FIGURE 8
CONSULTANCY SERVICES LTD

Evaluation of the Edinburgh central titration clinic (EdMAC)

MAIN REPORT

Prepared for the Edinburgh Alcohol and Drug Partnership

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FOR FURTHER INFORMATION PLEASE CONTACT

Figure 8 Consultancy Services Ltd

Room 6, Brook House

86 Brook Street

Broughty Ferry

Dundee

DD5 1DQ

enquiries@f8c.co.uk

www.f8c.co.uk

LEAD CONTACT

Andy Perkins (Director)

Room 6, Brook House, 86 Brook Street, Broughty Ferry, Dundee, DD5 1DQ.

☎ +44 7949 775026 (mobile) ✉ andy@f8c.co.uk 💻 www.f8c.co.uk

RESEARCH TEAM

Josh Dumbrell (Senior Researcher, Figure 8)

Sophie McCluskey (Researcher, Figure 8)

Andy Perkins (Director, Figure 8)

Sam Steele (Researcher, Figure 8)

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Table of Contents

Chapter 1: Background and context

1.1 Background: Scotland's drug-deaths crisis and the case for reform

Scotland's drug mortality rates remain amongst the highest in Europe. In 2024, there were 1,017 registered drug-related deaths, a 13% decline (155 fewer deaths) from 2023, and the lowest total since 2017 (National Records of Scotland, 2025). After adjustment for age, this corresponds to 19.1 deaths per 100,000 population, still 3.6 times higher than the rate recorded in 2000 (National Records of Scotland, 2025).

Opiates/opioids were implicated in 80% of those deaths; benzodiazepines in 56%, and cocaine in 47%, though the number of deaths involving cocaine remained stable at its record high (479) in both 2023 and 2024 (National Records of Scotland, 2025). Most deaths (91%) were classified as accidental poisonings (National Records of Scotland, 2025), and Edinburgh City had the second highest number of deaths in 2024 (92, or 9% of the national total).

Other features continue:

- The average age of persons dying from drug induced deaths has increased from 32 in 2000 to 45 in 2024 (Health Research Board, 2025).
- People in the most deprived areas remain 12 times as likely to die of drug use compared to those in the least deprived areas (National Records of Scotland, 2025).
- 'Hot spots' in Scotland (Glasgow, Dundee, Inverclyde) consistently record higher rates than the national average (National Records of Scotland, 2025).

These figures show that despite the recent decline, the scale of harm is sustained and deeply unequal. The drop in 2024 is welcome but must be understood in the context of persistent structural drivers, evolving drug markets (including new synthetic opioids such as nitazenes), and deeply rooted service gaps (BBC News, 2025).

In Edinburgh and the Lothians, these national pressures are magnified by local patterns of deprivation, trauma, and service fragmentation, which prior to reform translated into long waits, unstable prescribing access, and high attrition.

1.2 Scotland's National Drugs Mission, and the MAT Standards

In 2021, the Scottish Government responded to the drug mortality crisis by launching the National Drugs Mission, backed by the work of the Drug Deaths Taskforce (DDTF). A core element was the roll-out of the following ten Medication Assisted Treatment (MAT) Standards, intended to ensure that all people with opioid dependence have prompt, equitable, and high-quality access to 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 or continue MAT.

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

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

6. The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social networks.

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

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

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

10. All people receive trauma informed care.

The standards commit services to provide same-day initiation, medication choice, proactive outreach, integrated harm reduction, retention support, trauma-informed care,

shared-care with primary care, advocacy for welfare and housing, mental health integration, and psychosocial supports.

The ambition was transformational; no longer should people wait weeks or months to start treatment or be bounced between fragmented services. Over time, these standards are meant not only to reduce overdose risk, but also to embed continuity, dignity, and person-centred care.

Alongside the MAT Standards, the Scottish Government set a treatment target to increase the number of people receiving opioid substitution therapy from about 29,500 to 32,000 by 1 April 2024, with the target expanding from April 2024 to cover all drugs and alcohol. By 2024, progress Scotland-wide (including Edinburgh) was notable. Public Health Scotland reported that Standards 1-5 (rapid access, medication choice, proactive outreach, harm reduction, retention) were fully implemented in 90% of Alcohol and Drug Partnerships (ADPs), rising from 17% in 2022. Standards 6-10 (psychosocial, trauma-informed, advocacy, mental health integration) showed 75% attainment of full or provisional green status, though many remain in transitional stages due to workforce and experiential evidence gaps (Public Health Scotland, 2025).

However, implementation nationally has been uneven. The following key challenges persist:

- Shared-care transfers have not scaled uniformly.
- Some GP practices still refuse to provide opioid substitution therapy (OST) or apply restrictive ‘stability’ criteria.
- Third-sector supports (peers, housing, welfare) remain fragile in many areas.
- New drug types (nitazenes) impose fresh pressures on treatment systems (Turner et al., 2025).

Thus, Edinburgh’s MAT implementation is part of a larger, contested reform effort amid shifting risk landscapes.

1.3 Programme partners and delivery roles (NHS Lothian, CGL, Turning Point, hubs, third sector)

In Edinburgh, the Integration Joint Board (EIJB) and Edinburgh Alcohol and Drugs Partnership (EADP) lead the system of drug and alcohol treatment and care, commissioning, funding, and overseeing the work of multiple statutory and voluntary sector agencies. Its local plan for meeting the MAT standards was published and approved in October 2022 (EADP, 2022).

Prior to the establishment of the Edinburgh MAT Access Clinic (EdMAC), the key components of the OST system for people with problem opioid use were:

- The four locality hubs, each a co-operative venture drawing on the strengths of Edinburgh Health and Social Care Partnership, Change Grow Live (CGL) and Turning Point Scotland (TPS). The four locality recovery hubs provide community-based treatment in each area, offering individuals in need of or on OST holistic care to start treatment, achieve stability and progress towards recovery.

- Primary care practices which offer ongoing OST; approximately 60% of OST in Edinburgh is delivered in primary care. This does not, ordinarily, include people starting treatment – predominantly, treatment initiation was undertaken in the hubs/ Low Threshold Medication Programme (LTMP) and then moved to primary care once their treatment was established.

- The LTMP (NHS Lothian, 2025) has been offered at Spittal Street for a number of decades. It provides high intensity treatment (typically seeing people four times a week) enabling access to safe titration, whilst offering a high degree of support and clinical oversight.

Several years before publication of the MAT standards, Edinburgh services evaluated the strengths and limitations of their ORT provision (Edinburgh ADP, 2016, 2017). Complementing the DDTF's work with local evidence, these findings informed the design of EdMAC, which was co-developed as part of the Edinburgh MAT Standards implementation plan. Delivery roles were agreed as follows:

- NHS Lothian provides clinical leadership and governance, including prescribers (including non-medical prescribers), nursing, pharmacy, and oversight.
- CGL and TPS deliver recovery management, harm reduction, and psychosocial provision, and contribute administration, coordination, and service support.
- Recovery hubs (north-east, north-west, south-east, and south-west Edinburgh), operated by CGL and TPS, refer and signpost patients into treatment and receive patients post-titration, providing longer-term prescribing continuity, psychosocial interventions, and wrap-around support.
- Third-sector organisations (for example, welfare rights, housing, financial support, advocacy, and outreach) complement clinical provision, particularly by addressing non-clinical determinants of drug-related risk.

Overall, this distributed model was designed to combine the benefits of a single access route with local continuity of care; however, it was understood to require effective coordination, interoperable data systems, and sufficient resourcing.

1.4 Contextualising EdMAC clinic within national MAT implementation, clinical guidelines, and local treatment systems

EdMAC was launched in December 2023 as Edinburgh's tactical response to operationalising the MAT standards, principally Standards 1 (same-day initiation) and 2 (choice). The clinic is located at Spittal Street, designed as a walk-in, rapid-assessment hub with capacity for prescribing, monitoring, and transferring patients to secondary care in one of Edinburgh's recovery hubs.

Before EdMAC's inception, Edinburgh's OST pathway featured significant backlog, delayed assessments, fragmented referrals between hospital, custody, GP, and hub services, and high loss to follow-up (see evaluations in 2016 and 2017). EdMAC was intended to streamline this, absorbing high-risk flows, reducing waiting time, and improving system throughput.

Crucial to its design is low-threshold access – accepting self-referrals, minimising gatekeeping, and embedding the harm-reduction package from day one (naloxone, blood-

borne virus (BBV) testing, safer-use advice). The clinic's success depends on seamless handovers back to hubs or (more rarely) directly to GP shared-care and maintaining engagement through re-entry efforts (outreach, housing, welfare supports, etc.).

However, access equity was identified as a potential tension at the outset (that is, centralising services risks excluding patients unable to travel or connect easily, requiring mitigation mechanisms such as outreach and/or transport support). Moreover, interface fragilities with GPs, justice pathways, and third-sector withdrawals were also anticipated as potentially constraining the full realisation of EdMAC's ambitions.

The EdMAC model was developed in line with UK best practice set out in *Drug misuse and dependence: UK guidelines on clinical management* ('the Orange Book') (Department of Health & Social Care et al., 2017). This guidance provides UK-wide, evidence-based standards for assessment, risk management, and care planning, emphasising structured key-working, routine review of treatment and recovery goals, appropriate dosing, and close integration of pharmacological and psychosocial interventions. It identifies OST (methadone or buprenorphine) as an effective response to heroin and other opioid dependence, and stresses timely induction, avoidance of unnecessary delays, and robust arrangements for supervised consumption and ongoing monitoring. The Orange Book also highlights organisational requirements, including clear clinical governance, partnership working with primary care and pharmacies, trauma-informed practice, and meaningful involvement of individuals and carers in service design and review.

Chapter 2: Study aims and objectives

2.1 Study scope and limitations

This evaluation is focused on Edinburgh's EdMAC service across its early implementation period (December 2023 – August 2025). It examines service-level performance, system integration, and early outcome signals rather than long-term clinical trajectories or mortality-level impacts. It does not seek to quantify direct causation of overdose reductions, but rather the plausibility of EdMAC's contribution to reducing risk, within a complex, multi-intervention environment.

Limitations include reliance on aggregate and administrative datasets (RedCap, TRAK, DAISy), variation in data completeness, evolving systems maturity, and difficulty distinguishing EdMAC's effects from concurrent reforms, policy changes, and/or external shifts (for example, drug supply, national naloxone distribution, synthetic opioids). Qualitative data helps fill gaps, but sample bias and recall limitations must be acknowledged.

2.2 Evaluation design and contribution analysis approach

Because EdMAC operates in a complex, dynamic system, a theory-driven mixed-methods design was used. A Theory of Change (ToC) was constructed from MAT policy, early proposal, and contractual documentation, as well as primary data (including stakeholder surveys, and interviews, mapping patient and collective understandings of rationale, and anticipated causal pathways from inputs through outputs to outcomes and impact).

The evaluation uses Contribution Analysis (CA) to assess whether EdMAC plausibly contributed to observed outcomes, by iteratively testing hypothesis chains, validating mechanisms, and exploring alternative explanations. Quantitative service-activity data (from RedCap, ILLY, and TRAK) were triangulated with primary quantitative and qualitative evidence from interviews and surveys. This allowed mapping of evidence onto the ToC logic model domains and makes possible credible assessments of EdMAC's role in shifting system performance.

2.3 Structure of the report

The remainder of this document is structured to reflect the logic of the performance story:

- **Chapter 3**: Theory of Change and the evaluation logic model
- **Chapters 4-7**: Evidence on starting points, inputs, activities, outputs, and outcomes
- **Chapter 8**: Assumptions and external factors
- **Chapter 9**: The contribution of EdMAC towards long-term changes and impact
- **Chapter 10**: Recommendations for practice, policy, and further evaluation

Chapter 3: The EdMAC theory of change and evaluation logic model

3.1 Theory of change: assumptions, mechanisms, intended pathways

The EdMAC ToC sets out the underlying logic of how the clinic is intended to improve treatment access, retention, and outcomes within Edinburgh's opioid treatment system. It provides a structured narrative of inputs, activities, outputs, outcomes, assumptions, and external factors.

At its core, the ToC assumes that same-day access to high-quality, evidence-based OST, combined with trauma-informed care and wrap-around supports, will reduce barriers to entry and allow patients to engage at their moment of motivation. By stabilising patients safely and rapidly on appropriate doses, the model seeks to reduce overdose risk, support retention in care, and enable onward pathways into recovery supports and wider health and social services.

Key mechanisms underpinning the model (and supported by published guidance, such as Department of Health & Social Care et al., 2017) include:

- **Access without delay**. Reducing the waiting time gap, which otherwise risks losing people between referral and treatment start.
- **Therapeutic dosing and clinical oversight.** Enabling stabilisation and reducing harm from continued illicit use.
- **Trust-building and person-centred engagement.** Ensuring patients feel respected and supported, which fosters retention.
- **System integration.** Using interoperable information flows and structured transfer pathways to prevent drop-out at boundaries between services.
- **Social diffusion.** Positive peer word-of-mouth which extends the clinic's reach into marginalised networks.

These mechanisms are sustained by several assumptions, such as adequate resourcing, downstream hub and GP capacity to absorb transfers, and the continued availability of minimum social support pathways (for example housing, benefits). They also sit within a context of external factors that can strengthen or weaken delivery, such as national drug-market shifts, GP participation, justice-system interfaces, or funding stability.

3.2 Logic model structure and domains (inputs, activities, outputs, outcomes, assumptions, external factors)

The EdMAC evaluation logic model synthesises the national MAT standards, Edinburgh's local implementation plan, and qualitative insights from early pilot interviews with staff and partners. It sets out the full pathway from resources to long-term impact, whilst making explicit the assumptions, and contextual risks that shape performance.

Table 2: EdMAC evaluation logic model

Building-block	Key elements	Illustrative evidence sources
Inputs (resources invested)	• Dedicated funding stream for rapid-access MAT • Multidisciplinary workforce – prescribers, nurses, pharmacists, support / link staff, administrators • Premises and clinical rooms for same-day assessments • Training packages on MAT standards and trauma-informed care • Electronic health-record and monitoring platforms • Governance structures (steering group, MDTs)	• Budget statements/ Investment plan (City of Edinburgh Council, 2022) • Staffing rosters & CPD logs • Facility audits • Policy / protocol documents • System-access logs

Building-block	Key elements	Illustrative evidence sources
Activities (what the clinic does)	• Rapid access & assessment (same-day walk-in, triage, physical health screen, initial script) • Dose titration & clinical monitoring (early reviews, lab tests, ECGs as needed) • Harm-reduction bundle (naloxone, BBV testing, safer-use advice, injecting equipment) • Psychosocial triage & referral (groups, peer support, housing / benefits, mental-health pathways) • Planned transfer pathways (to locality teams, GPs, community pharmacies) • Re-engagement & outreach (texts, calls, home visits, prison-liberation pick-ups) • Data capture & learning (routine outcomes, audits, quality-improvement cycles) • Workforce support & supervision	• Clinic diaries • Assessment / script counts • Referral databases • Outreach logs • Continuous improvement meeting notes
Outputs (direct, countable products)	• Number of same-day assessments completed • Median waiting time from first contact to first dose • Number reaching therapeutic dose (see Department of Health & Social	• • Electronic health-record extracts • Quarterly monitoring dashboards • Training registers

Building-block	Key elements	Illustrative evidence sources
	Care et al., 2017) within target timeframe • Harm-reduction items issued (naloxone kits, BBV tests, IEP packs) • Psychosocial or social-support referrals made & accepted • Transfers to secondary or primary-care providers • High-risk reviews initiated • Staff training hours delivered	
Short-term outcomes (0–6 months)	• Attracting people who use drugs who have been deterred from accessing treatment previously • Significant reduction in waiting time for MAT start • Increased proportion of eligible patients initiating treatment • High patient satisfaction with access & choice • More consistent data capture across partner agencies	• Patient surveys • Routine data trend lines
Intermediate outcomes (6–18 months)	• Improved retention at 3- and 9-month review points • Greater proportion stabilised on therapeutic dose before transfer • Smoother continuity across service boundaries; fewer prescription gaps	• Follow-up outcome forms • Prescription-continuity audits

Building-block	Key elements	Illustrative evidence sources
	• Reductions in self-reported illicit opioid use & related harms	
Long-term outcomes / impact	• Reduction in drug-related morbidity and mortality in the catchment area • Lower unplanned hospital, ambulance, or justice contacts linked to opioid use • Increase in the total number of people in ORT in Edinburgh • Sustained recovery capital (housing, employment, relationships) • Cost savings from avoided acute/crisis interventions	• Public-health surveillance data • Cost-effectiveness modelling
Key assumptions	• Clinic opening hours and staffing are maintained. • Data systems remain interoperable. • Downstream services (hubs, GPs, pharmacies, psychosocial supports) accept transfers at agreed volumes. • Minimum housing / welfare pathways are available.	• Risk & mitigation logs
External factors / risks	• Variation capacity in other areas of the pathway (in particular in primary-care participation in ORT and staffing availability in hubs) • Recruitment or funding constraints	• Context scans • Stakeholder feedback

Building-block	Key elements	Illustrative evidence sources
	• Drug-market changes (for example, synthetic opioids) • Prison-release notification failures • National policy shifts (for example, contractual incentives)	

This logic model captures the intended causal pathway of EdMAC, showing how specific investments and activities are expected to generate measurable outputs, which in turn should lead to short- and medium-term improvements in access, retention, and safety. The explicit inclusion of assumptions and external factors acknowledges that EdMAC does not operate in isolation. Its performance depends on downstream service capacity, GP participation, and wider systemic enablers or constraints such as housing, justice coordination, and funding sustainability. This dual focus, on what EdMAC directly controls and what it cannot, provides the framework for mapping evidence in later chapters and assessing the plausibility of EdMAC's contribution to improved outcomes.

3.3 Evidence sources and analytic approach

Routine and administrative datasets

The evaluation draws on routine service monitoring and prescribing datasets for the early implementation period, with 2024 used for the core quantitative performance profile. Routine extracts from NHS Lothian systems (including RedCap and TRAK/ILLY) provide aggregate metrics on clinic activity, timeliness to assessment and first prescription, medication type, transfer destinations, and six-month treatment status. A supplementary system-level dataset (including tier-three and primary care OST prescribing) was also provided for 2024 to contextualise EdMAC activity within the wider Edinburgh MAT system. Where key fields were missing (for example, prescription date), results are reported on the relevant recorded denominator rather than assumed complete.

Surveys

Two targeted online surveys were used to capture structured feedback and free-text reflections: an EdMAC staff survey (n=6) and an external partner/professionals survey

(n=15; including hub staff and statutory/third-sector referrers). Patient perspectives were captured through a short patient survey tool administered alongside qualitative engagement (n=12). Survey findings are used primarily to characterise experience, perceived mechanisms, and areas of variation, rather than to estimate population parameters.

Interviews

Semi-structured interviews were completed with:

- EdMAC core staff and partner professionals (n=12; spanning all four localities, third-sector partners, and referrers); and
- EdMAC patients (n=12; gathered as interviews/survey-interviews).

Interviews are used to explain how and why observed patterns occur, identify delivery constraints, and test plausible contribution pathways in context.

Triangulation and contribution analysis logic

A theory-driven contribution analysis approach is used to assess whether EdMAC plausibly contributed to observed outcomes within a complex multi-intervention environment. Quantitative outputs (routine monitoring and prescribing records) establish the 'performance story', whilst survey and interview evidence is used to: (a) test mechanisms against the theory of change, (b) contextualise variation across settings and groups, and (c) assess rival explanations and dependencies (for example, downstream capacity, service interfaces, drug-market change). Claims are therefore framed as contribution rather than attribution.

Reporting conventions

Percentages are reported with the relevant base (n) where this materially affects interpretation, and denominators vary where routine data fields are incomplete. Direct quotations are presented selectively to illustrate mechanisms or recurring themes, without implying frequency beyond the qualitative sample.

Chapter 4: The EdMAC performance story – starting points

4.1 Introduction to EdMAC: why a central titration clinic was needed

EdMAC was established to address long-standing weaknesses in the city's treatment system for people with opioid dependency (EADP, 2016, 2017). Prior to its creation, patients often faced prolonged waits for OST, fragmented referral pathways across locality hubs, and inconsistent prescribing practices. These inefficiencies meant that people who were ready to start treatment frequently lost momentum, disengaged, or experienced preventable harms, including overdose.

Nationally, the introduction of the MAT Standards (Drug Deaths Taskforce, 2021) placed a clear obligation on services to provide same-day access to prescribing (Standard 1), ensure informed choice of medication (Standard 2), and deliver trauma-informed and psychologically-informed care (Standards 6 and 10). Locally, the EIJB recognised that Edinburgh's existing hub-based system lacked the clinical capacity and infrastructure to meet these standards in a consistent and equitable way. A centralised clinic was therefore proposed to concentrate prescribers, streamline triage, and offer rapid access to safe and effective titration.

4.2 Pre-MAT baseline: waiting times, postcode inequities, fragmented systems

A baseline review conducted before MAT implementation confirmed the need for major reform in Scottish ORT services (Scottish Drugs Forum, 2021). Previous local evaluations suggest waiting times for OST initiation in Edinburgh were typically 6–12 weeks, with significant variation across hubs depending on staff capacity and local caseloads (EADP, 2016, 2017). This created what was often referred to as a 'postcode lottery' in treatment access. The 2022 benchmarking assessment of MAT Standards implementation (Public Health Scotland, 2022) found that same-day prescribing was available only in two city-centre clinics (LTMP and Edinburgh Access Place), with over 50% of patients captured in the audit waiting at least two weeks from assessment to prescription. Medication choice and assertive outreach were likewise unevenly implemented across hubs, and consistent,

area-wide access to opioid substitution therapy, and initiation/retention support had not yet been achieved. The system was further strained by fragmented referral routes, with patients being cycled between GPs, hubs, and other services before receiving a prescription.

These barriers disproportionately affected those at highest risk, including people experiencing homelessness, poly-drug use, and those cycling in and out of structured MAT. The result was disengagement from treatment and preventable deaths. EADP concluded that without a clear and consistent pathway, Edinburgh could not deliver on the ambitions of the MAT Standards or reduce drug-related harms at the scale required (EADP, 2022).

4.3 Why rapid access and centralised titration matter for harm reduction and retention

Evidence from national and international practice demonstrates that speed and continuity of access are critical to engaging people with opioid dependency (Corace et al., 2023). The ‘window of opportunity’ when a patient seeks help is often short; if services cannot respond immediately, many drift back into high-risk use. A centralised titration clinic offers a way of streamlining access, regardless of which part of the city someone presents from.

Rapid and safe titration to a therapeutic dose is crucial for harm reduction and treatment retention (Klimas et al., 2021; Sordo et al., 2017; Strang et al., 2020). Delays or sub-therapeutic dosing heighten cravings and relapse risk, whilst early stabilisation markedly lowers overdose mortality (Degenhardt et al., 2011; McAuley et al., 2023; O’Connor et al., 2020; Pierce et al., 2016). Concentrating specialist expertise within a single multidisciplinary clinic enables close supervision, daily review, and swift dose adjustment – shown to improve safety and continuity in complex cases (Hickman et al., 2018; O’Connor et al., 2020; Roger et al., 2023).

In parallel, embedding trauma-informed and person-centred approaches ensures engagement extends beyond rapid prescribing to building trust and therapeutic alliance – key predictors of long-term retention and recovery (Emsley et al., 2022; Sweeney et al., 2018; Tompkins et al., 2016). Evidence from Scottish MAT reforms and wider UK evaluations shows that psychologically informed care enhances safety, empathy, and

patient confidence (Mahon et al., 2025). Collectively, these policy and practice mechanisms situate a centralised low-threshold, rapid access clinic as, not only a clinical safety intervention, mitigating early risk, but also a system reform, embedding humane, coordinated, more equitable care, across a city's treatment system.

4.4 The potential for EdMAC to contribute to local and national MAT ambitions

From the outset, EdMAC was positioned as a flagship service for the delivery of the MAT Standards in Edinburgh. Its design aligned directly to the National Mission (2021), which sought to reduce drug deaths through rapid access to evidence-based treatment and holistic supports. At the local level, the clinic was expected to:

- Attract people who use drugs who had been deterred from seeking treatment
- Clear hub waiting lists by diverting new opioid-dependent patients into a single point of entry.
- Provide equity of access across the city, eliminating postcode-based variation.
- Standardise clinical practice, and offer same-day prescribing, when clinically appropriate, and consistent titration protocols.
- Enable smooth transfers into hubs, GPs, or community pharmacies once stability was achieved.
- Generate robust monitoring data (for example, same-day assessment, therapeutic dosing, retention rates) to demonstrate progress against MAT standards.

In doing so, EdMAC was intended not only to improve patient outcomes but also to relieve structural pressures on the wider treatment system, allowing the locality hubs to better meet the needs of diverse caseloads.

4.5 What EdMAC set out to do: same-day access, therapeutic dosing, trauma-informed engagement

The early proposal and set-up planning documentation make clear that EdMAC's goals were ambitious but tightly defined. Its central mission was to operationalise MAT Standards through three interlocking commitments:

1. **Same-day access.** Anyone presenting at EdMAC – whether self-referral, hub referral, or via another service – would receive a same-day assessment and, where clinically appropriate, an OST prescription. This was intended to remove the structural delays that had previously undermined engagement.

2. **Safe and rapid titration to therapeutic dose.** The clinic was resourced and designed to support daily or near-daily reviews until patients reached a stable dose, using physical health checks, drug testing, and clinical oversight. This was expected to reduce overdose risk and support early stabilisation.

3. **Holistic and trauma-informed engagement.** Beyond prescribing, EdMAC aimed to provide psychosocial triage, signposting to housing and welfare support, and access to peer and group interventions. Trauma-informed practice was embedded as a principle, acknowledging the high prevalence of adverse experiences amongst the patient group.

At a system level, EdMAC sought to:

- Reduce waiting times and inequalities across the city.
- Standardise delivery against national MAT Standards.
- Relieve hub pressures by creating a dedicated titration function.
- Build robust data systems for monitoring outcomes and improvement.

Taken together, EdMAC was a proof-of-concept intervention – a test of whether a centralised, rapid-access clinic could transform the trajectory of opioid treatment and make a measurable contribution to Scotland's wider drugs mission.

In the chapters that follow 5-7, EdMAC's performance story is presented through a triangulated narrative that integrates qualitative interview evidence (embedded in-text and signposted using quotation marks), quantitative findings from individual and professional surveys, and relevant routine monitoring data, to build a coherent account of how the clinic has operated and what it has contributed over time.

Chapter 5: The EdMAC performance story – was the clinic delivered as planned? (Inputs)

This chapter describes the principal inputs and enabling conditions that have supported delivery of the model: partnership arrangements, funding and resource allocation, workforce, premises and infrastructure, information systems, and governance/oversight.

5.1 Partnership model and core service configuration

EdMAC is delivered through a multi-agency arrangement combining NHS clinical provision with third-sector psychosocial and administrative inputs.

> **'It was a joint venture between CGL, NHS and Turning Point (…) NHS provided the nursing… CGL provided a senior track (…) we provided a bit of admin'.**

This model deliberately pooled complementary capability across partners, establishing the core functions required to operate a shared service, including clinical leadership, nursing, pharmacy, psychosocial capacity, and administrative support.

Set-up inputs included securing a base within the Spittal Street Centre and developing shared standard operating procedures to support consistent delivery. One interviewee described these early milestones in sequence, noting first that '*there was obviously getting the space into Spittal Street*', followed by work on an '*initial version of the standard operating procedures (SOP)*', which provided the necessary framework to enable the clinic to begin operating. Workforce inputs were also put in place in advance of implementation, including the early recruitment of third-sector staff: '*They'd recruited third sector staff… four of those… in November beforehand, 2022.*'

5.2 Funding provision and resource allocation

EdMAC's initial financing was described as drawing on Scottish Government funding linked to the National Mission, allocated via the EADP including a grant secured from Corra. Delivery capacity also relied materially on partner contributions (NHS, Turning Point

and CGL), including secondments and split roles, enabling implementation without a long lead-in period.

Resource allocation evolved as implementation progressed. A hub manager described early deployment choices and how these were followed by learning-led adjustment:

> **'At first [we thought] let's put senior tracks in there (…) through the test of change we learned maybe we don't need that (…) the support workers that we have put up there are very qualified.'**

Another interviewee also linked subsequent, more recent staffing decisions to wider budget constraints: '*the cuts have impacted EdMAC a bit,* [although] *we think we've restructured it quite smartly'*.

Interviews and surveys across participant groups also referenced practical supports used to reduce attendance barriers and support engagement, including travel support.

> **'If you're in treatment with us you qualify for a six-month travel pass.'**

Other forms of practical assistance were also described (for example, bus tickets, food-bank vouchers, welfare support), typically delivered through third-sector partners and following referral to wider services.

5.3 Workforce, development, and roles

EdMAC was described as operating with a small multidisciplinary team whose core delivery is led through nursing and pharmacy alongside psychosocial/support roles and administrative coordination, supported by a small group of prescribers.

Interview evidence indicates that the clinic's core staffing configuration was multidisciplinary, bringing together nursing, pharmacy, and third-sector roles. One interviewee described the early staffing complement as '*two Band 6 nurses, two specialist*

pharmacists… and the four third sector people'. This workforce was supported by senior clinical leadership, with the nurse team leader taking up post in February 2023.

Flexible and ongoing resourcing to maintain cover was also described, including bank and cross-cover arrangements.

> **'We're using a bank nurse just now (…) over the holiday period we had other staff from the recovery hubs covering so that we could make sure that EDMAC got their annual leave.'**

Survey and interview respondents also referenced staff development inputs, including ongoing training in trauma-informed and substance-use practice.

> **'We do get quite a lot of psychology and substance use training around trauma-informed care (…) so the team (…) are up to date.'**

Overall, EdMAC's workforce inputs comprise a small multidisciplinary core, supported by clinical leadership, flexible cover arrangements, and ongoing training.

5.4 Premises and operational infrastructure

EdMAC operates from the Spittal Street Centre in central Edinburgh, co-located with other NHS and partner services. The physical environment and room availability shaped the clinic's operating model and constrain the extent to which opening hours can be expanded.

> **'It's only open restricted hours, I think it's like something like between 9 and 11, Monday–Friday… I think it's a room capacity, that's one of the main holdups (…) they don't have access to enough space.'**

The clinic environment includes security features (for example, buzzer entry and glass partitions) which can be perceived as barriers to access, particularly for some groups.

‘We have glass panels… doors you need to get buzzed in… lots of barriers to people coming in.’

Centralisation supports a single, consistent location, but distance, cost, and city-centre avoidance were described as potential access constraints for some. In the professional survey, 27% cited transport or distance as limiting attendance, and 40% mentioned city-centre fears or bans, including patients avoiding the area due to anxiety or court restrictions.

‘They may have an ex-partner that’s using EdMAC… or court restrictions.’

Interface infrastructure for medication delivery includes links with community pharmacies and locality services (including capacity planning for long-acting injectable buprenorphine sites).

‘Buvidal Clinic is at capacity (…) we partnered with Dears Chemists - they can take an extra 10 (…) Muirhouse Medical [Practice] starting injections too.’

Overall, premises and infrastructure inputs centre on a single, co-located city-centre base with finite room capacity and access features, alongside linked community sites used to extend medication delivery where specialist clinic capacity is constrained.

5.5 Data systems, monitoring, and reporting

Clinical record systems and multi-agency documentation (TRAK / ILLY / PRESS)
EdMAC delivery is documented across NHS and third-sector platforms, with staff describing routine use of both TRAK (NHS) and PRESS (third sector) to maintain shared visibility of care:

‘EdMAC notes appear on our PRESS system… NHS uses TRAK. CGL staff at EdMAC enter directly into PRESS.’

This dual-record environment was described as a practical feature of multi-agency working.

Alongside clinical records, structured monitoring is captured in RedCap to support internal reporting and MAT Standards submissions. One interviewee noted a shift in responsibility and capability as reporting approaches evolved: ‘*I do the DAISys but I don’t do the RedCaps… I know we’re moving over to that*’. Pharmacy activity was also described as feeding into routine performance reporting, including measures such as new starts and MAT Standard 1 monitoring: ‘*our numbers feed into the general activity reports* (…) *new starts, MAT1 compliance, that kind of thing*’.

Across interviews, timely and complete recording was described as essential for safe prescribing and continuity, particularly where decisions depend on dosing history and missed collections.

‘Everything gets logged in the electronic notes – last dose, gaps – because patchy compliance changes how we prescribe moving forward.’

Taken together, these arrangements provide the shared information base required to manage risk in real time and maintain continuity as people move between EdMAC and onward care.

5.6 Governance and oversight structures

Governance arrangements link EdMAC delivery to wider EADP oversight, with reporting lines into NHS and ADP management structures for decision-making, escalation, and system alignment. Interview evidence describes a partnership-level service management role with oversight responsibility and long-standing involvement in the development of EdMAC from its early planning stages.

Across accounts, governance and oversight inputs are reinforced through the development of shared procedures and reporting expectations across agencies, alongside clear roles for maintaining accountability within the multi-agency model.

> **'Once we had established what our model was going to be… we were able to start working on standard operating procedures, working closely with third sector.'**

Overall, these governance and oversight inputs provide the formal structure through which EdMAC's multi-agency model is coordinated, quality-assured, and kept aligned to city-wide MAT Standards delivery.

5.7 Summary of enabling inputs

EdMAC's delivery is underpinned by defined partnership contributions, multi-source funding, a mixed workforce (including nursing, pharmacy, psychosocial and administrative roles), central premises at Spittal Street, shared documentation across NHS and third-sector systems, and ADP-aligned governance arrangements. These inputs enable the activities described in Chapter 6.

Chapter 6: The EdMAC performance story – was the clinic delivered as planned? (activities and outputs)

6.1 Activities: rapid access, titration, harm reduction, psychosocial triage, transfer, outreach

Rapid access

EdMAC operates as a weekday morning drop-in. People who attend during clinic hours are offered an assessment and, where clinically appropriate, can start medication on the day of presentation. Where medication cannot be started (for example, if withdrawal is not evident), respondents described asking individuals to return and ensuring they leave with a clear plan.

'If somebody comes in within the time frame where we have clinic space, they would be offered an assessment (…) sometimes we're pushing ourselves really hard to actually achieve that but we would never turn somebody away (…) they should always go away with some degree of plan.'

Overall, rapid access is delivered through a consistent, open-door drop-in model that prioritises same-day assessment and initiation where safe, whilst using clear return plans and flexible use of limited space to avoid turning people away.

Titration to therapeutic dose

Following initiation, EdMAC provides rapid titration with frequent review and dose adjustment. Dose decisions are described as being guided by prescribing guidance alongside clinical presentation, comorbidities, and patient preference, with options including methadone, sublingual buprenorphine, and long-acting injectable buprenorphine where appropriate.

‘We very much follow the orange book guidelines around safe prescribing (…) within that it’s very much around clinical presentation and all their comorbidities (…) it’s very customised but within the prescribing guidelines.’

Titration is thus framed as an accelerated but protocol-bound process that adapts to individual risk and need whilst maintaining prescribing safeguards.

Harm reduction

Harm-reduction measures are delivered alongside clinical care. Staff describe offering or providing take-home naloxone, blood-borne virus (BBV) testing, injecting equipment provision (IEP), and safer-use advice at or around initial contact, with wound care and related support where required.

‘As soon as they walk in the door (…) we offer BBV test, naloxone, IEP, safer drug advice. We plug you in with a worker and triage you.’

Survey data from individuals using the clinic indicate that these harm-reduction offers were commonly made at the point of entry, with provision varying by individual need and circumstance.

Psychosocial triage and support

Psychosocial and practical needs are identified alongside clinical assessment. Third-sector staff and partner services support brief triage and signposting (for example, housing, finance, mental health, and wider health needs) and provide short-term practical assistance where available.

‘It’s not just about the prescription (…) there’s other kind of psychosocial input… helping people to register with GPs, support to appointments, outreach (…) bus passes, food bank vouchers (…) that makes a huge, huge difference to people.’

Taken together, this positions psychosocial triage as a routine component of first contact, aimed at reducing practical barriers to engagement alongside medication initiation.

Transfer and continuity

Once initial stabilisation is achieved, EdMAC coordinates transfer to locality recovery hubs or, in some cases, GP prescribing. This includes sharing prescribing information, aligning follow-up appointments, and communication to support continuity.

> **'I get an email (…) saying these people are ready to come back to the hub and I negotiate an appointment with him (…) He'll email me and say I have these people that are ready and I'll email him back appointments and negotiate what suits the person best.'**

Overall, this transfer process is intended to maintain clinical continuity by ensuring that prescribing arrangements, appointment timing, and handover communications are in place before responsibility shifts to locality or primary care teams.

Outreach and engagement

EdMAC's access route is open-door and does not require referral. Engagement activity includes signposting by partner services and, where needed, practical facilitation of attendance (for example, transport support).

> **'Certainly, here we encourage people to do it [take up the offer of a bus pass] because getting to appointments is a major… The least difficult that is… the more likely they are to come.'**

In practice, this approach aims to reduce friction at the point of access by combining an open-door offer with practical supports that make attendance more feasible for people who might otherwise disengage.

6.2 Partnership governance, MDTs, and quality-improvement cycles

Multi-agency partnership and governance

EdMAC is jointly delivered by NHS Lothian, CGL, and TPS. Oversight is provided through the Edinburgh ADP MAT Standards Group, linking clinic activity to city-wide implementation goals. Strategic and operational updates are reported through NHS and ADP structures for accountability.

> **'Since we started EDMAC, we've shifted from a system of having four locality managers and somebody in the middle to one person managing all of that… the step into EDMAC and then from EDMAC to the hubs, as far as I can see, works.'**

Collectively, these governance arrangements are intended to keep EdMAC aligned with city-wide MAT delivery priorities whilst providing clear routes for escalation, accountability, and operational decision-making across partners.

Operational MDTs and communication

Operational coordination is supported through routine multi-agency discussions that focus on shared risk management, continuity planning and practical arrangements for follow-up and transfer between EdMAC and locality services.

> **'We all meet up once a month… talk about clients at risk… need outreach… nice bit of partnership working.'**

These routine forums provide a consistent mechanism for joint problem-solving on higher-risk cases and for coordinating handovers, outreach, and follow-up across organisational boundaries.

Quality-improvement cycles

EdMAC was introduced using a 'test-and-adapt' approach. Initially a three-day pilot, it expanded to five days following review of early demand. Regular MDTs doubled up as quality improvement (QI) sessions where staff refined workflows, adjusted staffing requirements, and aligned processes with evolving MAT priorities. This iterative approach has ensured the model remains operationally viable and responsive to demand by enabling structured refinement of processes and resourcing over time.

6.3 Outputs and system performance (2024)

Service activity and demand

In 2024, EdMAC recorded 176 presentations, with activity captured each month of the year. Monthly presentations ranged from 7 to 27, and all attendances were entered into RedCap, providing a complete dataset for the year.

Timeliness of assessment and initiation

Table 3 shows that all 176 patients were offered a MAT assessment on the same day they presented. Average waiting time was zero days, and the maximum recorded wait for an assessment was one day, occurring only in June. In the rare cases where same-day assessment was not met, assessment was deemed clinically inappropriate.

Table 3. EdMAC presentations and assessments 2024

	2024 TOTAL
Total presentations recorded	**176**
75% of MAT assessment were offered within (N days)*	0
Minimum (N days)	0
Maximum (N days)	1
Average (N days)	0.01
No. of records where date offered MAT assessment was recorded	176
No. of records where date offered MAT assessment was not recorded	0

For prescribing, table 4 shows that 149 of 176 presentations had a recorded date of first prescription. Amongst these, the average time from assessment to prescription was 1.36 days across the year. Minimum waits were 0 days in every month, whilst the longest recorded wait was 36 days, occurring in an individual case.

Table 4. EdMAC presentations and prescriptions 2024

	2024 TOTAL
Total presentations recorded	**176**
75% of first prescriptions took place within (N days)	1
Minimum (N days)	0
Maximum (N days)	36
Average (N days)	1.36
No. of records where date of first prescription was recorded	149
No. of records where date of first prescription was not recorded	27

Geographical reach of EdMAC

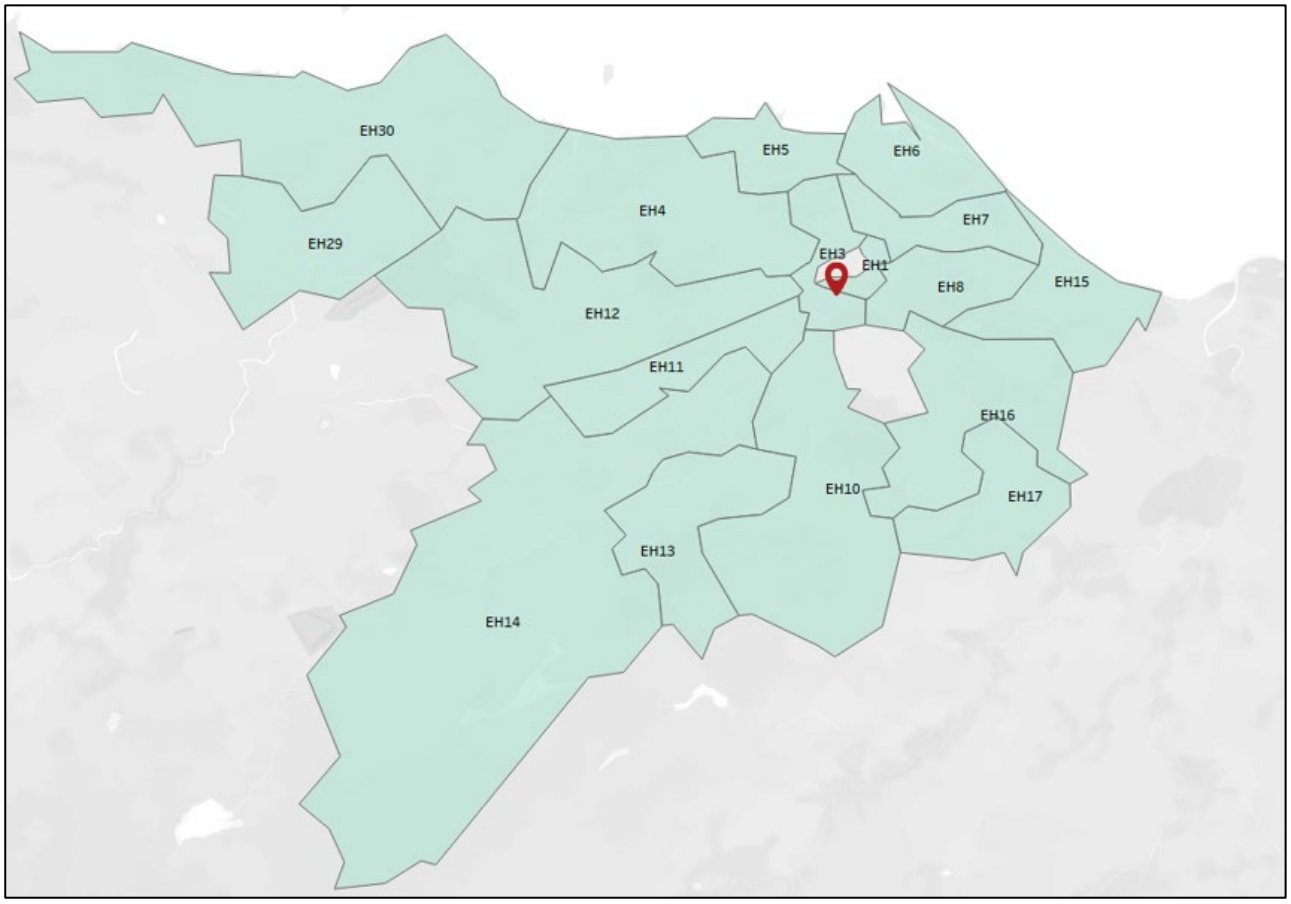
In 2024, EdMAC received presentations from a wide range of postcode districts across Edinburgh, demonstrating city-wide reach. As shown in Figure 1, patients attended from the following districts: EH1, EH3, EH4, EH5, EH6, EH7, EH8, EH10, EH11, EH12, EH13, EH14, EH15, EH16, EH17, EH29 and EH30. These areas span the north, south, east, and west of the city, indicating that the service was accessed by individuals from most parts of Edinburgh rather than a limited locality.

Presentation counts were concentrated in a subset of districts, whilst remaining districts were represented by fewer attendances. Districts with five or more presentations in 2024 were: EH7 (20), EH4 (18), EH6 (18), EH16 (15), EH17 (15), EH5 (14), EH11 (13), EH8 (13), EH14 (11), EH15 (9), EH12 (7), EH13 (6), and EH1 (5). Counts below this threshold are not reported to reduce the risk of disclosure in low-volume areas.

Two postcode districts, EH2 and EH9, are not represented in the 2024 data. These areas are generally more affluent, and their absence is therefore not unexpected within the

context of opioid treatment demand. Due to small numbers in several districts, it is not possible to present a meaningful density or heat map for comparative purposes. However, the map illustrates the breadth of geographical coverage achieved by EdMAC during its first full year of operation.

Figure 1. Map showing EdMAC's geographic reach



Profile of people accessing EdMAC

Demographic data were available for 160 individuals, as shown in table 5 below. Of these, 18.1% were aged 34 or under, 32.5% were aged 35-44, 39.4% were aged 45-54, and 10% were aged 55 or older. The recorded gender distribution was 71.9% male and 28.1% female.

Table 5. Age profile of patients presenting at EdMAC in 2024 (as at their first assessment in the year) (n=160)

Age group	Number	Percentage
34 and under	29	18.1%
35-44	52	32.5%
45-54	63	39.4%
55+	16	10.0%

Medication initiation patterns

Table 6 indicates that amongst the 62 new patients whose first OST prescription occurred at EdMAC in 2024, 31 (50%) were prescribed methadone and 31 (50%) were prescribed buprenorphine, including Buvidal. Across all patients prescribed OST through EdMAC in 2024, 73 received methadone and 70 received buprenorphine (including Buvidal).

Table 6. ORT medication breakdown (first prescriptions for new EdMAC patients in 2024) (n=62)

Medication prescribed	Number	Percentage
Methadone	31	50%
Buprenorphine (including Buvidal)	31	50%

Six-month retention and treatment pathways

Table 7 shows that of the 62 new patients who received their first OST prescription at EdMAC in 2024, 50 (80.6%) were recorded as still in treatment six months later, whilst 12 (19.4%) were not. Amongst the 50 individuals who remained in treatment, prescriptions were issued predominantly through specialist services, which accounted for 42 patients (84%), and the remaining 8 patients (16%) received their prescriptions from GPs.

Table 7. How many new patients are still in treatment after 6 months? (n=62)

Still in treatment	Number	Percentage
Yes	50	80.6%
No	12	19.4%

Within specialist services, prescriptions after six months were distributed across all four localities (table 8): 13 patients in North-West, 12 in North-East, 7 in South-West and 6 in South-East Edinburgh. A further 12 patients were recorded as receiving prescriptions from other specialist or GP locations, each of which was supporting between one and four individuals.

Table 8. Of those still in treatment, from what location were prescriptions being issued after 6 months? (n=50)

Location	Number	Percentage
North-West Edinburgh Specialist Prescribing	13	26.0%
North-East Edinburgh Specialist Prescribing	12	24.0%
South-West Edinburgh Specialist Prescribing	7	14.0%
South-East Edinburgh Specialist Prescribing	6	12.0%
Other**	12	24.0%

**Other locations include both specialist services and GPs. Each of these were treating between one and four of the new patients titrated at EdMAC during 2024.

Adding detail, table 9 shows the medication profiles of those retained at six months, reflecting that 23 patients (46%) were receiving methadone, 20 (40%) were receiving oral buprenorphine and 7 (14%) were receiving Buvidal. These figures reflect the recorded prescribing status of patients six months after their initiation at EdMAC.

Table 9. Of those still in treatment, what prescriptions were they on after 6 months? (n=50)

Prescription	Number	Percentage
Methadone	23	46.0%
Buprenorphine (excl. Buvidal)	20	40.0%
Buvidal	7	14.0%

Harm-reduction interventions and health outputs

Harm-reduction practices appear to have been embedded from first contact, with almost all patient respondents (n=11/12) reporting having been offered naloxone and BBV testing. DAISy data (Public Health Scotland, 2024) suggest that provision of harm reduction resources and routine monitoring were already embedded in the years prior to, and since the establishment of, EdMAC (2021-24) (see **Appendix 1** for graphical representation and local ADP comparative analysis). Amongst known cases in Edinburgh, 68.1% of people reporting recent opioid use were in possession of a naloxone kit in 2023-24, slightly below the national rate of 70.1%. This followed a peak of 75.1% in 2022-23 and 57.6% in 2021-22, reflecting a sustained increase over time and broadly comparable national coverage (Public Health Scotland, 2024).

In 2023-24, recent testing coverage amongst known cases in Edinburgh reached 60.5% for Hepatitis B, 59.7% for Hepatitis C, and 58.9% for HIV, each slightly below national levels (64.9%, 64.9%, and 64.6% respectively) but showing strong recovery from 2022-23 and overall upward movement since 2021-22 (Public Health Scotland, 2024).

System-wide MAT Activity and Retention (2024*)

In 2024, 350 new patients started MAT across Edinburgh services. Table 10 shows The Access Place (TAP) accounted for the largest share with 101 new patients (29%), followed by the Central Titration Clinic (EdMAC) specialist prescribing with 62 (18%). North-East Edinburgh specialist prescribing managed 53 (15%) and South-West 38 (11%), whilst South-East and North-West contributed smaller shares with 20 (6%) and 18 (5%) respectively. A further 58 new patients (17%) were distributed across multiple other locations, each with fewer than 10 starts.

*A key data limitation is that GP prescribing records appear to be missing non-medical prescriber (NMP) prescriptions until February 2023, which skews earlier counts. For this reason, system-level new patient outputs prior to 2024 have not been included, as they cannot be calculated reliably or compared year-on-year, and so have not been included.

Table 10. System-wide New Patient Starts by Prescribing Location including TAP (2024) (n=350)

Location	Number	Percentage
The Access Place	101	29%
Central Titration Clinic Specialist Prescribing	62	18%
North-East Edinburgh Specialist Prescribing	53	15%
South-West Edinburgh Specialist Prescribing	38	11%
South-East Edinburgh Specialist Prescribing	20	6%
North-West Edinburgh Specialist Prescribing	18	5%
Other (individual locations with <10)	58	17%

Table 11 shows medication type at initiation across the wider specialist MAT system (excluding TAP and other GPs) for 206 individuals. Methadone accounted for 51% in 2024. Buprenorphine (excluding Buvidal) made up 36% of prescriptions in 2024, whilst Buvidal was 13%.

Table 11. System-wide Medication at Initiation Specialist Services Excluding TAP (2024) (n=206)

Medication	2024
Methadone	51%
Buprenorphine (excl. Buvidal)	36%
Buvidal	13%

Table 12 displays retention after six months for new patients across Edinburgh's specialist drug treatment and recovery services. At six months, 76% of patients were retained in

2024, whilst the proportion not in treatment after six months was 24%. No other output data exist for this group.

Table 12. Six-Month Retention of New Patients (2024) (n=206)

Retention in treatment	2024
Yes	76%
No	24%

Table 13 shows the source of ongoing prescriptions for those retained at six months in 2024, and specifically the distribution between specialist services and GPs. 85% were supported within specialist services at six months, with 15% managed by GPs. Cohort sizes for these analyses ranged from 145 to 179 individuals.

Table 13. Prescribing Location After Six Months (2024) (n=156)

Prescribing location	2024
Specialist Services	85%
GPs including TAP	15%

Medication type at six months for retained patients (table 14) shows methadone was received by 49% of individuals in 2024. Buprenorphine (excluding Buvidal) accounted for 31%, as Buvidal prescriptions amongst retained patients was 21% in 2024.

Table 14. Medication at Six Months for Retained Patients (2024) (n=156)

Medication type	2024
Methadone	49%
Buprenorphine (excl. Buvidal)	31%
Buvidal	21%

6.4 Indicators and data monitoring (RedCap, TRAK, admin reports)

Routine monitoring outputs (RedCap extracts and MAT submissions)

RedCap generates routine extracts that underpin local oversight and MAT Standards reporting. The timeliness and activity measures reported in Tables 3-9 were derived from these structured extracts, which also support identification of incomplete follow-up fields.

TRAK/ILLY linkage outputs (prescribing, transfers, and continuity)

TRAK/ILLY provides the prescribing record and is used to produce continuity outputs, including transfer destinations and six-month status. Linking RedCap and TRAK/ILLY enables the follow-up reporting in Tables 7-9 and supports cross-checking against NHS prescribing records.

Administrative reporting and operational use of data

Routine summaries are compiled for MDTs, management, and ADP/Scottish Government reporting. These products support exception review, operational coordination, and service planning, with Section 6.3 presenting the resulting 2024 performance profile.

6.5 Patient experience and word-of-mouth reach

Patient satisfaction and experience

Patient feedback provides a direct indicator of how EdMAC is experienced in practice. Survey and interview data show high satisfaction, with 75% rating their overall experience as *Excellent* and 92% as *Good* or better; one respondent (8%) offered a less positive rating. Ratings were consistently strong across measures: 100% were happy or very happy with staff friendliness, 82% were very happy with the quality of care, and over 90% were satisfied with privacy and respect. Patients described EdMAC as '*the best I've been in*' and repeatedly emphasised respectful treatment, including '*not being made to feel like a junkie*' and that:

> **'Staff don't look down their nose at you – they're genuinely glad that you're back seeking support.'**

Exceeding expectations

Three-quarters of surveyed patients reported that EdMAC exceeded expectations, with the remainder saying it met them. Several contrasted the service with previous waits for treatment, highlighting '*how quickly they'll start you – anything can happen while on the waiting list*'. Others pointed to continuity and recognition ('*they remember you*') and described feeling a sense of accountability to staff.

> **'I was worried about disappointing them.'**

Overall, patient accounts emphasised dignity and hope alongside medication provision.

Peer recommendations

All surveyed patients (100%) said they would recommend EdMAC. Patients described advising peers to '*just go to EdMAC – they'll see you*', reflecting trust in the service and an apparent increase in self-referral via word of mouth. Professionals also noted a shift toward EdMAC and hubs being understood as 'one single partnership', rather than fragmented services. Feedback was positive across the respondent group, most of whom were aged 35–54.

Areas of patient-identified improvement

Patients also contributed constructive feedback, generating improvement outputs for future planning. The most frequent request was:

> **'Longer clinic hours – I found getting in before 12 difficult.'**

This sentiment was echoed by another patient: '*great if they could add an afternoon slot!*'. One woman suggested it might be beneficial '*having a female worker at the first appointment – they* [male staff] *were lovely though*', highlighting preferences relevant to trauma-informed care. Others mentioned comfort: '*more comfortable seating*', or even, jokingly, '*a pool table or café!*'.

Chapter 7: The EdMAC performance story – what outcomes can be attributed to the clinic?

7.1 Outcomes, evidence, and contribution

This chapter reports outcome findings from the evaluation evidence base described in Section 3. Unless otherwise stated, quantitative findings are drawn from routine monitoring datasets, whilst survey and interview evidence is used to explain mechanisms, contextualise variation, and test contribution claims. Findings are presented as evidence of plausible contribution within a complex system rather than as direct attribution to EdMAC.

Table 15. Outcomes Evidence Matrix

Evidence source → / Outcomes ↓	Routine data (RedCap, TRAK, admin reports)	Staff & stakeholder interviews	Internal staff survey (Appendix III)	Patient survey (Appendix IV)	External professionals survey (Appendix V)	Governance/ meeting observation & documents	Secondary/ national data (MAT monitoring, DAISy)
Outcome 1: Reduced waiting times and improved access equity	✓	✓	✓	✓	✓	✓	✓
Outcome 2: Increased initiation and stabilisation on therapeutic doses	✓	✓	✓	✓	✓		✓
Outcome 3: Improved retention and engagement with psychosocial supports	✓	✓	✓	✓	✓	✓	✓

Evidence source → / Outcomes ↓	Routine data (RedCap, TRAK, admin reports)	Staff & stakeholder interviews	Internal staff survey (Appendix III)	Patient survey (Appendix IV)	External professionals survey (Appendix V)	Governance/ meeting observation & documents	Secondary/ national data (MAT monitoring, DAISy)
Outcome 4: Harm-reduction gains (naloxone, BBV, safer use)	✓	✓	✓	✓	✓		✓
Outcome 5: Improved system integration and smoother transfers	✓	✓	✓	✓	✓	✓	✓
Outcome 6: Perceived quality-of-life improvements and reduced chaos		✓	✓	✓	✓		
Additional outcomes: Alcohol-focus relief for hubs, family, and peer impacts		✓	✓	✓	✓		

7.2 Outcome 1: Reduced waiting times and improved access equity

Eliminating waits

EdMAC has virtually eliminated historical waiting times for OST in Edinburgh. Both staff and patients confirm this '*rapid, low-barrier access*'. Patients note speed of access as the most crucial aspect of the clinic's success, with some reflecting on the potential for waiting lists to lead to setbacks or increased risk. In a survey of six EdMAC staff, all but one rated EdMAC's same-day access as 'effective or very effective', whilst external professionals with knowledge of referral outcomes (47%) noted that time to prescription was, *Same day* (n=4; 27%); *Next day* (n=2; 13%); *2-3 days* (n=1; 7%), with none suggesting a wait beyond three days. The convenience of self-referral, consistent weekday opening hours, and on-site prescribing has removed access delays. In 2024 alone, the clinic handled 176 presentations, with 100% being assessed on the same day of presentation, and 75% of patients receiving their first prescription within one day (mean 1.36 days, median 0 days) of presentation – essentially achieving MAT Standard 1 (same-day treatment) at scale.

'People used to wait at least six weeks, sometimes twelve… now they can be at EdMAC the same morning.'

Moreover, multiple clinicians reflected upon the system pre-EdMAC, arguing that if someone ready for treatment is told to come back weeks later, *'potentially they're lost'*, missing the window of motivation. By meeting people at the '*opportunistic moment*' of readiness, EdMAC appears to have significantly lowered the threshold for entering treatment.

Improved access equity

The introduction of EdMAC also appears to have improved equity of access across the city. Previously, waiting times and service availability varied by locality and were understood as having '*removed some of the postcode lottery'*. The clinic accepts self-referrals and referrals from all four localities and multiple statutory and third-sector agencies without bias or preference. A majority of external professionals (53%) reported *No barriers* to access following the establishment of EdMAC, whilst residual patient-level

(that is, city centre bans [40%]), and structural (that is, clinic hours [27%], local transport [27%]), may continue to suppress initiation amongst high risk groups. Early data suggest that groups who historically faced barriers (for example, people experiencing homelessness or those regularly cycling in and out of drug treatment), are presenting to EdMAC in significant numbers, indicating the clinic's equitable, low-threshold approach is reaching those in need.

High needs patients know they can go [to EdMAC] quickly.'

Indeed, over three quarters of external professionals credit both the *Single door drop-in*, and *same day assessment* as *major/absolutely critical* contributors to positive patient outcomes. These design features and operational principles uphold even, and especially where patients 'fall out' of treatment, allowing them to be rapidly re-titrated.

'It's quite a constant … there's always somebody in the team's patient that's off script at any one time.'

7.3 Outcome 2: Increased initiation and stabilisation on therapeutic doses

Rapid initiation, especially for high-risk patients

EdMAC has demonstrated a new capacity to engage and initiate treatment for high-risk, previously 'hard-to-reach' individuals. Despite the recognition of chaotic and extended opioid use histories, some EdMAC patients were described as having repeatedly initiated treatment, without ever fully stabilising. The dedicated titration clinic model (with immediate access, frequent monitoring, and dose adjustments), has been effective in moving a proportion of such patients from sub-therapeutic doses to within evidence-based therapeutic ranges.

'People who'd flirted with 30 ml for years are now on 100 ml and not injecting.'

External professionals noticed this impact as well – with 38% of surveyed external providers reporting an increase in the proportion of patients reaching a therapeutic dose since EdMAC opened, whilst the remainder saw no change (none perceived a decrease). National DAISy data show that the share of Edinburgh patients entering Tier-3 treatment already on OST rose from 79% in 2021-22 to 95% in 2023-24, whilst overall opioid use remained stable. Together with survey findings of fast access and smooth transitions, this indicates that EdMAC has become the main entry point for new OST starts, ensuring most patients enter structured treatment already stabilised, improving early retention and system continuity.

Reduction in illicit use and improved stabilisation

Getting patients onto adequate doses quickly, safely and in a structured, person-centred way has yielded early signs of reduced illicit drug use and better physical stabilisation. All of EdMAC's surveyed patients (n=12) described having achieved at least a level of stability, whilst just over a third reported, through open text box responses, the reduction, or ceasing of illicit drug use, for which credit is variably ascribed to the speed and responsiveness of treatment provision at EdMAC.

'I had a huge [heroin] habit… usual pathway is Subutex but they tailored it to me.'

Another patient stated that after years of instability, *'it feels like I cheated my addiction'* with his medication and was no longer using illicitly. Frontline staff echoed these findings, observing that EdMAC has done *'quite well getting repeat relapsers onto doses they realistically should be'*, enabling some to stabilise for the first time in years. Across Edinburgh's specialist MAT services (excluding TAP and other GP prescribing), 206 people started OST in 2024 and 76% were still in treatment at six months; amongst those retained, 85% continued to receive prescriptions through specialist services and 15% through GPs (including TAP). Against this benchmark, EdMAC's 2024 new-starter retention (50/62; 80.6% at six months) appears at least comparable, whilst recognising the cohorts are not directly equivalent.

Taken together, the qualitative feedback and available system-level data indicate that EdMAC is supporting timely initiation and, for some patients, improved stabilisation. Whilst the evidence is early and based on a small survey sample, it suggests the clinic may be helping more people to start OST and reach doses that feel clinically adequate, with some reporting reduced reliance on illicit substances.

7.4 Outcome 3: Improved retention and engagement with psychosocial supports

Early retention in treatment

Improved early retention was a key anticipated outcome of the EdMAC model – keeping patients engaged through the high-risk first weeks of OST. Quantitative data show that 80.6% of EdMAC new starters in 2024 remained in treatment at six months, indicating strong short-term continuity for a low-threshold cohort. Qualitative and survey evidence reinforce this picture: staff reported that most patients now stay in treatment through handover to community hubs, whereas early drop-off was previously common. Around one-third (31%) of surveyed professionals observed fewer first-month drop-outs since EdMAC's launch, 46% saw no change, and 23% perceived an increase – showing overall improvement but some variation across settings. A likely mechanism is EdMAC's proactive, non-punitive follow-up, where missed appointments trigger immediate outreach and re-engagement. Although staff describe this as '*labour-intensive and not fail-safe*' it has prevented a significant number of early losses during titration and transfer. Hub teams also report that patients arriving from EdMAC are more settled and ready to engage, reflecting reduced chaos and smoother transitions into longer-term care. A hub nurse confirmed that patients returning from EdMAC:

> **'... come back a lot more settled… chaos is significantly reduced and they're ready to engage with the programme.'**

Such onward programme engagement is delivered through the community hubs, where psychosocial support can be of greater effect once patients have achieved treatment stability.

Psychologically informed care

EdMAC's model explicitly combines psychologically informed medical treatment with psychosocial support (aligned with MAT Standards 6 and 10). In practice, the clinic offered on-site keyworker support (through both nurse prescribers and third-sector staff) and links to social services. Across patient, external, and internal feedback, there is consistent evidence that EdMAC delivers care that is both psychologically informed and trauma-aware, with high levels of perceived safety, understanding, and support.

From the patient survey, the majority reported positive experiences: 75% felt staff understood their past and worked in ways that did not cause further harm, and over 90% felt safe, supported, and better able to cope as a result of the service. Although continuity was weaker following transitions to other services (only 43% agreed trauma-informed care continued). Some patients also highlighted the value of interacting with practitioners who had lived experience.

> **'The individual doing the assessment had lived experience … and that put me at ease.'**

Feedback from external professionals reinforced this picture. Most partners (57%) rated trauma-aware, person-centred handovers as adequate, whilst 43% saw them as fully meeting standards. Joint working was generally viewed as trauma-informed, with 57% agreeing or strongly agreeing, and 85% identified EdMAC's trauma-aware staff approach and flexible appointment style as a major or critical driver of positive outcomes. Internal staff responses mirrored these strengths, showing universal agreement that staff are trained to respond sensitively to trauma. Most (67%) agreed or strongly agreed that procedures minimise re-traumatisation, and 83% said the service consistently provides a safe, supportive atmosphere.

Psychosocial engagement

EdMAC's trauma-informed, stabilisation-first model appears to have provided an effective foundation for wider psychosocial engagement, enabling patients to participate more meaningfully in emotional and social recovery once their immediate needs are met.

Amongst the 12 patient respondents, 66% said they *Agree* or *Strongly agree* with the statement 'I was offered easy-to-understand, low-level support to help with my feelings', whilst 34% disagreed. Similarly mixed were responses to the statement 'I was helped to build or maintain good social connections', with 59% selecting *Agree* or *Strongly agree*, whilst 33% disagreed. However, two of the four patients who disagreed expanded through open text box responses that they were already well connected and that this was not relevant '*I don't think I needed help*'. Several patients stated that EdMAC staff listened to them and were responsive in connecting them to additional resources (mental health referrals, bereavement support, etc.) as requested/needed.

As noted above for Outcome 2, EdMAC appears to have lowered barriers to psychosocial engagement by stabilising patients first. A hub practitioner observed that *'a good majority* [of EdMAC patients] *engage in psychosocial stuff'* once they are stable, whether that means attending recovery groups, counselling, or other support; others, he noted, *'just want medication to improve quality of life but may do family work instead'*, indicating that even those not interested in group work often reconnect with family or other positive social supports after stabilising. Quantitative feedback from external partners is mixed on this outcome – 36% of surveyed professionals have noticed increased engagement in psychosocial support amongst people coming through EdMAC, whilst 50% saw no change and 14% felt engagement might have decreased. Some third-sector respondents expressed concern that because EdMAC handles the initial engagement, patients may form less of a bond with community providers like peer support workers at first, potentially delaying psychosocial involvement. Indeed, a cutback in on-site third-sector staffing (from four full-time down to a much reduced presence due to funding issues) was cited by EdMAC staff as a threat to sustaining psychosocial support delivery.

'Unfortunately, this will have a negative impact on the clinic/delivery of service in the areas of practical support and psychosocial intervention.'

Despite these challenges, the overall evidence indicates EdMAC has improved early retention and created conditions for better psychosocial engagement.

7.5 Outcome 4: Harm-reduction gains (naloxone, BBV, safer use)

Harm reduction and risk management

Patient feedback indicates that harm reduction support is both accessible and valued. Half of respondents (6 of 12; 50%) said they were offered extra help because they were considered high risk, and all found it useful, three (50%) somewhat useful, one (17%) very useful, and two (33%) extremely useful. Amongst those who had moved to another service, all seven selected *neutral* when asked if high-risk support continued, suggesting uncertainty about continuity beyond EdMAC. Most patients reported access to harm reduction services on entry: 92% were offered *infection testing*, *83% naloxone*, *25% wound care*, and *25% needle and syringe provision*. Over half (58%) also received *other* supports such as foil, transport or energy vouchers, and onward referrals. Satisfaction was high, 67% were *happy* or *very happy* with the extra services. EdMAC's rapid stabilisation on OST also directly reduces harm; several patients reported cutting back or stopping injecting entirely once stabilised, feasibly leading to fewer overdoses, abscesses, and viral transmission.

Internal professional survey responses show a strong sense of effectiveness in identifying and supporting high-risk patients. All six staff felt the clinic performed *well* or *very well* in identifying and monitoring high-risk patients (83% positive overall). Satisfaction with follow-up was equally high, with all six reporting they were *satisfied* or *very satisfied* with the additional support provided. Staff explicitly see rapid OST initiation as a harm-reduction tool:

> **'The underlying thing is really harm reduction – the quicker people are on scripts, the less harm they're causing themselves.'**

Furthermore, EdMAC's on-site pharmacist and nurses ensure that high-risk patients (for example those with recent overdoses or other vulnerabilities) are closely monitored. Any concerning signs, like missed pick-ups or health issues, trigger prompt interventions (for instance, extra outreach or adjusted dosing) to prevent harm. Staff also indicated comprehensive integration of harm reduction measures: 100% said the clinic delivers *needle and syringe provision*, *BBV testing*, and *naloxone*, 83% reported *wound care*

integration, and 50% noted *housing or benefits advice* as part of the service. Though long-term outcomes like overdose rates will require more data to evaluate, the early harm-reduction gains from EdMAC are clear: virtually all patients leave the clinic better protected against overdose (with naloxone and knowledge) and health risks (with infection testing/treatment), and three of the present sample report no longer engaging in the most dangerous use behaviours which they link to being stabilised on OST.

External partner feedback indicates broad confidence in EdMAC's coordination of harm reduction supports. All seven respondents rated their own service as at least *somewhat well* aligned in providing trauma-aware handovers for former EdMAC patients, with 43% describing performance as *adequate* and 57% as *very well* or *fully meeting standards*. When asked about EdMAC's *on-site wrap-around supports* (including BBV testing, naloxone, and housing or benefits advice), most (9 of 13; 69%) felt these made a *major* or *absolutely critical* contribution to positive outcomes, whilst only two (15%) were unsure or had not observed an effect.

7.6 Outcome 5: Improved system integration and smoother transfers

Joined-up pathways

EdMAC was conceived as a central component of a more integrated treatment system, and evidence suggests it has indeed improved coordination across services. By acting as a single entry point and then rapidly 'handing back' stable patients to locality hubs or GP shared-care, EdMAC has clarified and streamlined the treatment pathway. A recurring theme in interviews was that the partnership between EdMAC and the community services feels more cohesive than the previous patchwork.

> **'People are getting the message that it's one single partnership… it looks smoother and will definitely feel it to people navigating the system.'**

Similarly, another partner credited 'the partnership working – sharing information, shared outreach, seamless transfer – [as] a big factor in the positive outcomes' seen, emphasising that EdMAC and the hubs function in concert rather than silos. Practical integration tools

support this: EdMAC uses shared electronic record systems (TRAK and the national prescribing database), so hub teams and GPs can instantly see assessments, dose histories, and notes once a patient transfers. According to the external professionals survey, over two-thirds (69%) agreed that they receive timely and accurate handover information when an EdMAC patient transfers to them, and importantly 0% disagreed. In other words, no respondents felt the communication was poor – a marked improvement from the pre-EdMAC era when information, and monitoring was variably spread across the system. Furthermore, 54% of external partners agreed that overall, the shared-care pathway maintains safe, uninterrupted care for patients, with the rest mostly 'not sure' but none actively disagreeing. These findings indicate a generally smoother transfer process and greater confidence that patients will not be lost between services.

Transfer challenges and mitigations

Whilst integration has improved, the EdMAC evaluation did identify a vulnerability during the transfer period. Because EdMAC is a time-limited, high-throughput service, patients eventually have to move on to a hub or GP for long-term care. This handover can create an 'exit gap' if there is any delay in the follow-up arrangements. About 25% of hub staff surveyed rated the EdMAC handover process as 'poor', however, reflecting instances where a patient was in the process of transferring from EdMAC to a hubs but then did not attend. In such cases, risks of disengagement or medication interruptions were potentially realised. One hub interviewee described how *'during that gap… other stuff* [is] *happening…* [the patient] *lasted a bit longer than normal but still slipped out'* – meaning despite EdMAC's retention boost, transfer may still result in dropout. EdMAC leadership described being aware of this risk window and have responded by keeping a flexible readmission policy. These rapid 're-loops' back to EdMAC (essentially safety-net readmissions) have been used to good effect. As a result, a proportion of patients get multiple opportunities to stabilise and transfer successfully. Still, this workaround was acknowledged as '*resource-intensive*' and highlights the need for even tighter integration, especially with primary care GP practices that historically have been reluctant to take on OST patients (and representatives did not respond to the survey or requests for interview in this evaluation).

7.7 Outcome 6: Perceived quality-of-life improvements and reduced chaos

Perhaps the most important outcomes of EdMAC are the qualitative, human improvements in patients' lives. Both patients and professionals report that EdMAC's interventions have led to stabilisation and a reduction in chaos for patients who were previously in highly unstable circumstances. By rapidly addressing withdrawal and cravings through proper OST dosing, the clinic helps patients move from crisis mode to a steadier routine. Hub staff consistently describe patients returning from their EdMAC titration period as fundamentally changed in demeanour.

'They come back a lot more settled… chaos is significantly reduced.'

Patients themselves have voiced significant quality-of-life gains. Freed from the constant sickness and anxiety of uncontrolled opioid use, they can focus on normal activities and personal goals. One patient, who was switched to her preferred medication (long-acting buprenorphine) through the clinic, described EdMAC's care as nothing short of transformative.

'if not actually lifesaving, it's been quality-of-life restoring care 100%.'

Others talked about improvements like establishing regular sleep and meal patterns, reconnecting with family, and feeling safer from overdose. These subjective outcomes, whilst hard to quantify, align with what the theory of change envisaged as medium-term results: greater treatment stability and enhanced recovery capital (the personal and social resources that support recovery). In essence, EdMAC's impact is not just clinical but holistic – by reducing drug-related chaos, it has allowed many patients to experience a better quality of life, describing themselves as healthier, more clear-headed, and more 'in control' than before.

Moreover, EdMAC's trauma-informed, person-centred approach likely contributes to these quality-of-life improvements. Patients consistently mentioned feeling *'listened to'* and treated with kindness at the clinic. This positive care experience can improve self-esteem and trust in services, which are themselves factors in well-being. One patient noted that EdMAC staff took into account her past trauma and adjusted her care accordingly, which made her feel respected and empowered in her recovery journey. Such feedback suggests EdMAC is delivering care in a way that makes patients feel safe and supported, further reducing the psychosocial 'chaos' in their lives (for example, less anxiety, more routine). Whilst formal outcomes like housing status or employment were beyond the immediate scope of this evaluation, a few patients indicated that after stabilising through EdMAC, they were better positioned to pursue education, work, or improved family relationships. These anecdotes illustrate an important point: stability begets opportunity. By helping patients achieve a stable medical regime and a foothold in recovery, EdMAC has supported broader life improvements that, though not directly measured here, were tangibly felt by the people involved.

7.8 Additional outcomes: alcohol-focus relief for hubs, family, and peer impacts

Alcohol relief for hubs

Beyond the core outcomes above, the EdMAC clinic has yielded some additional benefits to the wider system and community. One notable 'system-level' outcome is the relief of pressure on local hubs, allowing them to re-focus on alcohol services and complex cases. Prior to EdMAC, the four locality hubs in Edinburgh were responsible for all new OST inductions alongside their existing caseload. This often meant that staff time and resources were heavily consumed by urgent opioid cases, sometimes to the detriment of alcohol patients (who form a large portion of treatment demand). With EdMAC taking on virtually all new opioid treatment starts, hub teams have been able to shift attention back to alcohol and longer-term recovery work.

'EdMAC has allowed us to focus more on the alcohol clients – [now] 80% of my caseload.'

is alcohol-focused. In other words, the clinic helped clear the previous bottleneck of people waiting to start OST, and after that surge was addressed, the flow of opioid cases to hubs became a 'steady trickle' that is much more manageable. This rebalancing has likely improved care for people with primary alcohol use (who may have seen delays before) and reduced strain on hub staff. Additionally, hub clinicians report that when they do receive a transfer from EdMAC, that patient is already stabilised and often no longer in crisis, which makes the ongoing work less acute in nature. Overall, EdMAC's introduction appears to have facilitated a more efficient division of labour, with the clinic handling rapid initiation and stabilisation for people in drug treatment, and the hubs can dedicate more time to alcohol treatment, integrated care, and recovery support – a positive development for the local treatment system as a whole.

Family and peer impacts

EdMAC's influence extends beyond individual patients to their families and peer networks. From the outset, the clinic adopted a whole-person approach, offering support to relatives through a partnership with VOCAL for mediation, education, and counselling. As patients engage in treatment, families can access parallel support, helping to ease stress and rebuild relationships. Although family outcomes were not formally measured, staff report that many relatives expressed relief that their loved one '*finally got into treatment*' and have since used support services to aid recovery. Many former EdMAC patients have reconnected with peer support and recovery communities, with the North-West locality now hosting one of the city's busiest SMART Recovery groups (around 60 attendances weekly). EdMAC's rapid stabilisation appears to help patients join such groups sooner, and some have gone on to become peer mentors or recovery champions, encouraging others through lived experience. Staff with lived experience also strengthen this message – one such individual argued this helps '*show it's possible*', to current patients.

Chapter 8: Assumptions and external factors

In developing EdMAC's theory of change, certain core assumptions were made about enabling conditions, and the implementation has played out amid external factors that shape delivery. It is important to outline these assumptions and contextual factors, as well as consider any risks and alternative explanations, to fully understand EdMAC's performance.

8.1 Core assumptions underpinning the theory of change

Readiness windows and why rapid access matters

Interviewees consistently described a narrow 'readiness window' in which people are willing and able to engage and assumed that delays risk losing that opportunity.

> **'Someone could wake up in the morning and say right today I want to make the change… Today I need to get this sorted. Maybe in six weeks when I get an appointment I might not be as up for it.'**

This assumption was reinforced by accounts that people's motivation 'waxes and wanes', and that rigid appointment systems often fail to align with fluctuating capacity to attend, contributing to drop-off and continued risk whilst waiting. Several respondents also assumed that rapid access changes what can be achieved during an assessment, requiring sufficient staff capacity and broader information-gathering at the point of presentation, including social circumstances and service interfaces.

Clinical safety, appropriateness, and risk management

A second set of assumptions concerned clinical safety and the balance between speed and appropriateness. Staff assumed that treatment is generally the safest place for people to be, and therefore that rapid access reduces immediate harm by shortening exposure to high-risk use whilst waiting.

> **'The quicker people are on scripts, the less harm (…) 12 weeks they were at significant risk.'**

At the same time, participants assumed that same-day prescribing must remain conditional on clinical judgement, and that rigid eligibility rules could create unintended consequences by overwhelming parts of the system or driving unsafe starts.

Design assumptions: centralisation, consistency, and access trade-offs

Participants frequently assumed that centralisation enables reliability and reduces confusion about where and when to attend, supporting consistent same-day access. One interviewee articulated the underlying trade-off:

> **'If you're picturing that person (…) who really, really urgently wants a script, traveling to the middle of town and getting that reliably every day (…) was a good trade-off.'**

However, other respondents assumed that a city-centre model may not work for everyone, and that some people will require locally accessible options, evidenced by a small but consistent cohort choosing different routes to care (that is, initiation through the hubs). A related assumption was that '*no wrong door*' is harder to achieve where access depends on interfaces such as GP registration, creating potential friction for some groups.

Design assumptions: pathway functioning and interfaces (including primary care)

A further assumption emerging across primary evidence sources was that EdMAC's effectiveness depends on downstream pathway functioning, particularly timely access to primary care and reliable handovers between services.

> **'We must be careful of (…) making those assumptions that the system will just work.'**

This assumption was echoed in accounts of how delays in accessing GP appointments or collecting prescriptions could undermine continuity, and in justice settings where agreement to referrals may be shaped by acute stress, legal context, or perceived incentives rather than stable readiness to engage.

Person-centred and trauma-informed practice supports engagement

A further assumption was that engagement is strengthened when care is experienced as patient-centred, choice-based, and non-punitive, with practical supports reducing friction. One respondent linked choice directly to retention:

> **'You're much more likely to have people stay in a treatment if they feel they've had a say in it.'**

Across interviews and some survey responses, this was connected to assumptions about trust-building over time, the value of low-consequence re-entry after relapse, and the role of third-sector provision in enabling engagement through outreach, accompaniment, and basic practical support. Some participants also assumed that clinical complexity (for example, benzodiazepine risk) requires nuanced judgement in the absence of clear guidelines (reinforcing the importance of experienced staff and reflective practice).

System-level assumptions: pathways, commissioning expectations, and contribution framing

Finally, respondents made explicit assumptions about what commissioners and systems can reasonably claim and evidence, and how contribution should be framed.

> **'Commissioners can be very clear about: this is what we expect for the funding (…) but also being realistic about what can be delivered for the funding that is being given.'**

Several interviewees assumed that EdMAC is one component within a broader system response, that its contribution should be considered alongside other changes, and that stronger claims about population-level outcomes require longer-term tracking.

8.2 External factors shaping delivery: premises constraints, drug-market shifts, funding dependencies

EdMAC launched into a dynamic real-world context. Several external factors beyond the clinic's immediate control have influenced its delivery and must be acknowledged:

Funding and commissioning environment and third-sector capacity shocks

Accounts located a key external dependency in third-sector capacity, which respondents described as vulnerable to funding decisions and contract changes outside EdMAC. Interviewees linked anticipated reductions to the availability of practical and psychosocial supports that sit alongside clinical care, noting limited scope for the NHS component to absorb this loss.

> **'We are losing most of that quite soon… at the moment we rely really heavily on our third-sector colleagues… [and] the NHS side… won't have the capacity to do a lot of these things.'**

Retendering and short-cycle budgeting were also described as contributing to uncertainty and to staffing-mix decisions.

Workforce capacity constraints across the wider system

Respondents described external constraints in the wider workforce pipeline, including variability in locality capacity to pick up transfers and delays in filling key posts. Recruitment friction was described as persistent, with knock-on effects for timely allocation of psychosocial and clinical support.

> **'We've had all sorts of nonsense trying to fill [the social work post] (…) it's been out to advert about seven or eight times… it takes that long that people then get themselves other jobs… or decide that they're not willing to wait any longer.'**

Other accounts referenced reliance on small numbers of prescribers in some settings and additional continuity demand following hospital or custody initiations.

Estate, space, and operating-hours constraints

The physical estate was described as a continuing constraint on throughput and the potential to extend opening hours. Respondents across surveys and interviews linked restricted hours to limited room availability and noted that this may not fit all attendance patterns. One interviewee stated:

> **'It's only open restricted hours… [and] I think it's a room capacity… they don't have access to enough space.'**

Separate accounts also described accommodation instability and travel complexity as contextual barriers to sustained engagement.

Primary care, registration rules, and prescribing-system constraints

External constraints were described at the interface with primary care and prescribing infrastructure, including GP registration requirements, pharmacy/dispensing arrangements, and the work required to prevent duplicate prescribing. One respondent summarised the operational burden of same-day safety checks:

> **'What guards against the double prescription… [is] checking with the GP… phoning the hubs… [and] checking with the pharmacies… a detective walk before you can start prescribing the same day.'**

Other accounts described transfer 'snagging' due to dispensing arrangements and variability in pharmacy staffing continuity.

Justice-system context, licensing, and information-sharing constraints

Justice-linked interview data highlighted constraints on what can be delivered in court contexts, including the inability to hold or administer medication and reliance on upstream provision.

> **'The trouble with the court is, the court doesn't have any medications they can give out… we don't have a license to hold, handle, or give out any meds.'**

Wider accounts also described procedural volatility and necessary limits on what is recorded in generic health records, shaping continuity and situational awareness at the custody–community interface.

Drug market context and poly-drug risk environment

Respondents situated delivery within a high-risk poly-drug environment, emphasising overdose risk where benzodiazepines and crack cocaine remain in use during early treatment.

> **'Especially that first month of treatment… if they're still using benzos and crack on top—the overdose risk is high.'**

Other accounts referenced increasing cocaine injecting, limited pharmacological options for stimulant use, and fluctuations in availability and dependency trends.

System governance fragmentation and silo effects

A consistent external factor was described as system fragmentation, including siloed decision-making and limited integrated oversight across homelessness services, EdMAC, hubs, and primary care. One respondent stated:

> **‘Operationally the system doesn't work fluidly as one… it is still a set of silos.’**

Other accounts linked this to how service reductions are determined and communicated across partners, with implications for coherence and joint planning.

National policy and scrutiny context around MAT implementation

Respondents described a national context of scrutiny around MAT delivery, particularly same-day access, shaping expectations and performance narratives.

> **Previously, we were under escalation with the Scottish Government for not having implemented… specifically around… MAT standard one and the same day prescribing.’**

Other accounts referenced the political salience of drug death trends and the role of MAT Standards in driving local implementation priorities.

8.3 Risks and rival explanations for observed changes

EdMAC was introduced into a fast-moving, multi-intervention system. As such, observed improvements in access, stabilisation and retention cannot be treated as uniquely ‘caused’ by EdMAC, even where EdMAC’s contribution is plausible. In particular, the evaluation is retrospective and lacks a clean counterfactual (that is, a comparable group not exposed to the intervention), so attribution must remain cautious and theory driven.

Rival explanations: what else could be driving the observed improvements?

Several concurrent changes could plausibly explain some of the same outcome signals:

- **City-wide MAT implementation effects.** Improvements in access processes may reflect wider city-wide implementation of Medication Assisted Treatment standards as well as EdMAC itself. In this context, EdMAC’s strong timeliness performance should be interpreted as part of a broader reform environment, where faster pathways, clearer expectations, and more consistent handovers

were being prioritised across the system, rather than as an effect attributable to the central clinic alone.

- **Pre-existing or improving harm-reduction coverage.** DAISy indicators suggest harm-reduction provision was already embedded across the system and trending upwards over 2021–24. This means some apparent 'harm reduction gains' may reflect a longer trajectory and national/system effects (not only EdMAC delivery).

- **Parallel service adaptations (including decentralised capacity).** Capacity pressures have prompted wider distribution of provision (for example, Buvidal delivery extending beyond central sites). This can improve access and continuity independently of EdMAC's direct activity.

- **Changing demand and drug-market dynamics.** Shifts in opioid use patterns, poly-drug risk, and fluctuations in readiness/demand may change who presents and when—potentially affecting waiting times, retention, and 'stability' indicators without reflecting service performance alone. (This is consistent with the report's broader framing of a dynamic context around implementation.)

Key risks: why observed improvements may not generalise or sustain

Even if EdMAC is contributing materially, the following risks could limit durability, equity, or explain variation across outcomes:

- **Structural access constraints remain.** A portion of external respondents still identify barriers linked to clinic hours, transport, and city-centre restrictions/bans, which could suppress uptake amongst those at highest risk and complicate 'equity' claims over time.

- **Resource fragility and capacity compression.** EdMAC has already had to adjust staffing to meet ADP funding cuts, indicating limited slack. Reduced resourcing risks longer waits re-emerging, reduced outreach/follow-up capacity, or narrowed psychosocial support – each of which could mimic (or create) changes in outcomes unrelated to the model's underlying effectiveness.

- **System boundary risks (transfers and shared care).** Improvements in stabilisation and retention depend on downstream services absorbing transfers smoothly; any bottlenecks (GP engagement, hub capacity, pharmacy arrangements) can produce dropout or continuity gaps that may be misread as ‘patient disengagement’ rather than system friction.

Overall, the contribution story for EdMAC must be interpreted cautiously because multiple concurrent reforms and system constraints could plausibly account for similar patterns, and because the sustainability of observed improvements depends on fragile resources and downstream capacity beyond the clinic itself.

Chapter 9: The contribution of EdMAC towards long-term changes and impact

9.1 Introduction

This chapter considers EdMAC's contribution to longer-term change in Edinburgh's opioid treatment system. It draws on routine service data, surveys, and stakeholder interviews to assess plausible contribution beyond immediate outputs, whilst recognising implementation occurred alongside wider MAT reforms and within a dynamic service context. The focus is therefore on contribution rather than attribution, highlighting where evidence converges, the main rival explanations, and the dependencies that will determine whether early gains are sustained.

9.2 Evidence of contribution: triangulating outputs and outcomes

Across data sources, there is a consistent account of EdMAC's likely contribution to faster, more standardised access to OST and clearer initiation pathways. Evidence for downstream outcomes (stabilisation, retention, system efficiencies, and smoother transfers) is supportive but more contingent, relying on third-sector capacity, downstream hub/primary care absorption, and wider risk conditions. Table 16 summarises the core contribution claims, evidence base, key rival explanations, and dependencies.

Table 16: Key outcomes of EdMAC and supporting evidence from multiple sources

Outcome area	Nature of contribution (what EdMAC plausibly adds)	Convergent evidence base (types)	Key limitations / rival explanations	Confidence in contribution
Timely access to OST and reduced waits	Provides a consistent, low-threshold, same-day initiation route that operationalises MAT Standard 1 at scale	Routine clinic data; patient accounts; internal/external stakeholder reports	Wider MAT implementation and heightened system prioritisation of Standard 1 could account for some improvements; lack of counterfactual	Strong
More standardised entry pathway and clearer expectations	Simplifies 'where/when/how to start' into a single route, reducing variability by locality	Stakeholder interviews; partner survey; evidence of operational clarity across agencies	Other pathway simplification efforts within MAT could also drive perceived clarity	Moderate
Stabilisation during early weeks of treatment	Intensive early titration and monitoring plausibly supports movement toward clinically adequate dosing and stabilisation	Patient survey/interviews; staff reflections; partner perceptions	Outcomes depend on downstream supports (housing, mental health, psychosocial); drug market/poly-drug risk may confound stability	Moderate

Outcome area	Nature of contribution (what EdMAC plausibly adds)	Convergent evidence base (types)	Key limitations / rival explanations	Confidence in contribution
Continuity across transfer and shared care	Structured handover practices and shared recording systems plausibly reduce ‘loss’ at transition points	Interview evidence of coordination; partner survey on handover experience; routine monitoring capability	Transfer remains a known risk window; primary care and hub capacity constraints may explain variation	Moderate
System capacity and efficiency	Centralises starts and reduces pressure on hubs, potentially enabling reallocation to longer-term work (for example, alcohol and psychosocial)	Manager/staff accounts; system logic; observed workflow changes	Limited quantitative system metrics presented; efficiency gains depend on sustained clinic capacity and third-sector inputs	Moderate
Partnership working and integration	Provides a focal point that encourages multi-agency coordination, joint oversight, and shared routines	Qualitative accounts of ‘one-system’ working; governance/MDT evidence	Broader MAT governance reforms may also strengthen partnership behaviours; continued silos and commissioning fragmentation remain	Moderate

As Table 16 indicates, evidence from service data, surveys and interviews is broadly convergent. Stakeholders consistently describe EdMAC as a key mechanism for reducing waits and standardising access, with supportive signals for improved stability, engagement, and system functioning.

9.3 Plausibility of causal pathways

The available evidence supports a plausible contribution pathway between EdMAC's introduction and observed improvements in access, uptake, and early outcomes. Across participant groups, respondents link reduced waiting times and more rapid initiation to the central drop-in model and same-day prescribing capacity. Wider MAT implementation provides the policy backdrop, but EdMAC is described as the operational mechanism that translated this intent into practice.

Evidence strength varies by outcome. For access and early initiation, the evidence is strongest, including near-unanimous stakeholder accounts and consistent routine reporting post-implementation. However, comparable pre-implementation time-to-prescription metrics are limited, so inference relies partly on participant testimony and earlier local evaluations reporting prolonged waits. For intermediate outcomes (for example, stabilisation and reduced illicit use), evidence is encouraging but remains based largely on qualitative accounts and small patient samples, with benefit from larger follow-up datasets. For longer-term outcomes (for example, 12-month retention, overdose events, mortality impacts), evidence is currently insufficient because linked administrative follow-up was not available within this evaluation.

Overall, EdMAC's contribution to short- and medium-term changes is highly plausible on timing, mechanism alignment, and convergent stakeholder accounts, but longer-term impacts remain contingent and require continued monitoring and linked outcome data.

9.4 Sustainability of benefits and systemic risks

Sustaining EdMAC's benefits depends less on whether the model can deliver rapid access in principle, and more on whether the system can maintain the enabling conditions that make this possible in practice. Interview evidence consistently framed sustainability as

contingent on stable funding, resilient staffing, preserved wrap-around capacity, and reliable interfaces with wider services.

Funding and commissioning risk

Current delivery is vulnerable to short-horizon funding decisions. Participants described a 'regression risk' if the clinic's dedicated resourcing is withdrawn or reduced, with pressure displaced back to locality services and a return to reactive, crisis-driven pathways.

> **'If EdMAC were defunded they'd bottleneck back at the hubs… waiting times would shoot back to 6–12 weeks and we'd be firefighting again.'**

The February 2027 expiry of a key funding stream sharpens this risk, reinforcing the need to move from time-limited funding to an embedded commissioning position.

Workforce capacity, sustainability, and risk of burnout

Interview accounts emphasised the intensity of same-day initiation and rapid titration work, particularly where small numbers of staff carry multiple functions across clinic delivery and pathway coordination.

> **'They had two or three drop-ins but also 17 people being titrated… the clinic was incredibly busy… instead of just focusing on titrations, he was also chasing up transitions back to the hubs… it's not sustainable, he's going to end up burning out.'**

Sustainability therefore hinges on staffing depth, protected time for non-clinical coordination, and contingency for absence, vacancies, and fluctuations in demand.

Dependence on third-sector wrap-around capacity

A consistent sustainability signal was reliance on third-sector inputs for practical and psychosocial support that stabilises engagement around initiation. Multiple accounts linked

reductions in third-sector hours to a narrowed offer and increased pressure on clinical staff, with anticipated impacts on what can realistically be delivered alongside prescribing. In sustainability terms, this is not an 'add-on' risk; it is a risk to the functioning of the model as a low-threshold, engagement-supporting service.

Pathway interfaces and shared-care gaps

Interview evidence also points to durability risks at interfaces rather than within the clinic itself. Where a subset of GP practices do not prescribe OST, transfers can become slower or more complex, leaving specialist services holding responsibility for longer than intended. At current volumes this may be manageable, but stakeholders implied the risk becomes material if throughput rises or if other downstream constraints tighten (for example, hub capacity, pharmacy arrangements).

Operating model constraints and coverage gaps

Sustainability is further shaped by constraints that limit flexibility in responding to demand. Respondents described estate limitations and fixed hours as structural constraints that cap capacity and restrict extension to evenings or weekends. This creates an ongoing coverage gap for people seeking help outside weekday mornings and reduces the system's ability to absorb spikes without degrading performance. More broadly, interview accounts suggest some high-risk transition points (for example, justice-system movements) remain vulnerable to missed communication and incomplete linkage, implying that sustainability requires not only maintaining the clinic but strengthening the surrounding pathway.

The key sustainability risks sit in resourcing stability and pathway dependencies - particularly third-sector inputs, staffing depth, and the reliability of transfer and shared-care interfaces.

9.5 Broader systemic changes in treatment pathways and culture

Interview accounts described EdMAC as having consolidated a clearer, city-wide route into OST, reducing ambiguity about where people can access rapid starts and increasing shared expectations of timely access. Stakeholders also noted a more integrated working

culture, characterised by routine cross-service coordination, shared protocols, and a stronger sense of mutual accountability across the clinic and locality services.

Participants further indicated that the model has rebalanced system roles. By concentrating rapid initiation and early stabilisation activity in one place, EdMAC is described as enabling locality teams to orient more of their capacity toward longer-term recovery and broader caseload demands. This is framed less as a 'service substitution' and more as a redesign of workflow across the system.

Culturally, stakeholders repeatedly framed the clinic's contribution in harm-reduction terms – prioritising rapid engagement, safety, and continuity rather than abstinence as the sole marker of success. This was also linked to reflective tension: delivering a high-throughput model whilst sustaining trauma-informed practice and meaningful engagement, which stakeholders treated as a continuing design requirement rather than a settled achievement.

9.6 Moving beyond initial funding: embedding EdMAC into strategy

With clear early benefits, the next challenge is to embed EdMAC as a core component of Edinburgh's treatment pathway rather than a time-limited innovation. Stakeholders cautioned that this depends on sustained investment, noting the trade-offs involved

> **'Do I see it adding value… absolutely… would I fund that over some other services? Don't know (…) it's also about that range [of services].'**

A stronger cost-effectiveness narrative will therefore be important.

Embedding requires commissioners to specify EdMAC's role, capacity, and performance expectations within future service plans.

> **'Commissioners [should] be very clear about what we expect for the funding… and be realistic about what can be delivered.'**

Translating evaluation learning into a small set of practical targets (for example, maximum waits and continuity measures) would help anchor delivery and accountability.

The forthcoming re-tendering of voluntary-sector services provides an opportunity to formalise wrap-around support for EdMAC within contracts, protecting it as core pathway infrastructure rather than discretionary 'add-on' capacity.

Strategic planning should also focus on targeted evolution rather than simple expansion, including strengthening links at key transition points (for example, hospital discharge and liberation from custody), maintaining referral visibility, and developing local 'spokes' or outreach options for people who cannot access the city-centre site. As one stakeholder put it, 'Some people… will not be able to access a city centre service… we need local services as well'.

Ultimately, embedding EdMAC requires a strategic commitment to maintain multi-agency ownership and pathway alignment. The case is best framed as '*spend to save*' through avoided crisis demand, whilst remaining proportionate about attribution.

'It's never a silver bullet… but it's a factor.'

9.7 Concluding remarks

This evaluation indicates that EdMAC has made a material contribution to improving access to opioid substitution treatment in Edinburgh, with same-day assessment and rapid initiation now embedded as routine practice. Stakeholder accounts, patient feedback, and service monitoring suggest the clinic lowers the threshold for entry at the point of readiness, supports quicker stabilisation on effective doses, and strengthens early engagement during a high-risk period.

EdMAC's contribution is also visible at system level. By providing a consistent city-wide access route and structured titration pathway, it has helped reduce variation in access, improve pathway clarity, and support more coordinated working across NHS and third-sector partners.

At the same time, attribution should remain cautious. EdMAC operates within a wider reform environment and its longer-term impact depends on downstream capacity and interfaces beyond the clinic itself, including hub absorption, primary care uptake, psychosocial provision, and wider housing and mental health supports. Rapid access is therefore best understood as an enabling condition rather than a sufficient solution for sustained recovery or reductions in mortality.

The priority now is consolidation. Sustaining reliable same-day access, protecting clinical safety and wrap-around support, and embedding the model within mainstream commissioning and governance will determine whether early gains endure. On that basis, EdMAC is well-positioned to remain a critical part of Edinburgh's response to drug harms: not a standalone fix, but a durable, compassionate entry point that makes the wider system more likely to succeed.

Chapter 10: Recommendations

10.1 Introduction

EdMAC has demonstrated clear gains in rapid access, early stabilisation, and system efficiency, but it has also surfaced risks around sustainability, workforce resilience, and gaps at the interfaces with GPs, justice services, and downstream psychosocial care. Recommendations therefore focus not only on consolidating the clinic's successes but also on addressing areas where impact may be undermined if uncorrected. These recommendations are structured around four domains (system-level governance and commissioning, clinical practice, partnership working, and data and evidence), reflecting the interdependent nature of the service and its place in the wider treatment system.

10.2 Recommendations and actions for change

Overall, we recommend that EdMAC be retained and embedded as a permanent feature of Edinburgh's drug treatment system, but with adjustments and supports that ensure it remains both sustainable and person-centred. Key actions are listed under each thematic heading below.

10.3 SYSTEM LEVEL: Governance, funding, commissioning for sustainability

Secure long-term funding beyond pilot status

Commissioning agencies should treat EdMAC as a core-funded service, preventing regression to long waiting times. Cost-effectiveness arguments (for example, reduced crisis demand) should be explicitly documented in future commissioning rounds.

Set clear commissioning expectations

Future performance expectations should specify measurable standards (for example, maximum 24-hour wait, defined retention benchmarks, weekend capacity targets if funding permits) to ensure clarity of purpose and accountability.

Plan for workforce sustainability

Recruitment pipelines, succession planning, and protected time for training should be embedded to mitigate staff burnout and dependency on a small team.

Address estate constraints

If demand increases, options for satellite clinics or expanded premises should be explored, ensuring that physical capacity does not cap throughput.

10.4 CLINICAL PRACTICE: Maintaining rapid access, safe titration, trauma-informed ethos

Preserve the same-day access model

The defining strength of EdMAC is rapid initiation; commissioners and managers must resist pressures that could reintroduce bottlenecks.

Continue safe titration protocols

Clinical governance should maintain close monitoring of dosing and side-effects, ensuring that speed does not compromise safety.

Embed trauma-informed practice alongside efficiency

Staff training, reflective supervision, and psychosocial linkage should remain central, countering risks of throughput overshadowing person-centred care.

Expand out-of-hours responsiveness

Where resources allow, consider pilots of weekend or evening access to capture high-risk presentations and prison liberations that are currently missed.

10.5 PARTNERSHIP: Strengthening third-sector, GP, and justice interfaces

Resolve GP outlier practices

Engage with GP surgeries who offer no or restricted provision of OST through targeted negotiation, contractual levers, or alternative prescribing arrangements to ensure equitable shared-care capacity across the city (thus maximising throughput from secondary care and the capacity of EdMAC to respond to new presentations).

Strengthen justice-system pathways

Improve communication with courts and prisons to ensure no ‘slip-throughs’ at remand or liberation. A formal protocol for prison-to-EdMAC referral should be established.

Reinvigorate third-sector involvement

The reduction in third-sector input risks losing valuable wrap-around support. Commissioners should revisit partnership agreements to restore their role in engagement, advocacy, and psychosocial support.

Consolidate hub–EdMAC–outreach coordination

Regular joint MDT meetings should remain the norm, ensuring seamless transfer and consistent information sharing between all partners.

10.6 DATA AND EVIDENCE: Embedding monitoring and contribution analysis in ongoing practice

Integrate and rationalise IT systems

Dual entry into TRAK, PRESS, ILLY, and RedCap remains burdensome; movement towards a single interoperable platform should be prioritised.

Strengthen routine monitoring

Quarterly dashboards should include access times, titration completion, 30-/90-day retention, psychosocial uptake, and patient-reported outcomes, to track both activity and experience.

Embed contribution analysis cycles

Repeat mini-evaluations should be commissioned regularly to test whether intended causal pathways remain plausible and to identify emerging risks.

Expand patient feedback loops

Patient surveys and focus groups should be resourced and systematically reported, ensuring lived experience continues to shape service refinement.

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