substance use.

Table 2: Thematic Principles and their subgroups

Availability and Accessibility
Commissioning
Offer acceptable services
Services are available
Safety and Quality
Quality of care
Consistency
Provision of care
Patient safety
Governance and assurance
Integrated Care Planning
Integrated care
Care Coordination
Clinical guidance

Main Insights and Barriers

Our engagement during QTR4 2023/24 identified a range of insights, system barriers and recommendations to consider and to filter them we identified three key parts of our system that required specific mention, including:

- National as these would affect change for the broadest range of people using services and were identified as being system wide issues and require a systematic response.
- Local, it was quickly identified that there is local nuance in services and communities so recommendations to support local services reflects the insights we gained.
- Prisons, the Justice System and its capacity to embed MAT Standards felt unique due to the specific environment by which people can engage in and fulfil their treatment and recovery.

Please note that we have made additional considerations towards the end of this document relating to alcohol use and synthetic drug use.

1. National Insights and Barriers: Themes occurring across all interviews	
1.1 Availability & Accessibility	
1.1.1	**People feel they are being passed between services while trying to access support and treatment and stated we should provide access to treatment from multiple points of contact within the system, facilitating a no wrong door approach.** MAT Standard 1 creates the opportunity for same day prescribing; however, we heard that this is not consistently accessible due to the requirement to access more than one service for a referral and/or assessment, prior to receiving a prescription. People suggested that, to maximise the system capacity to prescribe MAT medication, it is essential that we broaden the range of, suitably qualified, professionals inclusive of Pharmacists, GP's and Hospital based medical staff to allow for the system to be able to reach more people and reduce the burden on current staff to meet Mat 1 safely. To support this, it was discussed that consideration should also be given to insight 1.1.2.
1.1.2	**Discussions revolved around the need to reduce the risk of harm while someone awaits suitable treatment by producing guidance on safe dosages of prescription(s) until the treatment of choice becomes accessible.** People told us waiting times were lengthy and demand for services was high, so delays were inevitable and that this led to a risky period. Discussions also highlighted the risks when transitioning between Drug or Alcohol services or where

1. National Insights and Barriers: Themes occurring across all interviews	
	there are changes in medication adding that the system needs to reduce the risk to those waiting to access MAT and other drug and alcohol services. Discussions also took place around how service operated in the past relating to prescription of low dosage substitute prescribing, while waiting to be seen by a service who could offer more appropriate treatment, was common. On multiple occasions these were described as "bridging" prescriptions and deemed to be a safer option than someone waiting for an appointment with no medication and so placed in a risky situation.
1.1.3	**Every area described a lack of support for people in their journey and a lack of clarity on their rights in relation to the initiation and cessation of medication under MAT or other forms of Alcohol and Drug treatments.** In conjunction with the discussion around 1.1.2 there was a recurring risk discussed that is associated with those who ask for help to cease taking drugs (prescribed or not) and who are left to do this without medical support and thus do so without the correct medication, correct dose of medication or without medical awareness and supervision, placing the individual at risk of harm. We were advised that when people chose to do this, they are likely desperate to do so and so asked that the system needs to recognise the levels of risk attached when people express that they wish to cease or reduce their medication and are given a lack of choice or options to safely titrate, reduce dose or detox completely. Many of those who highlighted this advised the were likely to "do it anyway" and so risks needed to be managed appropriately.
1.1.4	**Individuals did not feel that their family members, or wider support providers, were being encouraged to be involved in their support and so left them unable to maximise their recovery capital. There seemed to be a lack of opportunities for the wider support network to be connected and work together to plan and understand the resource that is required at a community level to establish an infrastructure to support someone through treatment, recovery or for those returning to an area after a period of prison, residential detox, stabilisation or rehabilitation.** Every area discussed the need for a range of opportunities for community-based groups, or community anchor organisations, who can support people to access funding opportunities and be involved in the design and delivery of services that promote recovery and wellbeing giving people hope and purpose.

1. National Insights and Barriers: Themes occurring across all interviews	
	Discussions also highlighted the need to bring together all organisations, or people, within the wider communities to ensure working practices can be developed together.
1.1.5	**Participants highlighted the barriers to incorporate suitable housing or accommodation at the heart of all integrated care plans, despite all areas advising they often felt this is where people's recovery journeys were hitting barriers.** **Some good practice was highlighted where their best support often came from their Registered Social Landlords (RSL's), specifically around elements of Standard's 3 (Assertive Outreach and Anticipatory Care) and Standard 8 (welfare rights, housing, and money advice), but also stated that although this was beneficial it was not always available or consistent across providers.** Housing providers were often discussed as a regular contact point for tenants, especially those identified at risk or where support is required and there were pockets of good practice where RSL's has assumed roles and responsibilities in supporting individuals within MAT, even where there was no current duty to do so. There were also discussions around extra work being done around homeless prevention even where eviction processes could have proceeded.
1.1.6	**Participants discussed issues around people not being aware of what they should expect from services, or what role the services would have in that persons' care or treatment. Those working in services added that there was also no continuity of care as services did not only not know who was involved in the persons case, but also did not know what care was being offered, making it harder to identify gaps in care, outcomes, and to manage expectations of those in receipt of care.** There is a lack of accessible directory about services available, including the location and operating times, and a format of this could only be found in one area and, even when this did exist, there was limited ability to clarify who is responsible for ensuring a full package of care is being offered to an individual and ensuring all services are aware of each other's roles and responsibilities. The lack of joint working, and data sharing, was also highlighted as leading to gaps or duplication in support.
1.1.7	**All areas discussed a lack of a shared referral or assessments that work across all providers of MAT, which often heightens the likelihood of trauma, due to the individual repeating their story, and created barriers to a consistent standard of support and continuity of care for those seeking support.** Individuals and services advised that people should not have to repeat their story due to services not using the same systems and/or not having processes in place to

1. National Insights and Barriers: Themes occurring across all interviews	
	safely share information. Services queried why, where possible, one shared care plan could not be used with clear notes on which service is responsible for delivering each element of the plan as discussed at insight 1.1.6. On a wider scale this was also discussed as something that is an issue where there is a lack of shared information for those who choose/have to move areas, highlighted predominantly by homeless households and those leaving residential rehabilitation where they could not return to their home area, and where people had to wait until their records were requested or received or where they felt they had to "start again".
1.2 Safety and Quality	
1.2.1	**Both professionals and individuals advised there was no clear single place to read or learn about the MAT Standards and instead described random information on MAT or information they had learned from other peers, some of which was not accurate. Additionally, there was described a lack of up to date, or live, information to understand what MAT is and who it is aimed at and so no clear standard of care set for all stakeholders and those accessing services.** Additional to this, our conversations raised that live and relevant information for each local area should be available and mirror what is accessible locally to avoid the disappointment felt when expecting a service that is unavailable. Similarly to discussions around services directories it was discussed that information should be available to enable people to understand all the necessary components to MAT such as advocacy services or other relevant advice and training sites to cover related issues such as welfare benefits and housing.
1.2.2	**During discussions, it was clear there is variation in how each area addresses treatment and recovery from substances beyond Opiate Substitute Therapy and that, due to this, there was no consistency or quality of care or how the system should respond, under the MAT Standards, to meet a broader range of needs including benzodiazepine, alcohol, stimulants use and consider how it responds to the influx of new synthetic substances.** People told us successful outcomes were only sustained by ensuring the local system could adapt to meet wider needs of people, as contained within the latter MAT Standards, especially where there was a lack of medical treatment or prescribing options for benzodiazepine, alcohol, stimulants and the influx of new synthetic substances. Additionally, discussions highlighted that there was success in this area when diverting those with stimulant use issues to alternative recovery options such as

1. National Insights and Barriers: Themes occurring across all interviews	
	sports, outward bounds, and the arts but that these were not consistent options across local authority areas never mind across all areas. This also showed better outcomes in areas that also provide recovery options such as meaningful training, qualifications, and employment to ensure individuals had the opportunity to chance thrive. There was also discussion around the added benefit of groups understanding the needs of those with protected characteristics to ensure everyone has an opportunity to access support.
1.2.3	**The relationships between individuals and Community Pharmacies (CP) were also discussed and highlighted across all areas as needing development and improvement.** Issues such as the collection of medication within restrictive time periods (some had advised windows between 10am and 12pm and 2pm and 4pm), mandated entry and exit points that are not the normal shop front doors and segregated queuing systems were all discussed as areas of needing improvement to foster better relations between the individual and the CP, alongside addressing the stigma that many felt when attending a pharmacy. Very few conversations believed that CP services were psychologically informed environments and noted this as an area they would like to help with.
1.2.4	**People advised they were often not aware, or signposted to, community-based recovery services and/or psychosocial support, and unsure of the local options during their treatment and support.** Individuals advised they benefited more when they had choice and control to choose which services are most beneficial for them and ensured their wider support needs were being met beyond the provision of medication. Many stated that they often felt they had been placed on medication and "forgotten" and that there was a lack of options to work on their wider recovery needs.
1.2.5	**There seemed to be a perception that the MAT Standards are linear and that those accessing them must start at MAT Standard 1, which has been described as a barrier to accessing treatment for those who are not being offered substitute prescribing, not wanting medication, or where there are limited options for licensed medication to offer (e.g. cocaine use). This was described as a barrier to those using non-opiate substances approaching to request help or, where they did ask for help, it was limited.**

1. National Insights and Barriers: Themes occurring across all interviews	
	This perception was that the Standards are only applicable to opiate treatment and that the only difference in the treatment being offered is prescription medication with a lack of understanding around the wider options available under MAT and specifically the Standards applicable to areas such as Housing, Psychosocial Support and Advocacy.
1.2.6	**Discussions highlighted that there were barriers to quality, and continuity of support and care when engaging with multiple agencies meaning there was a need for people to retell their story to all agencies, with many services refusing to share data with each other and a view that many were misunderstanding or allegations of "hiding behind" GDPR, specifically around the use of GDPR and the Caldicott Principles on who can share information and when, even where consent had been given.** A consistent key theme was in relation to data sharing and GDPR, variation in interpretation is driving an inconsistency in care. Reports also indicated that there was no live guidance, training, or support on data sharing and GDPR leading many to be fearful of sharing information and potentially breaching GDPR.
1.3 Integrated Care Planning	
1.3.1	**Discussions highlighted that there did not seem to be any consistency on who should be sharing data, what it should include, and when – even where permission has been given by the person whose data it is (data subject). Due to this there are barriers in supporting the best health outcomes possible and capability to intervene where people are at risk of harm.** Feedback highlighted a belief that more proactive data sharing will reduce unnecessary delays in treatment, especially where this reflected the Caldicott Principles, as there was awareness, especially in those providing services, in sharing data where it might breach GDPR, even though there was fragmented understanding of GDPR across everyone we spoke to.
1.3.2	**Discussions highlighted barriers in working relationships and practices between those who are duty bearers within all of the elements of the MAT Standards, these barriers also included insights where a lack of cross department budgets. Barriers were also highlighted by those who were or had been homeless when trying to navigate addiction, housing, homelessness and mental health services despite what is described here within the NICE guidelines. Within discussions it was described as feeling that an individuals support needs were often seen as "someone else's" issues to deal with.**

1. National Insights and Barriers: Themes occurring across all interviews	
	This was also discussion that this issue extends between different healthcare settings including hospitals, GPs and dentists etc and those services who do not provide addiction support or treatment and where it was described as easier to state they did not need to work in partnership. This was highlighted as an issue across all areas with different levels of concern in each area.
1.3.3	**There was discussion from participants who raised concern that addiction, treatment or recovery needs were routinely ignored by homelessness services or housing services when allocating accommodation, often to the endangerment or detriment of the individual, even were a suitably qualified professional had documented the needs of the individual. This was repeatedly highlighted as an issue on demission from prison, hospital, or residential rehabilitation setting, and where it was often left until it became an emergency and so any accommodation was far from suitable and had on occasion led to harm.** Almost all who highlighted this advised that their homelessness/housing needs had not changed when leaving the above institutions and so there was confusion as to why this could not have been discussed at the earliest opportunity, ensuring the needs of those leaving a residential service for their addiction unplanned, or released from prison during remand period, were already documented and expected, including any support needs. Existing legislation and guidance around homelessness processes and those contained within other policy documents such as the Sustainable Housing on Release for Everyone (SHORE) Standards were mentioned during these discussions and questioned as to why they did not reflect the journeys experienced by this client group.
1.3.4	**Despite being a recurring conversation those who worked in the addiction sector did not feel equipped in assessing someone's housing needs, specifically in line with relevant housing legislation, and so advised the did not feel they were equipped to challenge in this area, even where it was part of someone's care plan and so the accommodation needs element continued to be a barrier within a multidisciplinary approach.** There was a feeling that referrals were being made to a housing or homeless provider that included all addiction treatment or recovery needs that would allow sufficient information to allow for allocation of suitable housing and support, but that this was almost always an issue, even when there was knowledge in the area they did not feel equipped or knowledgeable enough to challenge this and so often

1. National Insights and Barriers: Themes occurring across all interviews	
	advised the individual to accept it even where they felt it was detrimental to their recovery pathway or even on occasion a risk to life.
1.3.5	**Discussions highlighted that there did not seem to be a requirement under the MAT Standards for good working relationships between homeless duty bearers, housing, and addiction duty bearers to ensure that those in addiction, treatment and recovery have their needs assessed at the earliest opportunity, and for these needs to be considered across all services to find the most suitable outcome and instead where the services work in silos and to different duty outcomes. This was also discussed in relation to housing providers looking for support for those tenants caught in addiction who are under threat of eviction and could not find this, despite knowing that entry into the homeless system would further compound the addiction issue.** Some discussions elaborated knowledge of the Homeless Code of Guidance, and the duty to assess the special needs of households under Unsuitable Accommodation Order, yet this often not the case and some discussion highlighted occasions where this led to harm and even death.
1.3.6	**Issues were also repeatedly highlighted that services supporting children, such as schools, CAMHs and children's panels, did not have integrated referral pathways to seek support for parents/guardians who need to access support for their addiction, even where there has been a risk to the child identified and that this has then led to outcomes that normally would not be pursued if suitable support for the family could have been found, including the removal of children.** Discussions highlighted that this is a current frustration within the sector, and these services are unsure who to refer to, referrals are not picked up or they instead can only raise a child protection referral which doesn't always result in the desired outcome to keep family units together and can create further trauma and stigma for those involved or for reluctance from carers/parents to admit they need support.

The following insights discussed here were raised by areas where it was clear that there are different approaches being taken locally.

2. Local Recommendations: Themes that were area specific	
2.1 Availability & Accessibility	
2.1.1	**Each area reported different levels of understanding around standards of care and responsibilities across all services involved in the implementation and delivery of the MAT Standards, leading to individuals reporting that they had their medication**

2. Local Recommendations: Themes that were area specific	
	ceased due to an action that they had no prior knowledge would result in them being negatively affected. There was also evidence that there were inconsistencies in this approach from individual to individual or practitioner to practitioner even within the same area. The removal of necessary medication then often had resulted in higher risk of overdose or increased use of illicit substances until resolved. There were some who were consulted with, who had knowledge of the charter of patients' rights and responsibilities, who felt there should be added local information around this issue.
2.1.2	**There were discussions around the way in which services were being commissioned locally and a common belief that this was often only done with finances in mind with no real focus on any additional commissioning principles.** Conversations highlighted this drove insecurity and instability for trusted services and relationship-based support, that would then lose their commission, often leaving people more vulnerable while impacting individuals and the wider community even further. This also highlighted that it often led to a lack of choice on which services someone could use and lead to a lack of individualised recovery journeys and a lack of control of their own care and treatment. Participants also highlighted that when this has happened, they are often forced to travel unreasonably to reach a similar service in another area.
2.1.3	**Participants advised there were huge barriers in accessing services due to the lack of accessible childcare services, or where it was not appropriate to take a child into a service with them. This meant that people were unable to access a service required for their ongoing recovery.** There was a feeling that this affected single parent/carer households more and thus affected females more than males, leading to options being unfair. Discussion then included the need for services that are catered towards all groups with protected characteristics, especially in local areas where this approach is necessary and would have the greatest impact.
2.1.4	**Services advised that they were having to manage people's expectations of access to MAT so as to maintain trust and reduce the likelihood of any further trauma to an individual especially where local authorities hadn't fully implemented all options that should be available under MAT.** There was discussion that local areas need to be honest about what is available to people locally and an acknowledgement that this may impact on local areas being

2. Local Recommendations: Themes that were area specific	
	able to fully evidence implementation of the Standards but should have consideration that the lack of transparency around this is leading to further issues. Some areas reported that there were issues when there was an assumption that an option would be available to access, when it wasn't. This was advised to be a greater issue when people would be advised they should request an option, only to be refused and could lead to further trauma, mistrust, or anger.
2.1.5	**There were multiple discussions around the successes, and need, for navigator style advocacy services who employ people with lived experience to assist in supporting people through treatment, specifically those who have experienced the same treatment option as the individual and that the feeling was that despite the success of this approach in multiple areas there was a lack of such services available to people.** Stakeholder discussions further highlighted that to support people with lived experience to be valued in the sector they require to be appropriately paid with access to adequate support, training, learning and development to maximise the value of their contributions. It was highlighted that it is important that the system does not exploit an already vulnerable population group by using this as a more affordable option for employing people on lower that average wages. Feedback also highlighted that areas should design appropriate support and supervision processes that go beyond those processes in place already to ensure that people feel supported in their role with an understanding many could have been out of work for a lengthy period and so require additional support and supervision.
2.1.6	**Recurring issues around the availability and accessibility of services administering MAT, in line with the lifestyles of those in active addiction seeking treatment and recovery, were highlighted. Standard office hours were viewed as a barrier to access, especially for those who may be in employment, or wish to enter employment, or general difficulty in attending office hour services. This also highlighted that many interdependent services all closed at same times (GP and Community Pharmacy as example) and so often, during these times, individuals were unable to speak to anyone. It was also highlighted that statutory addiction services did not seem to have an out of hours service that could offer MAT 1 prescription services beyond normal office hours.** There was various feedback around the benefits, and limitations, of 24hr access to treatment or even extended working hours so they would meet the needs of the local population, with an out of hours treatment option to manage any demand out with the extended opening times. This issue was specifically felt by those who

2. Local Recommendations: Themes that were area specific	
	reported the requirements to access a Pharmacy daily between standard office hours.
2.2 Safety and Quality	
2.2.1	**Individuals within local community settings advised on a lack of accessible recovery services within the local community, or even within a reasonable and safe travel distance of their community. They also added that many of these services have certain requirements for entry that they felt were a barrier in accessing them, some even advising that they had been asked to leave a service when they had used substances prior to it, leading to them not going back.** It was also discussed that these services, if available, should also be able to provide services, where required, to specific groups based on gender, sexuality, disabilities etc to reduce stigma and promote access. This will ensure they promote low threshold, safe, spaces to engage and recover. Many we spoke to reiterate the fact they were being asked their views at this point gave them encouragement that change may happen and added they would welcome the idea of being involved in local and national policy or planning. Some added caution though that they had been involved in some lived and living experience development groups previously and did not feel they were being listened to and so advised this would need to be fixed.
2.2.2	**Feedback highlighted that Level 1 Injecting Equipment Provision services were sporadic and not always available from a Community Pharmacy, including One-hit kits. This led to situations were individuals had to travel to the nearest service or use old IEP if they could not, leading to increased harm and risk of physical damage when injecting.** Feelings were also that many had good relations with their local Pharmacy teams but that often they could not help when it came to the supply of more specialised pharmacy harm reduction services including vaccination and wound management. In isolated or rural areas, there were discussions around postal and mobile services during the Covid-19 pandemic, that had since been removed, that had worked for people and had led to them using more safely and with less risk, there did not seem to be any update on why these services had ceased. This had been specifically highlighted as beneficial to those living in rural villages, those with a disability or those whose mobility was limited.
2.2.3	**Some areas highlighted that they were aware of larger scale lived and living experience focus or development groups but a lack of such groups at a local**

2. Local Recommendations: Themes that were area specific	
	community level and even less again who work with duty bearers in developing addiction treatment responses and provisions for their specific community or area. Many added that they did not feel their views or ideas were important. They advised that these groups should be impartial, to ensure these forums allow open and honest discussions about the current provision and what is required to progress improvements to service provision. Some discussed how they felt they lacked the experience or training to effectively tell their story and lend their voice in this capacity and stated the need to access training, gain qualifications and ultimately employment, this should specifically consider how people with lived experience access employment or opportunity in Senior roles, especially at decision making levels. Many reiterated that they felt current, similar, roles were more tokenistic and a feeling they were not qualified enough to assist in making strategic decisions. Participants stated that these local community groups should have their voices feed into local strategic planning and national LLE groups to influence policy at a national level to ensure everyone has a voice, especially in communities that normally do not have a big enough voice. Almost all areas reported that they did not feel listened to or that these groups were something that happened in other areas, some stating this conflicted with the rights they were being told they had.
2.2.4	**Many participants who had accessed advocacy services, under MAT Standard 8, advised they often did not feel it met the wide range of needs and disciplines required under the full MAT Standards, such as addiction treatment, welfare rights, children's rights, mental health or physical health treatment rights and housing/homeless rights.** Stakeholder discussions highlighted that the advocacy services they have used have not had the expertise, knowledge base or organisational ability to deal with more complex cases in areas such as mental health, children's rights, and housing and/or homelessness. Organisations reported this was also felt more in areas that required knowledge of legislation and some highlighted the use of specialist services such as Shelter Scotland, CAB Housing Services, and other law centres instead.
2.3 Integrated Care Planning	
2.3.1	**Within local community settings the stakeholder groups advised on what local services they need and who works well with each other, also who doesn't. When discussing this they reported on issues with data sharing and advising that often MDT style work was broken due to the lack of local joint working between local services, even where it affects the individuals care planning or care in general.**

2. Local Recommendations: Themes that were area specific	
	Practitioners added that a joint working approach, where data sharing was no issue, allowed for better outcomes, shared practise, resolving complex cases, and work closely together on shared solutions and disciplines. A service diary exercise we accrued out advised that, local membership of any joint working should include Community Pharmacy, Registered Social Landlords or Housing Providers, GP, Community Link Workers, Community Anchor Orgs, Advocacy Services, DWP and family support groups. They concluded there should be a way to ensure that sharing of data should not be difficult within a joint working approach.
2.3.2	**Services advised that there was a lack of use, if at all, of single patient records that encompasses MAT and other addiction treatment support. This often led to people receiving duplicate care or no care in certain areas as different services were using different tools to record data and outcomes.** This was leading to an unnecessary volume of times they must share their story, increasing harm and reducing positive outcomes for the individual. It was also advised as leading to services working towards their own outcomes with no knowledge of what other services are doing with the same individuals.
2.3.3	**During stakeholder discussions, it was heard that choosing to reduce medication can be more difficult than increasing medication. It was added that this should not happen and that additional support should be available for people when doing so, as many will do this themselves without support mechanisms in place potentially increasing the risk of harm. This was especially the case where people felt they had no option but to "do it themselves".** There seems to be a lack of care planning and support for those who choose their own pathway through MAT, specifically those who wish to titrate, cease, or reduce dose of their medication. This also highlighted inadequate referrals to mental health services for this group, even with the heightened need for support due to the reduction in medication/drug use increasing issues related to their mental health that substances were potentially subduing. There did not seem to be any way to highlight this group as a priority, despite the risk although those who reported good outcomes doing this themselves spoke about the benefits of having to attend community support services or mutual aid groups for support and that this had led to better outcomes.

Prisons

Prison estates presented multiple issues that would render sections of the MAT Standards as inappropriate to offer in the same way they would be within a community setting, such as injecting equipment or the provision of choice of some medication due to the risk of the "sell on value" within the prison estate. This was raised during discussions despite the acknowledgement that there should be no difference in the provision of medical assistance within prison estate compared to the provision within a community setting as the loss of liberty has already occurred, which should be the only difference, as referenced within the Justice Vision and Priorities Delivery Plan.

3. Prisons	
3.1 Availability & Accessibility	
3.1.1	**During stakeholder discussions it was evident and agreed that the MAT Standards cannot be fully implemented within the prison estate due to multiple safety risks that would be present.** There was an evident lack of clear understanding or guidance on what can be offered within prisons in line with the MAT Standards and a general view that these would be the same as those found within the community. Services and people with LLE discussed the risk that certain medication would pose and around the provision of IEP, with some advising they could not ask for this anyway as it would pose a risk to certain privileges they had built up.
3.1.2	**Stakeholder discussions highlighted the lack of good quality aftercare support, if any support was available on release at all. Those who had been working, or in, the system for several years referred to the older throughcare support services that was run by the prison service itself as a model that had great success before the funding was removed for it and staff returned to their normal posts. Success stories included descriptions around the navigation of necessary elements such as benefits, prescriptions, and housing/homelessness, as referenced within the Sustainable Housing on Release for Everyone (SHORE) Standards.** They added it ensured one point of contact to support, advocate and navigate people through services when they need them and lessen the risk of relapse or reoffending.
3.1.3	**Those we spoke to reported that the option to become drug free in prisons has been largely removed for many years now and that, even where it was desired, the prison environment did not allow for this with ease due to the availability of drugs. Many stated they would have chosen the option to do this within prison if the**

3. Prisons	
	environment was right but stated that this would be difficult within the current estate due to the availability of drugs or the proximity to those using them. Some questioned why they are being given the option to go to residential rehabilitation after they gained their liberty as opposed to being able to do this while serving their sentence, adding that leaving prison with no connection to recovery is a dangerous time for them and that many did not consider this an option as it was felt to be an extension of being detained as opposed to gaining liberty. Almost all that we spoke to, both within the prison discussions and within the communities, highlighted the benefits of drug free wings to enable those who request it the option to become drug free, stabilise (if appropriate in same wing) and/or enter recovery and programmes of rehabilitation while still in prison. With the knowledge that liberty was the only difference in treatment they stated that this should also incorporate a programme of education and employability alongside other psychosocial activities such as recovery cafés and mutual aid meetings to fully ensure the MAT Standards can be fully implemented in the estate, where it is safe to do so.
3.1.4	**Issues were discussed around the provision of substitute prescriptions for those entering the prison estate due to the absence of an accessible to prison staff single patient record from a community setting, leading to a delay in the provision of substitute prescriptions.** There are instances of practice that is resulting in positive outcomes for a person through the provision of same day Dihydrocodeine to meet someone's withdrawal needs short term and as a viable option for harm reduction as a bridging prescription pending receipt of the individuals records and appropriate assessment or screening.
3.1.5	**Participants described a lack of the additional services required to implement the full MAT Standards within the estate and often left until the individual is due for release, if at all.** There is acknowledgement that some of these services, e.g. homeless or welfare rights, can't be enacted within prison or only offered closer to liberation, and feeling was this is often too late to ensure a positive outcome. The fears around homelessness and accommodation was a recurring barrier in almost all discussions.
3.2 Safety and Quality	
3.2.1	**Participants described a lack of support for prisoners in treatment and/or recovery in areas such as employment or full-time education as part of their recovery journey, which was stated to be a necessary element of their journey through the MAT Standards.**

3. Prisons	
	It was added this should be available to ensure a constructive use of time when liberated, in conjunction with links to recovery communities, to ensure the best possible chance of sustained recovery and prevention of reoffending.
3.2.2	**People told us about situations where they had their prescription medication withdrawn for breaking prisoner rules and is considered a barrier to seeking support whilst incarcerated. These actions may affect a prisoner's access to engage in other options to support their treatment and/or recovery within the prison, such as recovery groups, this may lead to increasing harms and escalation of addiction.** We were advised that people were reluctant to engage with staff for new medication, or increased medication, due to the risk an admission of illicit drug use would lead to some form of punishment.
3.2.3	**Participants advised there are Near Fatal Overdose's (NFO's) every day, and these are not being appropriately responded to by the care or services being offered. It was stated that NFO prisoners were returned into the general population where the risk of further harm exists.** There did not seem to be sufficient practices in place that allows those who have experienced a near fatal overdose immediate access to support or treatment and instead the priority was to return them back to their respective halls.
3.2.4	**Barriers to recovery were described relating to locking individuals in cells for up to 23 hours per day, this was especially being felt where someone is actively engaged in their treatment plan and needing more support, including the attendance at recovery or fellowship meetings and engagement with any other activities to support their treatment and/or recovery.** There is acknowledgement that, due to the nature of prison itself, there should be a "rights and responsibility" agreement that people would need to adhere to ensure no loss of any extra privilege within the estate but that prison services should consider how best to address this issue and allow individuals to engage in meaningful recovery programmes.
3.3 Integrated Care Planning	
3.3.1	**Barriers to continuous care were described not only for those entering prison but also for those being liberated where a lack of integrated care planning was leading to gaps or delays in their treatment. This was described as a lack of communication, or even systems that do not speak to each other.** Systems do not alert services when someone is being liberated or even when they could be liberated pending remand, meaning it often became an emergency when they were. Current systems do not "speak" to each other and currently rely upon

manual communication between providers, creating a delay and a break in the continuation of care.

Alcohol

See: Appendix A Alcohol in Scotland: Briefing paper.

The below paper aims to provide a brief overview and snapshot of the current landscape and situation in relation to alcohol in Scotland based on the most recently available data and literature, it is not intended to by a systematic and exhaustive review of the literature and evidence available.

Our discussions highlighted that although parts of the MAT Standards, particularly the medical prescription and retention elements, may be perceived to not apply in their entirety to those seeking support for their alcohol use, the underlying principles and overall intentions of the Standards do provide a framework to ensure someone is able to access the treatment and support they require. The MAT standards are intended to ensure that individuals with addiction issues receive safe, effective and evidence-based care. This includes increasing access to treatment, standardising treatment protocols, incorporating person-centred and trauma-informed care, and ongoing evaluation and quality improvement. Furthermore, there is a need for a comprehensive approach to addressing problematic drug use, including alcohol, and the importance of involving people with lived and living experience of addiction in the development and implementation of MAT.

In summary the principles and standards outlined in the MAT framework can be applicable to individuals with alcohol use issues, but clear guidance should be given around the difference in some of the standards for this group. In our discussions, issues around choice of medication and even length of time on medication, could be limited in scope due to the types of medical treatment that is available, and the length of time required to complete the treatment, which is in most cases for alcohol treatment includes a short-term detox followed by ongoing prescribing of anti-cravings medication and vitamins such as B12, Thiamine etc.

Synthetic drugs use

Our discussions around the rise of synthetic drugs showed that there was very limited knowledge as to what drugs being purchased are, or aren't, categorised as synthetics. The principles of MAT can also be applied to help individuals struggling with synthetic drug use.

MAT combines medication, counselling, and behavioural therapies to treat substance use disorders effectively. In the case of synthetic drug use, medications such as buprenorphine or methadone can help reduce cravings and withdrawal symptoms, while therapy and counselling can address the underlying issues contributing to the drug use.

Evidence needs to be gathered, and published, in relation to suitable harm reduction approaches for each drug, however once someone is accessing services in line with the MAT Standards, then the pathways and processes in place through MAT should be effective in managing a persons' withdrawal symptoms and/or any associated risk, regardless of what substances were being used. It was felt therefore that a comprehensive package of care for everyone seeking support due to alcohol or drug use was the main priority and not focussing on one substance as requiring more focus than any other.

The effectiveness of MAT does depend on individual circumstances, and it's important to highlight the need for individuals to work closely with healthcare professionals and agree, in partnership, the best course of treatment for their specific needs. By integrating MAT into an integrated treatment plan, individuals struggling with synthetic drug use can receive the support they need to overcome their addiction and enter recovery, if this is what they want to do.

Recommendations for Improvement

See: Appendix B Stakeholder Engagement Recommendations

The following recommendations have been developed and collated from our engagement work and where we feel we could offer support to stakeholders and allow Healthcare Improvement Scotland to form its National Improvement Plan for the MAT Standards.

Annex B shows all discussed recommendations for improvement, and we acknowledge that these additional recommendations may be best placed within other bodies and duty bearers, and we will make time to discuss the best way forward to ensure continued improvement across the MAT Standards and beyond.

	1. From National Recommendations: Themes occurring across all interviews
	Availability & Accessibility
1.1	**Help support the production of guidance that supports people in their journey to recovery by clarifying the rights of people to initiation and cessation of medication under MAT or other forms of Alcohol and Drug treatments.**

1. From National Recommendations: Themes occurring across all interviews	
	Guidance should ensure MAT pathways tie into the whole system of care to ensure people are treated with dignity and respect and their experience of care is seamless.
1.2	**To ensure suitable housing or accommodation is at the heart of all integrated care plans, every area should engage with, and commission where necessary, Registered Social Landlords (RSL's) to support the implementation of the MAT Standards, and specifically Standard's 3 (Assertive Outreach and Anticipatory Care) and Standard 8 (welfare rights, housing, and money advice), where there is already a partial duty to provide these services within social housing providers.**
1.3	**Help support local areas to develop, agree and implement the use of a shared referral and assessment tool to ensure a set standard across all providers, which will lessen the likelihood of trauma and ensure a consistent standard and continuity of care for those seeking support.**
Safety and Quality	
2.1	**Help support Community Pharmacy Services to ensure they work to eliminate any practices that may be perceived as stigmatising to anyone accessing treatment to support their substance use in line with the MAT Standards and to ensure services are psychologically informed.** **This will facilitate improved relationships between a patient and the Pharmacy team.**
2.2	**Help local areas produce local resources and guidance that enhances the quality of treatment and improvement of health outcomes by ensuring people are aware of and signposted to community-based recovery services and/or psychosocial support, ensuring people are aware of the local options during their treatment and support.**
2.3	**Through the national learning system, to ensure quality and continuity of support and care (while also lessening the need for people to retell their story to multiple agencies), design and deliver webinars and help produce guidance in relation to information and data sharing, specifically around the use of GDPR and the Caldicott Principles on who can share information and when.**
Integrated Care Planning	
2.4	**In line with 2.3, help produce clear guidance should be set out, in line with regulations, on who should be sharing data, what it should include, and when – with specific guidance on situations where permission has been given by the person whose data it is. This will ensure services involved in a person's care and treatment are confident about information that can be shared supporting the best**

1. From National Recommendations: Themes occurring across all interviews	
	health outcomes possible and capability to intervene where people are at risk of harm. This guidance should reflect the Caldicott Principles, ensuring there is clear guidance that would ensure people are acting within GDPR when sharing data.
2.5	**Help support local addiction teams to understand and assess an individual's housing needs by helping produce housing needs assessments. We should also help produce a learning system for adequate training and support in assessing someone's housing needs and to be available to those within the addiction sector to ensure that any housing or homeless accommodation meets the needs of the individual. Guidance should also be issued to those within the addiction sector to ensure these needs are incorporated into a comprehensive care plan that encompasses a multidisciplinary approach across various sectors. This work should also consider addition needs to be inserted in the relevant guidance available to housing and homeless teams.**
2.6	**Help connect relevant duty bearers, through community engagement and bespoke support, to promote improved working protocols between homeless duty bearers, housing, and addiction duty bearers to ensure that those in addiction, treatment and recovery have their needs assessed at the earliest opportunity, this should include the provision to best support those in addiction who are under threat of eviction where entry into the homeless system would further compound the addiction issue. This will ensure the needs of those with addiction, in treatment or recovery are recognised in parallel with housing or accommodation need.** This may require an update to national guidance, such as the Homeless Code of Guidance, to ensure addiction treatment or recovery needs are considered within the duty to provide homeless accommodation.
2.7	**Help support local areas to create referral pathways that ensure services supporting children, such as schools, CAMHs and children's panels, have pathways to seek support for parents/guardians who wish to access support for their addiction, where there has been a risk to the child identified.**

2. From Local Recommendations: Themes that were area specific	
Availability & Accessibility	
3.1	**To support local areas to best commission services that help ensure community-based recovery capital and services are sustained and developed. We can help support local commissioners and planners, through Ethical Commissioning Principles, to support greater collaboration and outcomes-based commissioning. Local areas should be supported to understand what recovery services are used**

2. From Local Recommendations: Themes that were area specific	
	locally, including mutual aid groups, and develop referral pathways into statutory services including prescribing services, detox, stabilisation and rehabilitation.
3.2	**Additional to 3.1 help support areas to increase accessibility and equality of access to services, to commission recovery services that operate in conjunction with a child or youth service, assisting parents/carers to access recovery services despite having childcare responsibilities.** Help support and produce, as part of the commissioning process of any service, an equality impact assessment to consider the desired impact on those with protected characteristics, for example single parents as a high proportion are single females. This EQIA approach can also consider the commissioning of services that are catered towards all groups with protected characteristics, especially in local areas where this would have the greatest impact.
2.2 Safety and Quality	
4.1	**Additional to 3.2 help support local areas to ensure the provision of recovery projects within local community settings that have a low entry threshold and ensure availability of services specific to groups based on gender, sexuality, disabilities etc to reduce stigma and promote access.** Support these community-based services to develop LLE focus groups and to have an independent voice, ensuring authenticity and independence, and have the function to feed into local and national policy or planning.
4.2	**Help support pharmacies, within the wiser community areas, to provide Level 1 IEP services, including One-hit kits, with low level interventions and signposting to other services also available. This work should also support rural areas to develop bespoke programmes to address issues found within rural settings.**
4.3	**Help support local authorities to set up LLE focus groups at a local community level to work with duty bearers in developing addiction treatment responses and provisions for that specific community or area. We should ensure that these groups are impartial, to ensure these forums allow open and honest discussions about the current provision and help local areas, and services, identify what is required to progress improvements to service provision.**
4.4	**Help support local authorities, and additional stakeholders, to ensure any independent advocacy service commissioned under MAT Standard 8 can meet a wide range of needs and disciplines required under the full MAT Standards, such as addiction treatment, welfare rights, children's rights, mental health or physical health treatment rights and housing/homeless rights. This work should also include identification of available expert organisations to work in partnership in this area and help input into a national learning platform and guidance.**

2. From Local Recommendations: Themes that were area specific	
2.3 Integrated Care Planning	
5.1	**Help local areas to develop, establish, and support, community based joint working to form a local 'Safety Net' with membership including Community Pharmacy, Registered Social Landlords or Housing Providers, GP, Community Link Workers, Community Anchor Orgs, Advocacy Services, DWP and family support groups.**
5.2	**Help support the design, implementation and use of a single patient record that encompasses MAT and other addiction treatment support. Access, pending patient/individual consent, should be available to all parties who provide care and support to the individual, the level of information access should be relevant to each service.**
5.3	**Help local authorities develop guidance, care plans and adequate support for those who choose their own pathway through MAT, specifically those who wish to titrate, cease, or reduce dose of their medication. This should also include a protocol for urgent referrals to mental health services due to the reduction in medication/drug use increasing issues related to their mental health that substances were potentially subduing.**

3. Prisons	
Availability & Accessibility	
6.1	**Help develop guidance on what can be offered within prisons in line with the MAT Standards while considering other barriers facing the prison system while managing safety risks that would be present in the prison estate.**
6.2	**Help commission, establish and develop throughcare support services within prisons that will ensure someone is supported prior to and upon liberation, including the navigation of necessary elements such as benefits, prescriptions, and housing/homelessness, as referenced within the Sustainable Housing on Release for Everyone (SHORE) Standards.** This will ensure one point of contact to support, advocate and navigate people through services when they need them and lessen the risk of relapse or reoffending.
6.3	**Help investigate and develop the use of drug free wings within the prison estate to enable those who request it the option to become drug free, stabilise (if appropriate in same wing) and/or enter recovery and programmes of rehabilitation while still in prison. This should also incorporate a programme of education and employability alongside other psychosocial activities such as recovery cafés and mutual aid meetings.**

6.4	Help develop protocol around the use of safe, low-level prescriptions for those entering prison who advise on having a drug addiction pending further assessment or confirmation from community-based prescribers. This protocol should allow the individual to remain on the substitute drug if it is deemed beneficial to their recovery journey.
6.5	Support prisons to consider the access and availability of the additional services required to implement the full services necessary under the MAT Standards and where it would be appropriate to offer these within the estate.
	Safety and Quality
7.1	Help develop bespoke guidance to ensure medical advice is fit for purpose within a prison environment, especially within the context of the aims of the MAT Standards. Support Prisoner healthcare staff and Prison staff to work together to manage risks and explore options for people to sustain their recovery with no detriment because of their prison environment. It should ensure people are not taken off, or threatened with being taken off their prescriptions, if breaking prison rules such as admission of using illicit drugs, which are described as a barrier to asking for support.
7.2	Help develop healthcare pathways that allows those who have experienced a near fatal overdose (NFO) access to immediate and safe support or treatment following the incident.
7.3	Help support the enhancement of the quality of treatment by seeking improved alternatives relating to locking individuals in cells for up to 23 hours per day, especially when someone is actively engaged in their treatment plan and needing support, to attend meetings and engagement with any other activities to support their treatment and/or recovery.
	Integrated Care Planning
8.1	Support the system to better facilitate integrated care planning and ensure healthcare continuation, with no gap or delay in treatment, by helping support the establishment of systems that allow communication between all relevant healthcare professionals for someone going into prison and upon liberation.

Conclusion

There was no doubt, from almost all parties we engaged with, that the best way to treat addiction is from within a comprehensive and multi-faceted approach that addresses the whole needs of individuals who seek help for alcohol or drug addiction. This approach

should encompass all interventions, including Medically Assisted Treatment (MAT), residential rehabilitation, support for housing and reintegration into the community.

It was also deemed essential to consider the broader determinants of addiction, such as homelessness, mental health issues, in conjunction with social inequalities, to provide a holistic, integrated care and treatment plan that addresses each of these factors as a whole package and not the current environment that seeks to work in silo, often attempting to address one issue at a time, if at all. Practitioners we have spoken to in various sectors often felt that their own roles were being hindered due to barriers being created by other sectors, where addiction teams felt homeless teams could do more and in turn homeless teams feel addiction teams could do the same. Those we spoke to added that only by bringing these stakeholders together will we be able to develop an approach that not only seeks the best outcome for the individual but also be more cost effective.

Improving access to MAT is crucial, including increasing the number of providers, reducing barriers to accessing and remaining in treatment, and standardising treatment protocols between all providers and duty bearers. Incorporating person-centred and trauma informed care into MAT standards is also essential, ensuring the needs and choices of people are at the heart of integrated care planning, and that individuals' choices of treatment are not hindered by the opinion of those delivering services.

To ensure the effectiveness of the MAT Standards, ongoing developments, evaluation, and continuous improvement during and following the implementation of the standards is essential. This needs to include the involvement of those with lived and living experience, as well as the creation of national guidance, and a governing body, to monitor and enforce the standards.

In addition to MAT, addressing homelessness and providing suitable accommodation is a critical component of addiction treatment. A whole-system approach is needed to tackle the underlying economic and social inequalities that fuel the cycle of homelessness, which should prioritise the supply of suitable, affordable housing in conjunction with ensuring early integrated care planning for someone's treatment journey which involves all sectors and/or providers.

Appendix A - Alcohol in Scotland

Alcohol in Scotland: Briefing Paper

This paper provides an overview and insight of the current landscape of alcohol in Scotland including:

- The most up to date data that has been published around deaths, demographics, harms and consumption trends.
- The current level of alcohol specific service provision and examples of innovative practice.
- A brief overview of insights from recent qualitative studies.

Appendix B – Stakeholder Engagement Recommendations

A full list of stakeholder recommendations for improvement developed in our engagement events can be found here.

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