Healthcare Improvement Scotland

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Breakout B: Responding to Scotland's changing drug landscape

Leading quality health and care for Scotland

NHS SCOTLAND

Agenda

11.45am	Welcome to the room	Benjamin McElwee, Senior Improvement Advisor, Healthcare Improvement Scotland
11.50am	Towards a Medication Assisted Treatment Standards legacy in a complex and changing drugs landscape	John Mooney, Consultant in Public Health, Medication Assisted Treatment Implementation Support Team, Public Health Scotland
11.57am	Substance use presentations in primary care	Dr Carey Lunan, GP chair of the Scottish 'Deep End' project, and senior medical advisor on health inequalities and mental health, Scottish Government
12.04pm	New approaches and psychosocial interventions to support people with mental health and substance use concerns	Professor Susanna Galea-Singer, Clinical Lead & Consultant Psychiatrist, NHS Fife Addiction Services
12.11pm	Introduction of facilitated group discussions	Benjamin McElwee
12.15pm	Facilitated group discussion	All
12.50pm	Feedback to the room	All
1.00pm	**Close**	

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Legacy or Launchpad? MAT evolution in a complex and changing drug landscape…

John Mooney & Marion Wilson
For the MAT Implementation Support Team

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Overview

- The 10 MAT Standards and rationale
- Progress & Current Focus 2025/26
- Standards with significant mental health: MAT **6**, **9** & **10**
- Necessity of accommodating changing drug use patterns
- Integration of human rights-based approaches & implications
- Future scoping work for MIST Legacy (or launchpad…)

What are the MAT Standards

- **Medication Assisted Treatment (MAT) standards: access, choice, support:** "Evidence based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland.
- **MAT 1 to 5:** Access; Choice; Pro-active Outreach; Harm Reduction & Retention
- **MAT 6 to 10:** Psychologically & Trauma- informed care; Shared Care; Advocacy (incl. Welfare & Housing); Mental Health
- **From 2024/25:** All strongly underpinned by alignment with 'Charter of Rights' as informed and validated by lived and living experience.

Chart 1: Percentage of ADP areas with RAGB Score per MAT standard 1-5: Scotland: Publication cycles (year from April-March) : 2022, 2023, 2024 and 2025.

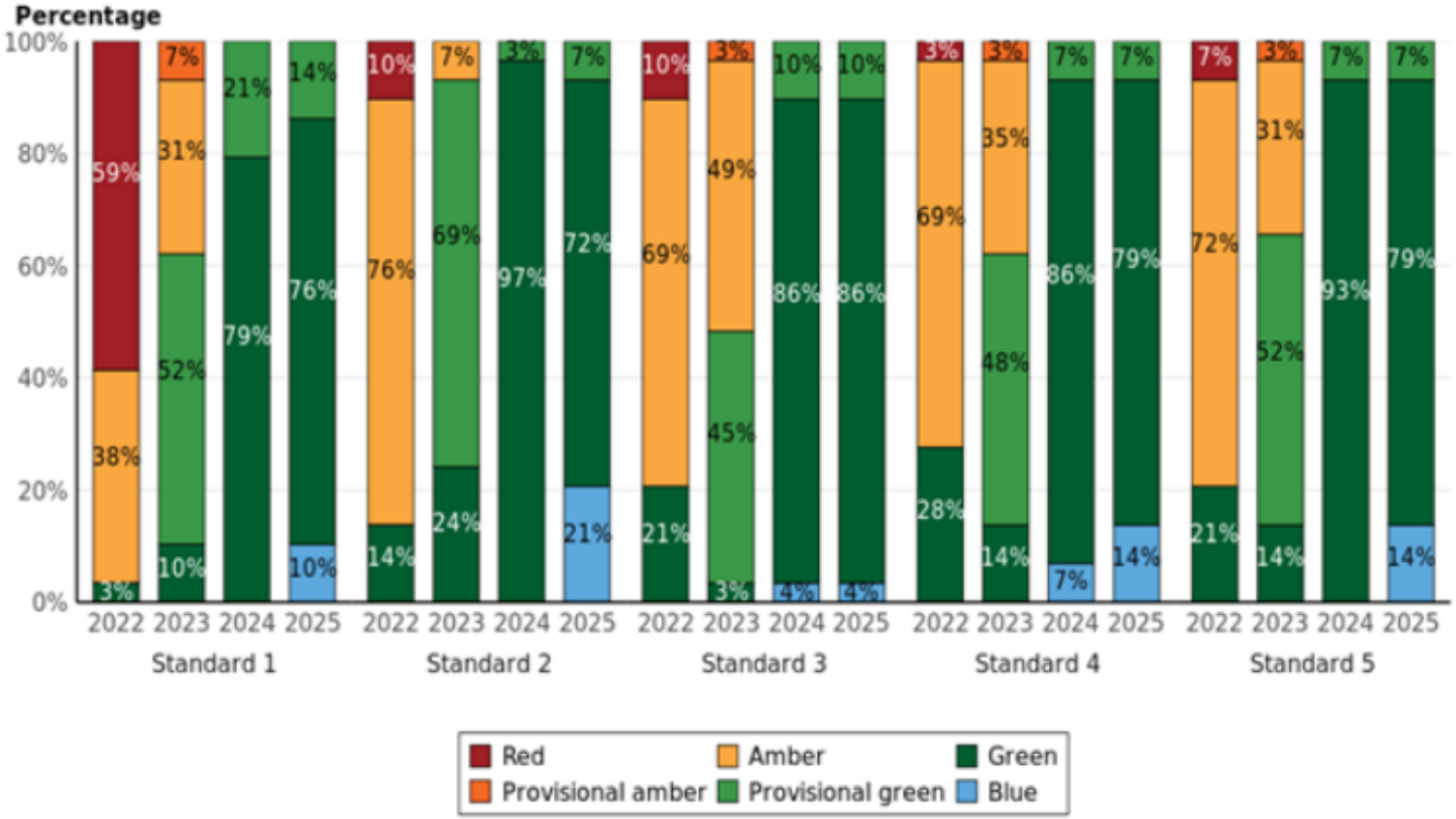
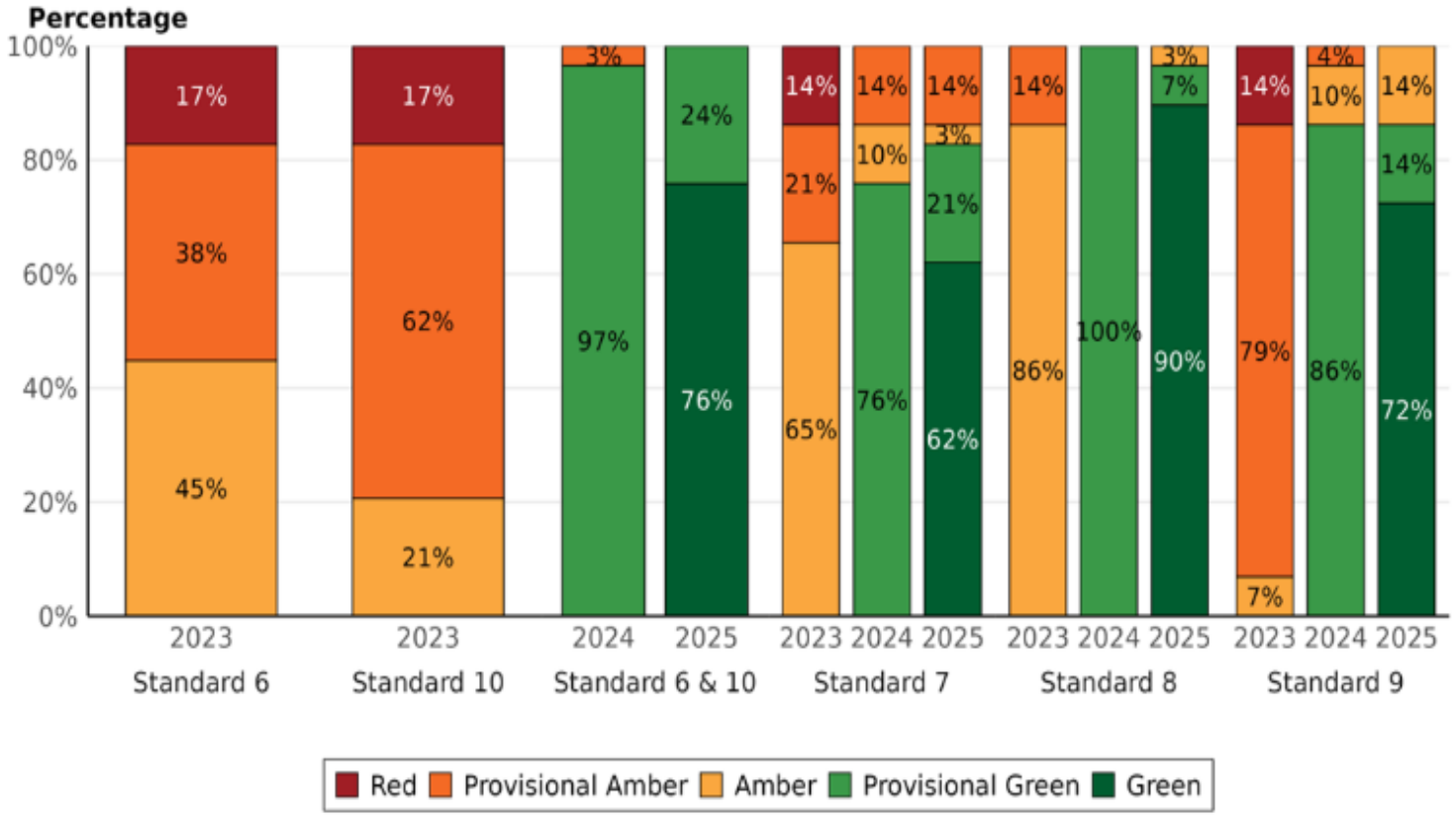


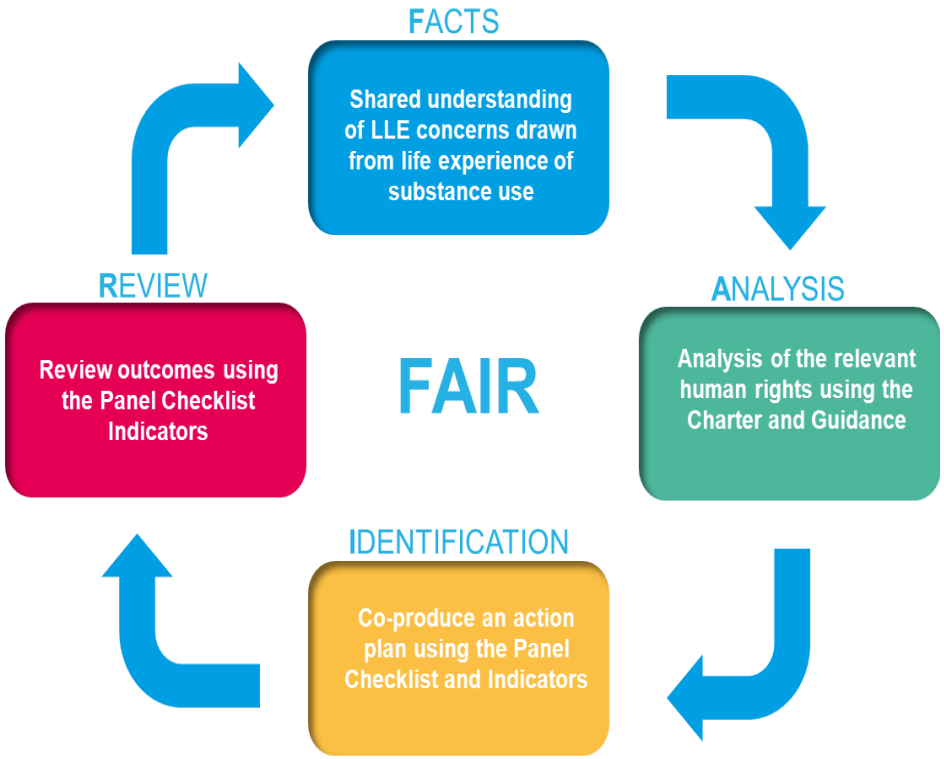
Chart 2: Percentage of ADP areas with RAGB score per MAT Standards 6 to 10 Publication cycles (year from April-March) : 2022, 2023, 2024 and 2025.



RAGB Summaries 2024/25

- For **MAT standards 1–5**, 91% have been assessed as fully implemented (RAGB blue or green). This is an increase from 90% in 2023/24, 66% in 2022/23 and 17% in 2021/22.
- For **MAT standards 6–10**, 75% were assessed as RAGB green, 16% provisional green. This is an improvement from 2024/25 when 91% were provisional green.
- From previous graphs, significant year on year improvement, with only **MAT 6+10** (combined assessment); **MAT 7** & **MAT 9** showing less than 75% full implementation…

FAIR Model & Charter of Rights (National Collaborative, 2024)



The Charter of Rights for People Affected by Substance Use (recognised as the first of its kind in the world by the UN), helps to ensure people know their rights and the support they can expect to receive, and that those who use drugs and alcohol, and their families, are treated with dignity.

It contains key human rights, most importantly: '*the right to the highest attainable standard of physical and mental health, along with the right to an adequate standard of living and the right to a healthy environment*'.

FAIR Model Reflections around MAT 9 (n=12)

- Lack of clear, cohesive pathways between Alcohol and Drug Recovery Service/ Drug and Alcohol Recovery Service and mental health services for those experiencing problems with substance use and mental health.
- Barriers due to criteria in place for mental health services, i.e. substance use was a contraindication to referral to or acceptance by mental health services.
- Limitations in support for those experiencing less severe mental health problems, and for specific groups such as women…

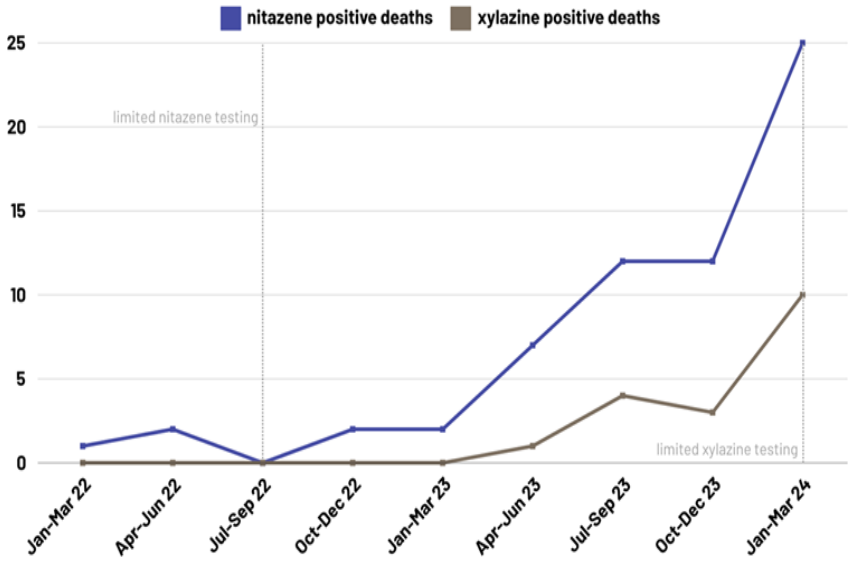
The bigger picture when applying human rights…

- By necessity (and by definition…) MAT Standards have been focused from their inception on opioid substitution therapy
- While understandable from a clinical and data availability perspective (limited treatment interventions for other substances), it becomes increasingly untenable in a world characterised by poly-substance use including alcohol.
- In order to fully embed a rights-based perspective therefore, MAT Standards (or its successor) needs to pro-actively accommodate other substances – which has informed some horizon scanning activities…

Aside: Synthetics and Polydrug use: The Challenge…

- Drug deaths increasingly driven by a rise in poly drug use, particularly street benzodiazepines and more recently **cocaine** and **gabapentionids** (most commonly alongside opiates in deaths).
- Most recently **nitazines**, a group of new synthetic opiates up to 100+ times more potent than heroin are emerging in global markets. Nitazine overdoses often require multiple doses of naloxone.
- RADAR Alerts have been issued previously for Nitazines, Xylazine and Bromazolam

Nitazenes and xylazine: Detections are increasing in Scotland, often in samples sold as heroin and bromazolam *(Wedinos data – limited testing)*



MAT Response to date (with a restricted brief..)

- **MAT 6** thematic group (psychologically informed care) to inherit / embed recommendations of SLWG on benzodiazepines
- Several ADP areas have been developing pilot pathways for benzo treatment / referral based on psychological therapies
- Edinburgh MPH student (supervised by JM) undertook a review of prospects for addressing benzodiazepines in Scotland (see next slide)
- Aberdeen MSc placement student looked at adaption of all 10 MAT standards for alcohol and found there to be a clear rationale especially around areas where MAT has been challenging: **MAT 7 & 9**
- Merger proposal for **MAT 7 & 9 Thematic groups**, given overlapping challenges and potential solutions (with a view towards medium to longer term legacy).

Cocaine harm reduction measures: add to MAT 4?

- **BBV:** maximise IEP; advocate for consumption by inhalation
- **Wound Infections:** WAND measures; Drug testing for xylazine contamination
- **OD prevention:** Supervised consumption; purity checking(?)
- **CHD risks**: Cardiac health screening & other risk factors

Adapting MAT Approach for Other Substances

Prospects for Alcohol:

- Increased use / adoption of pharmacological interventions (e.g. acamprosate) (MAT 2)
- More pro-active identification of those at risk of harm to facilitate early intervention (MAT 3), followed up by tailored shared care (MAT 7), wider advocacy (MAT 8) and Psychol'l / trauma informed support & MH (MATs 6, 9 &10).

Prospects for Benzodiazepines:

- Tailored psychological interventions
- Monitor replacement therapy pilot evaluations (medium – longer term)
- Drug testing with supervised consumption

Conclusions & Next steps

- MAT Standard Implementation has been associated with demonstrable improvements in specialist substance use services, verifiable by lived experience feedback
- The genuine embedding of a human rights-based approach has for the most part been welcomed by ADPs and used to systematically implement solutions to identified problems
- One clear emergent need is the adaption of MAT approaches to accommodate poly-drug use landscape – where clear crossovers and potential gains exist, including for alcohol, cocaine & benzodiazepines…
- MAJOR CAVEAT: MAT Standard Remit remains for the time being focused on OST and extending implementation to other settings (most notably prisons).

Thank you!
Questions / Comments?

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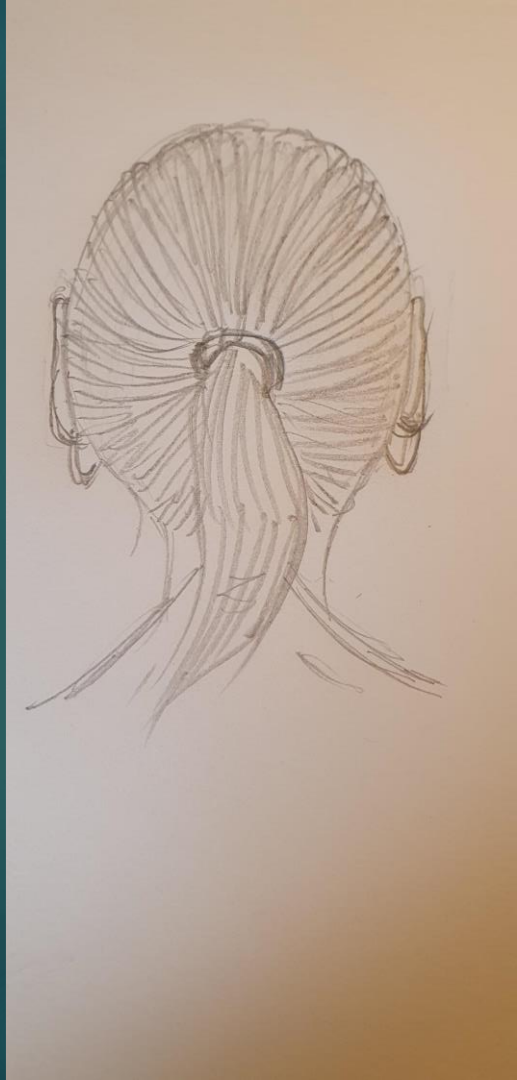
Substance Misuse presentations in primary care (general practice)

Dr Carey Lunan

GP Chair of Scottish Deep End Project.
Scottish Government Senior Medical Advisor on Health Inequalities & Mental Health.
Honorary Senior Clinical Lecturer, University of Edinburgh.

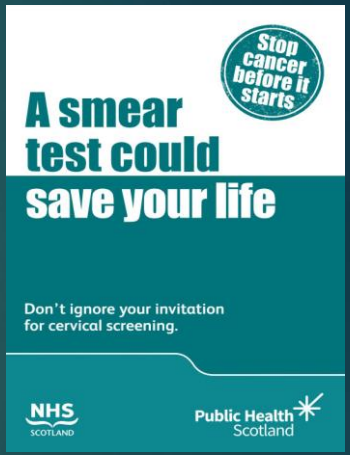
Case study (female, 32 yrs)

- Drug dependence (opiates, benzos) many years
- On methadone, some more recent instability on script (BDZs, gabapentinoids, cocaine)
- 3 children at home, one child with additional support needs
- Working 2 part-time carer jobs, bullying at work
- Recent separation from partner, history of GBV
- Other health issues: anxiety and depression; chronic pelvic pain (undiagnosed); recurrent back pain; CIN2 (declined smears); hepatitis C (untreated)
- Meds: methadone 80mls, fluoxetine 20mg, ibuprofen, omeprazole.



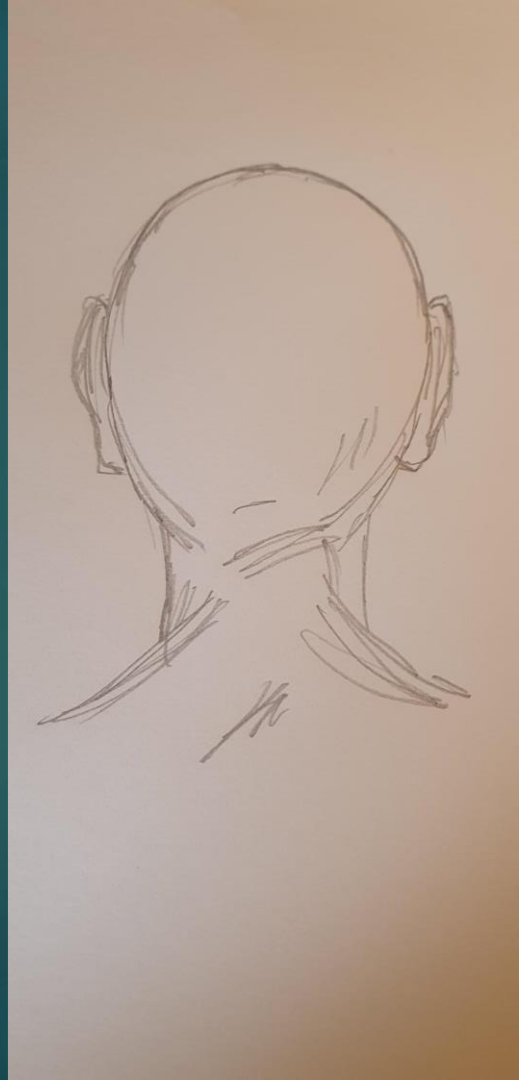
Approaches?

- Consider script safety (tox, dispensing)
- Support for children (HV, school, social work)
- GBV support
- Practice community link worker (social supports)
- Practice-based mental health support
- Practice-based Hep C clinic
- Opportunistic cervical smear
- Discuss support communities
- Early follow up arranged



Case study (male, 55 yrs)

- Drug dependence (opiates, benzos) many years
- Previous injecting drug use, been stable on script
- Recent loss of employment – financial stress ++
- Escalating use of alcohol, recent injecting drug use
- Recent admission with cellulitis and CAP (self-discharged)
- Carer for partner who has unstable BPAD
- Other health issues: alcoholic hepatitis, early-onset COPD (cough worse), previous DVT/PE, T2DM, poorly controlled HT, CKD4, post-traumatic epilepsy, new prostatic symptoms.
- Meds: methadone 110mls; diazepam 20mg/d; thiamine, inhalers, apixaban, metformin, lisinopril, simvastatin, levetiracetam.

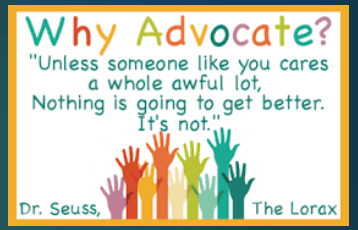


Approaches?

- Consider script safety (tox, dispensing, supervision)
- Harm reduction advice (drugs, alcohol, naloxone)
- Consider specialist addictions input
- Physical exam (chest, prostate)
- Link with practice nurse – inhaler review, plus arrange CXR
- Reschedule secondary care f/u post-admission
- Practice financial inclusion worker (benefits, rent arrears)
- Med3 for benefits
- Discuss support communities
- Early follow up arranged

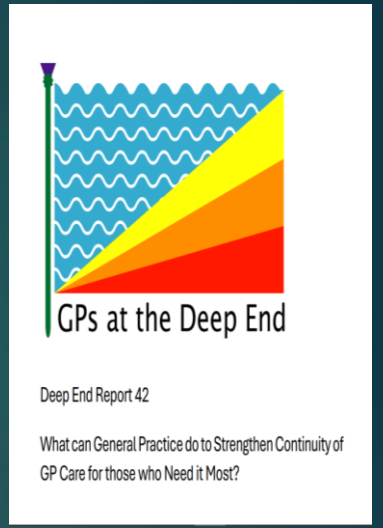
What makes general practice well placed?

- In addition to the OST itself…
  - Mental & physical health needs (often very significant needs)
  - Health promotion and prevention activities (MDT)
  - Contextual care (families, communities)
  - Coordination of care (general practice as ‘hub’)
  - Access to social supports (ideally practice-embedded)
  - Inclusivity of care
  - Opportunistic care
  - Advocacy role
  - **Continuity of care.**



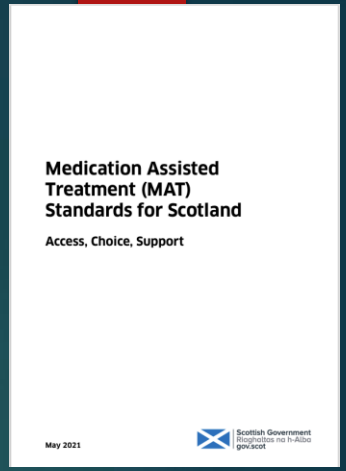
The importance of relational continuity

- Care is safer and of higher quality.
- Care is more cost-effective and sustainable.
- Treatment adherence and uptake of prevention is better.
- Patient and clinician experience is better.
- Efficiency and access improves.
- More accountability, more trust.
- Addresses health inequalities.



Continuity of care *may be the treatment itself.*

MAT standard 7



"All people have the option of MAT shared with Primary Care

- People who choose to will be able to receive medication or support through primary care providers
- These may include GPs and community pharmacy
- Care provided would depend on the GP pr community pharmacy and as well as the specialist treatment service"

Standard 7 Primary Care - Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot (www.gov.scot)

Why don't more GPs prescribe OST?

- Training needs
- Time consuming work (workload pressures)
- Challenging work (emotional, practical, medico-legal)
- Not viewed as a priority area
- Belief that it is specialist work
- Not adequately resourced
- Lack of access to on-site or local pharmacy to administer
- Concerns re access specialist addictions help when needed
- Lack of access to mental health services
- Stigma eg concerns about negative impact on recruitment

Source: Camarus survey (n=46); personal communications with GPs

GP perspectives: why is drug dependence and treatment of people with drug problems difficult?

"Drug users are difficult, time consuming and potentially violent"

"Best dealt with by specialists"

"We don't have enough experience or time"

"We don't have any patients with drug problems in our practice"

Drug users are;

- "Complicated"
- "They don't turn up for appointments"
- We have a contract with drug using patients, if they break it they are asked to leave"
- "impossible to have a normal consultation with drug users as they lie and are dishonest"

"We don't have the expertise "

Source: Meetings with groups of GPs who currently don't offer services to patients with "drug problems" (RR 2016)

Solutions to enable general practice?

- Easy access to high quality training
- Adequate resource to do the work
- Trauma-informed, stigma-informed teams (training, supports)
- Systems that support inclusivity and relational care/continuity
- Professional support/role modelling (RCGP, BMA)
- Caring for PWUD 'everyone's role' (regardless of OST)
- Rapid access to specialist support
- Equitable access to mental health support
- Practice-embedded social supports

Fife Health & Social Care Partnership

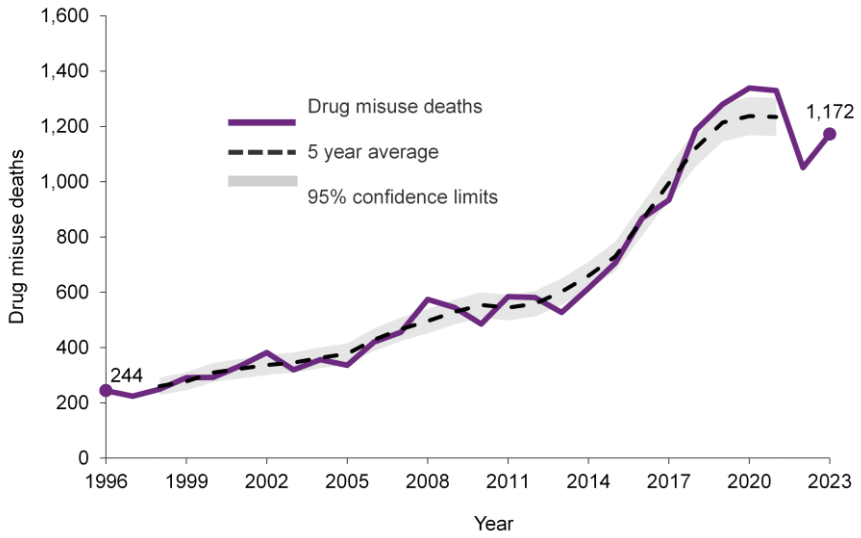
Responding to Scotland's Changing Drug Landscape: A focus on novel approaches

November 2025

Susanna Galea-Singer

What do we know?

A steady increase over the years
Although we saw a decline in past 5 years



	Constants	Changing
Prevalence	Highest in Europe Highest in the UK	Increasing prevalence in other countries
Age	Young age (35-54yrs)	Average age has increased from 32 to 45 since 2020 Increase in under 25 deaths
Gender	Males > Females	Female deaths are on the increase
Accidental vs Intentional	> 90% accidental	No change
Services	Around 40-60% not known to addiction services	Upward trend in access – 13% increase
Social deprivation	Increased risk of death	Reduced from 15x higher risk to around 13.5 x
Trauma	Most users	Type of trauma – gaming; gambling

Substances	Constants	Changing
Opioids	80%	Nitazenes
Benzos	58% Street benzos account for majority	Rise in bromazolam deaths Rise in diazepam deaths Etizolam deaths decreased
Cocaine		2008 – 6% 2023 – 41%
Gabapentinoids		38% (From < 1%)
Combination	Multidrug toxicity	Increase: 4-6 substances
Drug-related harm		Increase: 45% increase in naloxone administration 19% increase in ED attendances
Toxicology		Contamination on the rise

Co-existing mental health & substance use: The constants

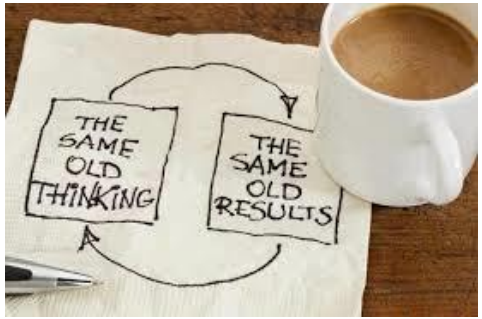
- A common occurrence
- Co-occurring pathways:
  - AOD use can ***cause*** psychiatric symptoms and ***mimic*** psychiatric syndromes which disappear when use ceases
  - AOD use can ***reveal*** *or* ***worsen*** symptoms of mental illness
  - AOD used to ***manage*** psychiatric symptoms and syndromes
  - Psychiatric symptoms can ***mimic*** AOD use presentations
- Symptom complexity with treatment challenges
- Worse treatment outcomes and patient satisfaction with treatment
- Drugs and/or alcohol implicated in around 50% of suicides

Co-existing mental health & substance use

What's changing?

Partial implementation of MAT 9: Received MH care at point of MAT delivery

Implications



“Increase the skills, reduce the pills”

Fife Benzodiazepine clinic

Purpose

Aims to provide a trauma-informed service which offers a range of psychosocial interventions to tackle mental health problems and distress, alongside a benzodiazepine reduction, based on each individual's psychological formulation

What do we know?

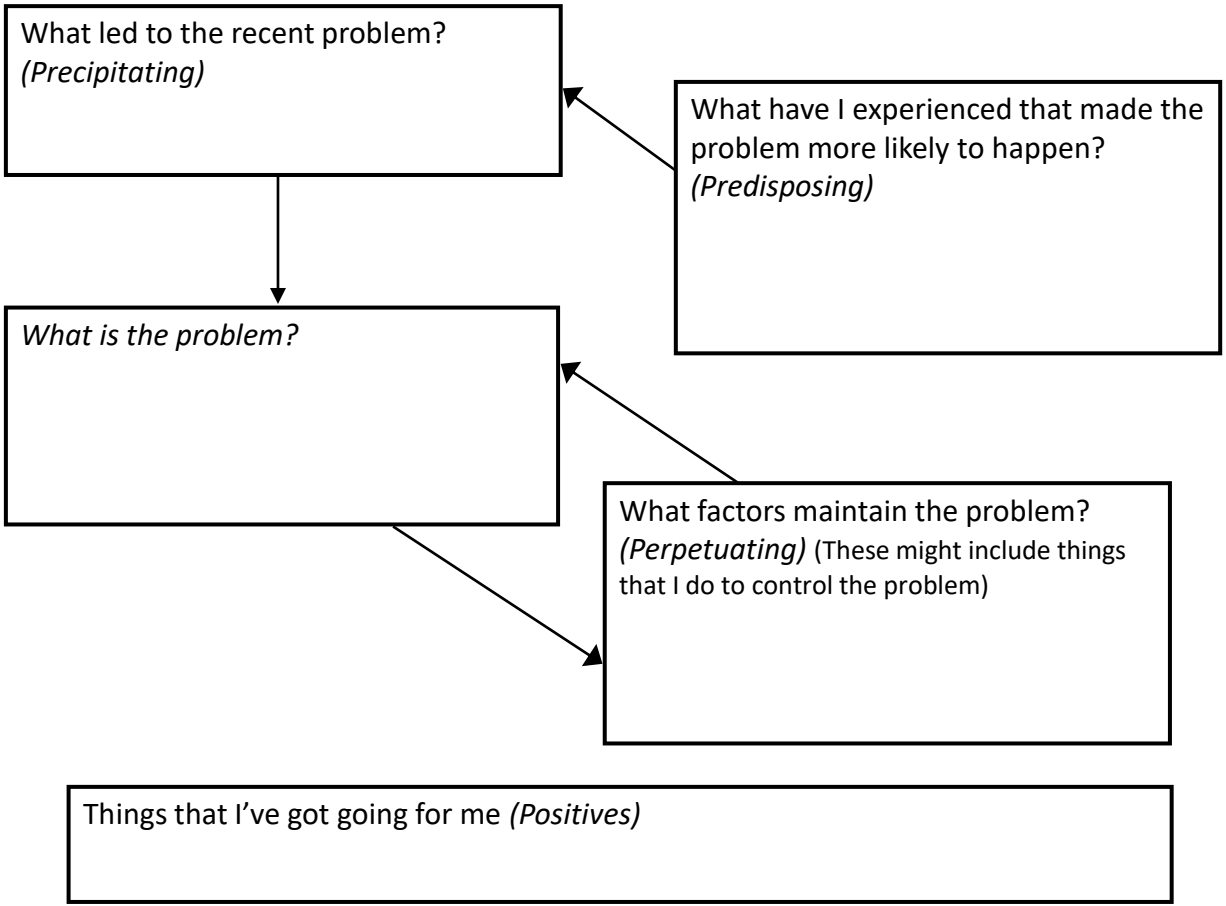
- Strong correlation between benzo dependency and mental health disorders;
- Treatment of one can lead to worsening of the other;
- Long term benzo use – linked with cognitive impairment;
- Not addressing benzo dependence increases harm;
- Long term prescribing increases harm;
- Poor treatment outcomes if prescribing is not accompanied by psychological interventions;
- Person-centred and person-driven

Conceptual Framework

Weekly MDT Discussions

- Severity of dependency;
- Type of benzo used – ‘street’/prescribed;
- Is formulation an option?;
- Stability;
- Patient’s goals for treatment;
- Would prescribing of diazepam be beneficial at this point?

5P Formulation Template - How did the "problem" develop?



The programme

Collaborative care

The Fife Way

Stratification of cases

Multidisciplinary reviews

- All stakeholders
- Breakdown silos
- Shared approach
- Collaborative care planning
- Accept what we can do and accept what we can’t do
- Shared risk
- Autonomy & choice

Screening & Brief intervention

Work in progress

How can I “ASSIST”?
Screening and intervention for substance use problems in mental health settings

The ASSIST-Lite-MH

What is the ASSIST & ASSIST-Lite?

- **A**lcohol, **S**moking & **S**ubstance **I**nvolvement **S**creening **T**est
- Full questionnaire - 8 item clinician-administered: 10-15 mins
- Cross-culturally neutral
- ASSIST-Lite: Ultra-rapid ASSIST: 5 mins
- Screens for risky substance use
- Determines risk score for each substance: Low, moderate or high risk
- Provides an opportunity to start discussion (Brief Intervention) with client about their substance use

12 Steps of Brief Intervention for individuals with Mental Health Problems

Step 1	*"I would like to go through your results with you, explain what the scores might mean"*
Step 2	Discuss known associations between use of each substance & MH & physical health problems. Ask what effects (harms) the patient has personally experienced from using specific drugs.
Step 3	*"The best way you can reduce such harms is to either cut down or stop using (drug)"*
Step 4	*"what you do is up to you……I'm just letting you know about the risks"*
Step 5	*"How concerned are you about the risks?"*
Step 6	*"What are the things you like about using (drug)…..?"*
Step 7	*"So what are some of the less good things about using (drug) for you…..?"*
Step 8	*"So on one hand you really enjoy…. AND on the other hand….. What do you make of that?"*
Step 9	On a scale of 1-10: concern; commitment; confidence. How would you change the score?
Step 10	Take home info
Step 11	Next steps / patient goals
Step 12	Recommendation by clinician - affirmation

Digital inclusion

Detection & Response

Drug Overdose Detection and
Response using Care & Respond with CHAI999

RESCU2 - Clinical Validation of Virtual Safe
Drug Consumption Technology

Saving SAM: System for Alert and Monitoring
of Potential Overdoses

LifeSavr: Unobtrusive Wearable Device
to Detect Overdose

ASSESSOR: A soft skin-interfacing sensor for overdose
detection and prevention through remote monitoring

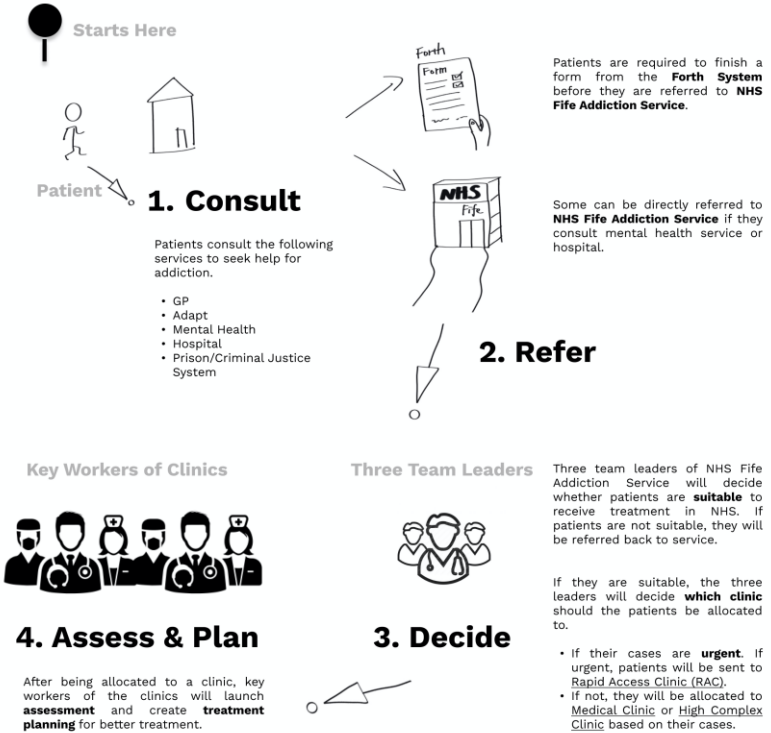
Intervention

RescuePatch: A controlled-release combination
patch for naloxone and flumazenil delivery

Ultra-portable fast-dispersal buccal naloxone
for constant carriage: testing feasibility and acceptability

The patient journey

Patient Journey Mapping



Group discussion