

# SCOTTISH DRUG DEATHS TASKFORCE

## Medication Assisted Treatment MAT Standards for Scotland

### Access, Choice, Support

### Interim report

On behalf of the MAT Subgroup

March 2021

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

## 1. Introduction

Scotland has a high level of drug-related deaths. In 2019 1,264 drug-related deaths were registered in Scotland, 6% (77) more than in 2018. Based on the evidence that Medication Assisted Treatment (MAT) is protective against the risk of death, the Scottish Drug Deaths Taskforce and the Scottish Government has prioritised the implementation of MAT standards for people experiencing problems with their drug use.

The standards aim to ensure that MAT is safe, effective, acceptable, accessible and person centred.

### The standards of care for Medication Assisted Treatment

1. All people accessing services have the option to start MAT from the same day of presentation.
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.
3. All people at high risk of drug-related harm are proactively identified and offered support to commence, re-commence or continue MAT.
4. All people are offered evidence based harm reduction at the point of MAT delivery.
5. All people will receive support to remain in treatment for as long as requested.
6. The system that provides MAT is psychologically and trauma informed (Tier 1); routinely delivers evidence based low intensity psychosocial interventions (Tier 2); and supports the development of social networks.
7. All people have the option of MAT shared with Primary Care.
8. All people have access to advocacy and support for housing, welfare and income needs.
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery
10. All people receive trauma informed care.

In November 2019, the MAT Subgroup of the Scottish Drugs Death Taskforce set out the following programme of work:

- Agree the 10 MAT standards with implementing partners including people experiencing problems with drug use and their families.
- Provide support for local implementation of the standards through quality improvement and an evaluation framework to measure success.
- Promote sharing of successful practice through networking, the facilitation of national benchmarking and a review of published literature and successful practice in Scotland and elsewhere.
- Collaborate with Healthcare Improvement Scotland, Public Health Scotland and the Scottish Government to establish formal standards and quality assurance.

Following the announcement of the First Minister on 20<sup>th</sup> January 2021 it is anticipated that the above programme of work will be scaled up from the second trimester of 2021/22.

This report summarises progress of the work programme to date.

## 2. What we have done

Engagement visits by the MAT Programme Team have been ongoing since November 2019, initially in person and then online. The team scheduled meetings with Alcohol and Drug Partnership (ADP) Coordinators and service providers to gather feedback on the proposed standards and identify opportunities to learn how to implement them through quality improvement. Further engagement and feedback meetings have been held with a range of stakeholders and partners including Scottish Families Affected by Alcohol and Drugs, the Taskforce Lived Experience Reference Group, national substance use Clinical Directors, Lived Experience Recovery Organisations, RCPsych Scottish Addictions Faculty executive group, and the Chief Nurses.

During this time the MAT Programme Team have provided direct support to 16 ADP areas for 20 locally lead quality improvements projects covering standards 1-5. The team have facilitated dissemination of experiences, innovation and learning across Scotland. Progress with direct support against the standards is available online through the [Taskforce website \(please click to view\)](#) and Quality Improvement Project Charters are available on request. A further four projects are funded by the Taskforce Innovation Fund (see Appendix 1) and another five projects are in development to implement Standards 6-10 with a focus on psychological interventions, advocacy support and trauma informed care.

As part of the work, the team have sought to gather and disseminate existing successful practice and tools, such as standard operating procedures, to support areas with implementation of standards. Learning networks and communities of practice are also in development. A benzodiazepine working group has been established to consider existing practice and approaches to care including prescribing. All the above work is ongoing – please see initial summary of learning in section 3 below.

In November 2020 a full consultation process on the proposed MAT standards was started and closed in February 2021. The Ministerial launch webinar coordinated by the Scottish Drugs Forum was attended by over 400 people and has since been viewed over 1000 times on YouTube. This was followed by a series of 44 workshops facilitated by expert stakeholders including the Scottish Drugs Forum, Advocard, Consultant Psychiatrists, people from the Taskforce Lived Experience Reference Group, GPs, Clinical Psychologists, and NHS Education Scotland. An online survey was also available and there were responses from every ADP area.

The feedback received has been collated by the Drugs Team at Public Health Scotland to inform this report – please see summary in section 4 below. All the information will be reviewed to revise the standards and inform the programme of work by the MAT Programme Team 2021/22 – see milestones at the end of this report.

### 3. What has been learned through implementation

The experience and learning from engagement across the country demonstrates that local teams are motivated to do improvement work to reduce barriers and improve access for people using their services. Teams are committed to work towards implementation of the MAT standards of care, but most have limited experience in quality improvement work and limited support for data access, analysis and interpretation to provide evidence of improvement. Local areas are keen to showcase improvement work and meet with other areas to share learning and innovation.

Staff feedback in areas undertaking quality improvement work indicates that the implementation of the MAT standards was a positive experience for them, as they could see the benefit for people using their services. The quality improvement work has also led to better engagement and positive feedback among people using services.

#### 3.1 Examples of successful implementation of the standards

The following innovative quality improvement projects have been completed, with local learning consolidated over the course of the last 15 months. The MAT Programme Team supported this work through knowledge exchange and direct support for processes, reporting and dissemination of results.

##### ***Borders Addiction Services – Eyemouth Drop-In***

*“If it was not for the drop in I would never have got on to my prescription, it was only through meeting the staff and getting to know them that I felt like I could fully open up and tell someone I was using heroin”*

The drop-in was developed to better meet the needs of the community; bringing together NHS, council and voluntary sector staff to support people trying to overcome problems caused, or affected by, drugs and alcohol. The development of this service sees an important shift in practice, moving away from a formal clinical format to one that promotes inclusion and equality through its relaxed and enhanced person centred approach. Results indicate that the drop in has improved individual experience and been instrumental in getting people into care and treatment. Since the development of the drop-in there is an average wait of six days from referral to MAT and in total 77% of all referrals were commenced on a prescription within seven days. The drop-in has facilitated the start of same day prescribing, with 44% of all referrals started on an opioid substitution therapy on the initial day of assessment.

Project Leads: Fiona Nicol, Kate Ainslee

***Edinburgh Access Practice - A crisis intervention for people experiencing homelessness and substance use within a fluctuating paradigm of risk.***

*"I was started on methadone whilst street begging on a pitch, I was living on the street with absolutely nothing, 12 months on – I have a beautiful flat of my own, I feel healthier, I no longer wake up ill every day but best of all I can smile again."*

People who experience homelessness and substance use are often marginalised and stigmatised. Non-medical prescribers used an assertive outreach model to locate people where they are. Only 11% of people on MAT were assessed in a traditional clinic setting and 89% were assessed elsewhere including in hostels and graveyards. The model of care was trauma-informed, non-judgemental and acknowledged client autonomy and responsibility for their treatment. The majority had symptoms of complex trauma going back to childhood and although resilient, they lacked alternative coping strategies and protective factors.

Project Lead: Lynne Drysdale

***Aberdeenshire Responsive Intervention Engagement Service (ARIES)***

*"The service was very good. I asked for support from my GP previously, but this was not followed up and I have been struggling since. It feels like a weight has been lifted since ARIES visited."*

The ARIES is a near fatal overdose assertive outreach service. The ARIES team aim to see the individual within 48 to 72 hours from point of referral to provide intensive, brief, interventions that will address immediate risk and link the person to community or clinical services. The assessment used by ARIES covers areas of substance use, self-care, physical health and mental health. There are links with the Scottish Ambulance Service but also referrals for all other services so that ARIES can undertake a home visit and assessment to address immediate risks. Since commencement of this project there have been 45 people referred, with 33 being seen within 24 hours, 9 within 72 hours.

Project Lead: Dave Taylor

***Naloxone Peer Support – CGL Edinburgh/West Lothian***

*"Four years ago my girlfriend gave me Naloxone after a heroin overdose. Today I train others to use Naloxone. It's better to have it and not need it, than need it and not have it. I'm living proof Naloxone saves lives"*

*Scott, CGL Peer Trainer*

Due to the COVID-19 pandemic, there has been support from the Lord Advocate to expand the number of services able to distribute take-home naloxone (THN) kits to anyone who may be supporting someone at risk of, or likely to witness, an opioid related overdose. This project aims to expand the provision and supply of THN using peer naloxone volunteers who can use their own lived experience to access and influence 'not in treatment' drug using cultures more effectively than staff members. The peers go out on foot patrol in Edinburgh City Centre. Our measurement of success is simple - how many people can we train, how many kits can we give out, how many overdose conversations can we have? We need every person at risk or in contact with someone at risk to have access to naloxone. In the first 40 days the peers supplied 121 THN kits to people in need across Edinburgh and Livingston. This truly is life-saving work.

Project Leads: Yanni Yannilous, Dave Kelly

## 4. What has been learned from the consultation

Approximately 400 responses were received through the workshops and online survey; this includes 100 from people with lived experience of problematic drug use. There was widespread support for the ambition of the standards and the need for a system-wide approach to improve outcomes for individuals. Feedback demonstrated a clear commitment to change, with lots of opportunities for learning and improvement identified. This indicates that the ambitions of the standards are well founded.

Learning from the consultation will be incorporated into the final MAT Standards document that will be published in May 2021.

### 4.1 Themes from the consultation feedback

The following were common themes reported across the feedback

- There was significant support for all the MAT standards, with each standard considered likely to make a positive difference to reducing drug deaths in Scotland.
- The term 'treatment' was clearly understood to mean holistic care and support.
- Acceptability to people in need, and building trust and confidence in the system, was highlighted as critical to successful implementation of the standards.
- Equity in implementation of all the standards across the whole country, and accountability for reporting the quality of care defined in the standards, were clear expectations.
- People in services reported mixed experiences of the type of support defined in the standards, and reported feeling that the proposed standard of care would make a positive difference to them.
- There is a need for:
  - communication on the standards, and in particular rights-based information for people who may use services
  - more explicit recognition of the need for family inclusive practice to be embedded in the standards
  - Investment across all sectors of the workforce to enable the change people want to see

### 4.2 MAT standards

Below is a summary of feedback received against each of the standards.

#### **Standard 1. All people accessing services have the option to start MAT from the same day of presentation.**

- Support for offering same day prescribing, noting this as a key harm reduction and engagement tool.
- Delays and waiting times to get into treatment were seen as a contributory factor in overdoses and other health problems.
- The importance of a person centred rights-based approach for good quality care emphasising wider support to individuals, beyond solely medication.

- Noted that same day substitute prescribing may not be appropriate for everyone, and that there are risks from polysubstance use, including benzodiazepines.
- There is a need to raise awareness of this standard of care for staff and people accessing services, and clarification is required in interpreting the standard.
- Whilst recognising that administrative and clinical staff time could be used more efficiently through a same day model of care, comments also identified that staffing and service capacity as well as working patterns, were key challenges.

**Standard 2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.**

- Choice over medication was seen to support retention, confidence and engagement of people in services by shifting the power balance and ensuring ownership for people in their treatment and care.
- Safety in choice and clinical outcomes is important with a recognition that clinician and patient may have different treatment aims.
- There is a role for advocacy in supporting informed choices and decisions.
- Resource implications include staff training and supervision, infrastructure and the cost of medications. How variability in formularies may influence the choices on offer was also recognised.

**Standard 3. All people at high risk of drug-related harm are proactively identified and offered support to commence, re-commence or continue MAT.**

- The importance of assertive models of outreach to work with the most vulnerable individuals was highlighted.
- An effective proactive approach is dependent on appropriate staffing resource, including for work with those not currently in services.
- There is a need for clarification on the intent and scope of the standard; specifically defining proactive, assertive and high risk.
- People with mental health difficulties were highlighted as a key consideration in how this standard is achieved; their potential for increased risk and needs must not be missed.

**Standard 4. All people are offered evidence based harm reduction at the point of MAT delivery.**

- Recognition that harm reduction should still be a focus as people are likely to continue to use drugs whilst in treatment.
- Workforce training would be needed across services to ensure accessibility and consistency of harm reduction messages, including pharmacies and hospitals.
- Perception that people using services who had previously experienced punitive practice might not trust their prescriber to ask for injecting equipment or other harm reduction support.
- Poor resourcing, infrastructure and limited appointment time were seen as potential barriers.

**Standard 5. All people will receive support to remain in treatment for as long as requested.**

- Multiple and complex needs are recognised and that recovery is a journey so people need to know they will be supported for as long as they need.
- Punitive discharge remains an issue in some areas whereby people are taken off prescribed treatments for illicit use, 'non-engagement' or 'challenging behaviours'.
- Services need to be flexible and it was noted that offering the correct support was key, with partnership across recovery orientated services including recovery communities recognised as having an important role.
- Some people felt that this could lead to people being on opioid substitution therapy for a long time and prevent them from moving forward, whereas others felt that remaining in treatment was protective against the risk of harm.
- Some suggested the standard should be explicit in saying treatment is more than medical.
- Support will be needed in terms of national guidance and workforce development for caseload management.

**Standard 6. The system that provides MAT is psychologically and trauma informed (Tier 1); routinely delivers evidence based low intensity psychosocial interventions (Tier 2); and supports the development of social networks.**

- Support for this standard highlighted the need for holistic support to address complex needs of individuals and ensure continuity of care, for a rights-based approach beyond a solely medical model.
- Need for clear referral pathways with investment in services and training for appropriate interventions and settings to deliver this standard.
- Need for a trauma informed approach across all health and social care services for a whole systems approach, training for staff competence and confidence to improve access and quality of care.
- Focus on coping strategies and connectedness to promote recovery and prevent relapse, developing social networks with peers and families.
- Investment in workforce capacity and training must include coaching and supervision for staff to ensure systematic and sustained skills development for consistent trauma informed care.
- Support for therapeutic environments to ensure psychological and trauma informed care.

**Standard 7. All people have the option of MAT shared with Primary Care.**

- Seen as very difficult to meet in some areas due to lack of shared care for MAT prescribing within primary care, with service providers reporting no influence over GP services.
- Potential stigmatisation may affect uptake of GP prescribing.
- GPs may not feel confident to prescribe MAT and require additional support or training.
- A strong sense that there needed to be better joined up working with clearer pathways between primary care and specialist services to meet the complex health needs of people using drugs.



**Standard 8. All people have access to advocacy and support for housing, welfare and income needs.**

- Advocacy was recognised as core to successful implementation of the MAT standards and was particularly noted in relation to MAT Standard 2 (choice).
- Need for this to be independent advocacy.
- Need for consistent training across Scotland was highlighted and should be considered within workforce planning and development.
- Advocacy was seen as core in empowering people using services by shifting the balance from the service expectations of treatment to what the person wants.

**Standard 9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery**

- Relationships between staff and services to enable joint working, cannot separate out mental health difficulties and addiction.
- Mental health strategies need to recognise difficulties in this population.
- Availability of appropriate support and conditionality of mental health services were seen as a barrier to access.
- Tackling stigma between services and ensuring that support is needs-led with person-centred information sharing was seen as critical.
- Working more closely within statutory, and between statutory and third sector with direct referral pathways, to improve access.
- Learning from mental health experience included the integrated nature of mental health advocacy support and opportunities afforded under the Equalities Act.
- Need to build capacity and competency in addiction services, and potential for co-location of mental health and addiction staff – targeting training and curriculum in both professions.
- Funding for both mental health and addictions services is needed to expand both parts of the system.

**Standard 10. All people receive trauma informed care**

- This standard was seen as underpinning the whole approach, to really make a difference and achieve the change we want to see, we need to address underlying issues of people's experiences.
- Care and compassion across the workforce was recognised, with a further need for confidence and capability to know when to work with trauma and when to seek specialist support from psychological services.
- Need to build awareness and ensure training and a workforce development strategy to support embedding a trauma informed approach in practice.
- Need to ensure therapeutic relationships, attitudes and environment in services.
- Institutional policy and procedures can be barriers, for example punitive practice is not trauma informed decision-making.
- Investment in coaching and supervision work to ensure skills development for systematic and sustained approach to trauma informed care.

### 4.3 Learning from examples of practice

#### Drivers of change identified through examples of practice.

- Efficiencies in service redesign.
- Appropriate training and support for prescribers and confidence and flexibility in dispensing regimes. A rights based approach in staff training, including the non-clinical workforce, of treatment options and communicating this to people in services. Effective supervision of staff.
- A multi-agency approach that includes peers and third sector as well as working with families. Fostering relationships between services to support changes.
- Person centred prescribing protocols and availability of a range of medications. A strong therapeutic relationship with access to patient information and advocacy support.
- Effective referral pathways and liaison with efficient information sharing protocols (between multiple services, particularly transition points such as custody and hospital) and accurate patient records.
- Availability of post-MAT care and support, therapeutic relationships to prevent drop out from service. Improved prison through care.

#### Challenges and barriers to change identified through examples of practice

- Attitudes of the workforce, including management, and stigmatisation of the workforce. Stigma of treatment itself.
- Current and historic lack of funding and other resource implications, including staff capacity and development, service design (opening hours) and infrastructure.
- Lack of prescribing capacity and of general capacity in different settings for example prisons (e.g. lack of through care) and community pharmacies.
- Lack of trusting therapeutic relationships, perception and understanding of different medications, as well as structural factors such as availability, licences and costs of different medications. Failure to prioritise need and manage difficult relationships with clients, assuring consent and respecting the privacy of individuals.
- The configuration of different services including lack of effective referral processes or mechanisms for engagement (e.g. reliance on letters, role of police).
- Lack of information sharing and local information sharing protocols.
- Rural issues around access, transport and availability of staff.
- The scale and complexity of need.

## 5. Measuring success – process, experiential data and indicators

Work is underway to establish an evidence framework to measure success with implementation of the standards. Evidence will have three purposes:

1. To assess progress through process, experiential and numerical evidence.
  2. To promote quality improvement and the diffusion of innovation between teams.
  3. To produce learning that can feed into the development of national indicators and quality assurance.
- Process evidence demonstrates that the criteria required to be in place to implement a standard are in place. For example documented governance structures and pathways.
  - Experiential evidence will demonstrate how MAT Standards of Care are experienced by those using or delivering the services.
  - Numerical evidence will take the form of one or more high-level measures set out for standards 1-5 and demonstrate key metrics such as the time people wait from first presentation to commencement of opioid substitution therapy.

The process, experiential and numerical evidence are all necessary to get an idea of progress and success. No single piece of evidence is sufficient on its own. These measurements are a guide to support local improvement; they are not indicators for performance management.

The next phase of the MAT programme will include work with Healthcare Improvement Scotland, Public Health Scotland and the Scottish Government to establish an appropriate quality assurance framework that can ensure sustainability of MAT standards of care and alignment to other national strategic initiatives.

## 6. MAT Programme outline 2021/22

Milestones	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
MAT standards publication												
Expert Reference Group established												
MAT Programme plan for 2021/22												
MAT Implementation Support Team (MIST) Work plan	Phase 1: development and implementation of MAT standards scale up						Phase 2: implementation, consolidation and dissemination of learning					
Communication plan and rights-based 'plain English' resources	Engagement and development of resources					Publish resources	Dissemination of resources					
Programme development for standards 6-10 (criteria/system needs)												
Review of progress with implementation – dissemination of learning												
Consolidate national intelligence on impact of MAT standards												

The implementation, scale up and sustainability of MAT standards is reliant on integration with and support from other national work to develop the workforce, professional and community networks, quality assurance processes and clear lines of accountability.

## Appendix 1. Innovation Fund projects

Project Title	MAT Standard	Summary
<b>Tele health innovation</b> University of St Andrews research team with NHS Fife and NHS Lothian	1, 2 (choice)	Digital Health Technology in Addiction Services (DigitAS) project, Sept 2020. The aim of the project is to develop good practice guidelines for MAT via telehealth.
<b>Communication of the MAT Standards</b> Scottish Drugs Forum Dave Liddell	All	Communications work to promote and support implementation of the MAT Standards (autumn 2020 to November 2022)
<b>Glasgow Overdose Pilot Team (GORT)</b> <b>Turning Point Scotland</b> , with Simon Community Scotland Trish Tracey, Thomas Hobbs	3 – assertive outreach	12-month test of change pilot for an assertive outreach approach in Glasgow that aims to provide wrap around care at the point of crisis and follow up near fatal overdoses (10am to 10pm, 7 days a week).
<b>Peer to peer naloxone supply project</b> Scottish Drugs Forum Kirsten Horsburgh	4 – harm reduction	A two- year project to develop and support peer to peer naloxone supply by people who have experience of drug use. Project Steering Groups are established in the 3 areas taking part in year one – We Are With You (Borders), Hillcrest Futures (Dundee) and the three prisons in Glasgow (HMP Barlinnie, HMP Low Moss and HMP Greenock).
<b>Developing Psychologically informed Environments (PIEs) across the Aberdeenshire ROSC.</b> Wayne Gault, Claire Campbell	6,10 (psychological interventions & trauma informed care)	This 24 month project focuses on practical implementation of MAT, ensuring trauma is everyone’s business and where those accessing support and services are responded to in a way that considers what has happened to them versus what is wrong with them. Psychologically informed environments aim to reduce barriers and improve access for those who have problematic alcohol and/or drug use who may also present with complex mental health needs.
<b>Trauma Informed Practice – New ways of working</b> Edinburgh Access Practice Isabel Nisbet	6,10 (psychological interventions & trauma informed care)	A new integrated centre is due to open in Edinburgh in August 2021 - health, housing and social care will all be located in a psychologically-informed environment with staff training and support focused on improving staff wellbeing and resilience. This combined approach aims to improve quality and care for people who experience homelessness (PEH).