ADVOCACY PROJECT

6 MONTH REPORT

MARCH 2022

FAVOR·UK
FACES & VOICES OF RECOVERY

INTRODUCTION

At the start of 2021 FAVOR UK updated its strategies and objectives to reflect our evolution and discussed and agreed the next 3–5-year strategic goals. The strategic plan for the organisation initially focused on the development of an Advocacy project. It was envisaged that this would require a team of four Advocacy workers plus a manager to engage across Scotland. It was accepted that this was ambitious for a new service. However, desperate times require new ideas and with record-levels of drug-related deaths remaining impervious to responses from even the Drug Death Taskforce it was clear that mechanisms to empower the voices of those most affected were essential.

However, desperate times also tend to make responses more risk averse through the fear of making things even worse, and convincing funding bodies that this approach was a necessity was only partially successful. Through the CORRA Foundation, complemented with a portion of unrestricted funding provided to FAVOR UK from the Robertson Foundation, we were able to secure the funds to employ an Operations Manager at 30 hours per week and one full-time Advocacy Caseworker. This would be a pilot to demonstrate the need that had been identified.

The initial aims in setting up the Advocacy project within FAVOR UK is to help those with a history of substance use problems to overcome barriers within the system. This may involve advocating for access to residential rehabilitation, working with other professional bodies and agencies to amplify the needs and aspirations of our clients and working to promote the notion that a one size fits all approach to recovery is not appropriate for everyone. Often the starting point is simply assuring that their wishes and expectations are valid and reasonable.

These two roles were also introduced to challenge the current restrictions that exist within addiction policy areas. There is a distinct lack of collaboration with other bodies within local authority planning and practice in this area. The Advocacy project endeavours to promote effective treatment for all a reality. This needs to be affected and enabled through dialogue, collaboration, listening and on occasion radical change where proof exists that the current system simply doesn't work. The ongoing record-levels of drug-related deaths remove any pretence that the current system is fit for purpose.

On a strategic level, in the face of such system failings, it was agreed that there was an urgent need to develop a professional rights-based service to individuals to challenge the current decision-making processes. With over 100 people in Scotland dying every month from drug-related deaths, it will take time to identify and address where things are going wrong. In the meantime, though, there had to be greater protection for those who were subject to decision-making processes that have been contributing to this intolerable situation.

Operationally we work towards identifying recovery pathways that are in line with the wishes of our clients, even where the preferred options are not immediately available. Referral pathways designed by services are insensitive to the needs of the individual and often contrary to their wishes or needs. As our client group include some of the most marginalised people in society at times when they are most vulnerable, we recognise that they need assistance in articulating their points of view to those who make decisions about them.

This report will focus on the progress that has been made since the Advocacy project started in October 2021. It will outline the initial development of the service, who we have been advocating for. The types of support that we have been able to offer our clients that have approached us will also be discussed. We will outline the successes that our clients have had and look too at some of the challenges that we have experienced while advocating for those that have asked us for help.

Lastly, we will look towards how the Advocacy project has evolved since we began, and how we intend to proceed when looking at the development of the service.

FAVOR·UK
FACES & VOICES OF RECOVERY

OUR APPROACH TO ADVOCACY

One of our key objectives is to reduce barriers to drug and alcohol treatment, whilst looking at local issues facing people seeking support from statutory services.

There are various models that can be utilised when advocating. Every case that we commit to requires us to engage dynamically with problems to develop a plan which falls in line with the client's wishes, and how we approach a client's case to achieve a desired outcome. The most suitable model to work towards this, which we have adopted is a blended case and self-Advocacy model.

Case Advocacy , also referred to as crisis or short-term Advocacy, focuses on one issue or a set of issues, and is not intended to have long-term involvement. The support may be needed because a lot of work needs to be done, because of a breakdown in the provision or service from a statutory agency, or because issues requiring an additional intervention which might have arisen due to other issues faced by a client, e.g., in law, child protection, education, housing, employment, and financial matters. Underpinning all of these factors are the power imbalances experienced by those at the margins in trying to engage with decision-makers.

A **vital element** to the Advocacy work that we have carried out so far has been to **promote self-Advocacy.** We involve and inform our clients of every step that we take on their behalf, and the rationale behind each possible approach to be considered. As we are constantly respectful of the fact that we are advocating on their behalf we compel ourselves to ensure that they are as informed as possible at every step of the process.

By involving our clients in the discussion around their rights and options, we are not only assisting them to negotiate the current situation but raising their awareness of the processes involved to empower them to be better equipped to confront similar situations in the future.

Our operational strategy for advocating is guided by two simple and interdependent core values; **actively listening** to our clients and **respecting their wishes** in everything we do.

We are effective as, first and foremost, we listen. This might seem obvious but many of our clients have a long experience of being listened to but never heard or, even worse, ignored completely. These experiences of our clients are the consequences of practices within the system that are a part of the problem we need to address.

The best way for us to respond is through leadership, by employing the standards that we expect others to match. Therefore, the personal stories and the experience of our clients is at the core of everything that our organisation does.

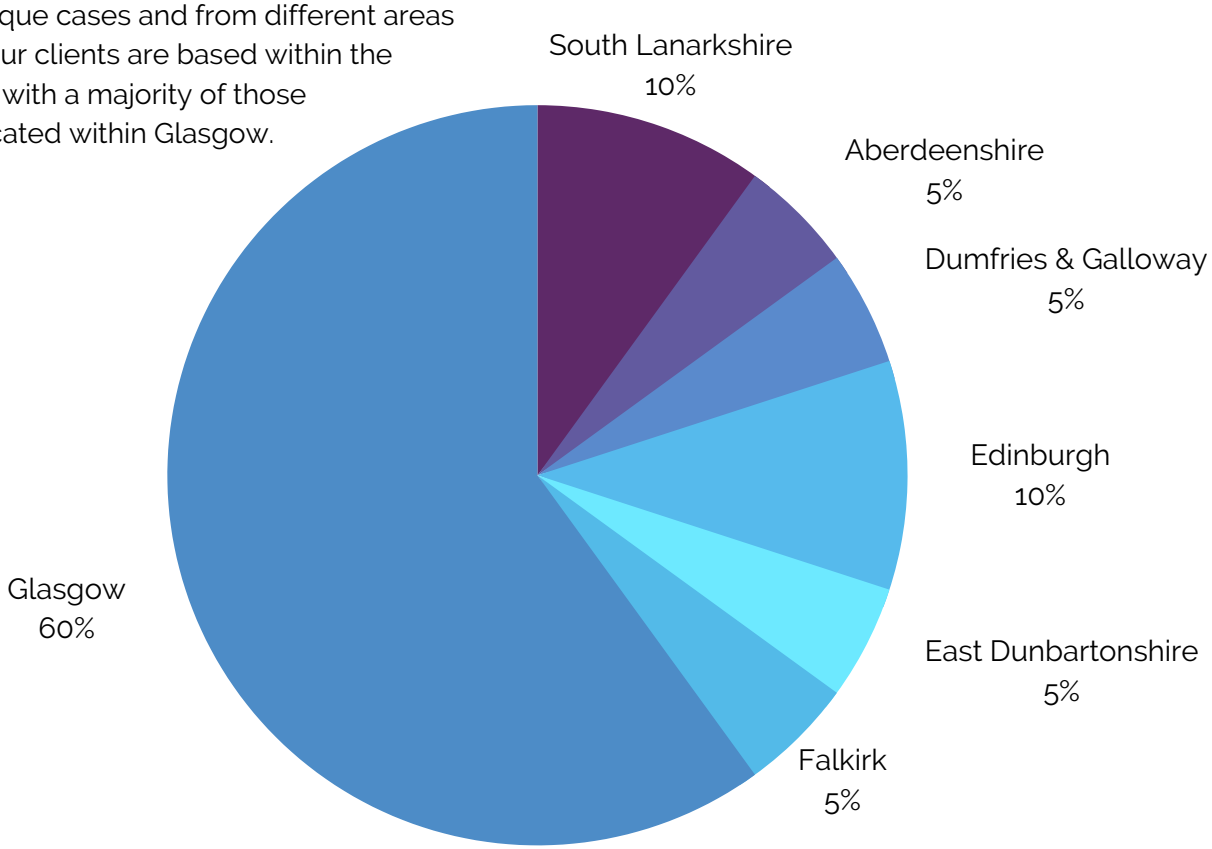
Secondly, we maintain a clarity of purpose by keeping our clients' wishes in sight. Our plans must always endeavour to work towards an end which is purposeful, with clearly defined goals, our goals are client focused and always measured against the aspirations and needs of the people that we work for.

Since the start of this project, we have worked with twenty one individuals and their families over seven separate local authority areas. Our initial approach is to physically meet with our clients wherever they may be. We are an outreach-based service which is community-focused in its outlook. By taking this approach we learn about and understand the types of localised issues that people might face when looking for help.

Understanding local issues and services that exist within each locality where we work has allowed us to build up a unique understanding of the policy differentiation that exists between local authorities and how they manage their duties when dealing with those in their care. This understanding of local landscapes has also enabled us to build up relationships with other organisation that address addiction and recovery within the public and third sectors.

WHO WE ADVOCATE FOR

To date we have taken on twenty-one clients. Seventeen of the clients are male, and four females. Each have presented to us with some with unique cases and from different areas of the country. Most of our clients are based within the central belt of Scotland, with a majority of those approaching for help located within Glasgow.



Our Advocacy project, although concentrated predominantly within the central belt (a function of the limitations of this pilot stage), is well placed to ensure that our staff team are responsive when called upon to work within other areas within Scotland. Our staff team have committed to helping those who need it, within their communities as and when called upon.

Every client that we have worked with so far are at different points in their journey towards recovery. In Scotland, each local authority offers a statutory service to respond to the needs of those with addiction issues within their boundaries. These Alcohol and Drug Recovery Services (ADRS) would be the first point of contact for most people looking for help with addiction issues.

Local ADRS teams are briefed with supporting individuals to access client specific treatments, to implement care plans and work with other statutory services such as social work services, NHS mental health teams and local authority umbrella organisations that look to offer support for addiction within communities.

The graph below shows that at the point of FAVOR UK getting involved with a client, more were already currently engaged with statutory services than were not.

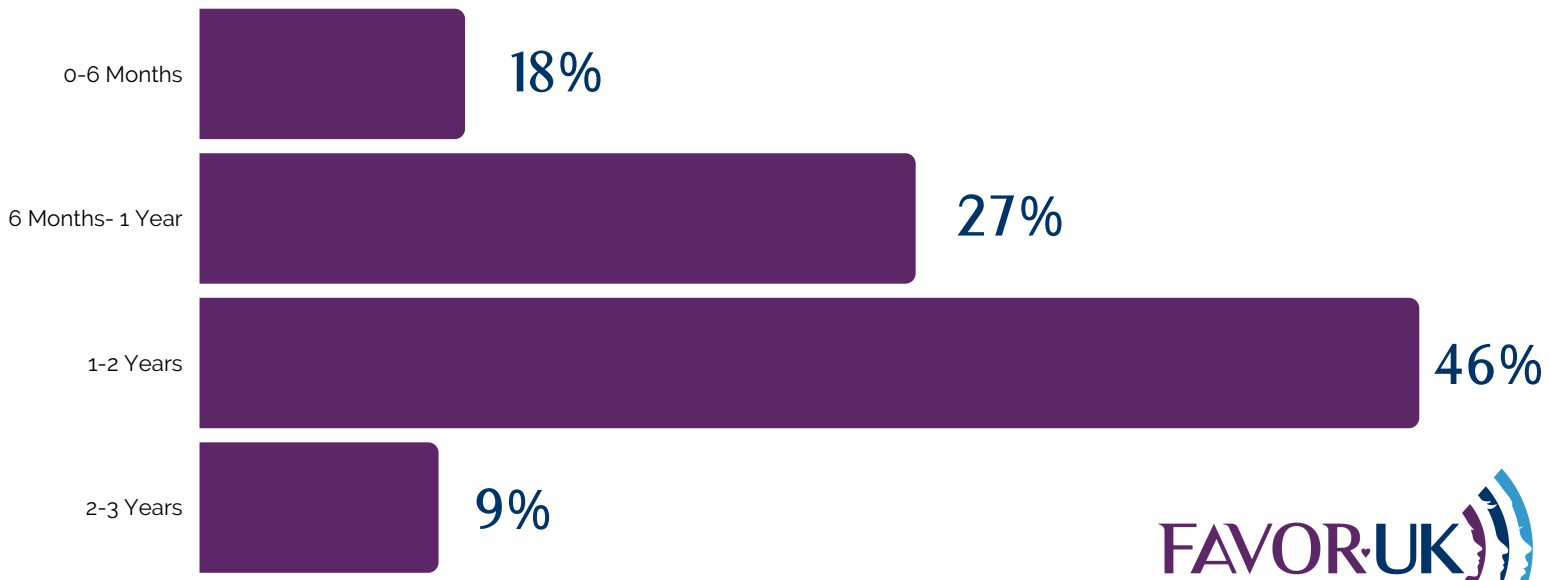
FAVOR·UK
FACES & VOICES OF RECOVERY

WHO WE ADVOCATE FOR

The chart below outlines one of the main problems that individuals face when engaging with their ADRS. Clients express a desire to get the treatment option that they consider to be right for them. For addiction problems that have reached the severity that someone is asking for help, time is a crucial factor. However, for those who identify their need as residential rehabilitation, services don't appear to take this into consideration when building a plan for individuals to move forward to anything other than community-based treatment.

This undermines factors such as hope, that keep people alive when everything else has gone. It also undermines factors such as motivation, which is crucial for change.

TIME CLIENT ADVISED THEY HAVE WAITED FOR RESIDENTIAL TREATMENT SINCE BEING INVOLVED WITH ADRS



FAVOR·UK
FACES & VOICES OF RECOVERY

Eleven of our clients were already engaged with services, and each of these were involved in different ways prior to FAVOR UK taking on their case. **All** reported negative experiences of the system. The rest of our clients were not currently engaged with services. Most of this group reported that this was due to them not knowing who to ask for help.

For those clients who were not involved with services, we have linked them all to their local ADRS.

The eleven clients who were already engaged with, their ADRS teams all reported to their FAVOR caseworker that they were having major issues with the time that they had spent waiting for progress with their case. Each client was fully engaging with their local service, and they were looking for a form of residential treatment.

The desired outcome for all these clients was to be able to access a residential rehabilitation programme.

It is important to note that for those eleven clients who the ADRS have been working with, all have been offered varying degrees of support and been provided access to varying levels of community-based programmes for them. However, these eleven individuals **all felt that their voice and their wishes to access residential programmes had not been listened to.** All felt like they were being told to recover within their communities, which they assessed as impractical due to the exposure to drugs and negative influences within the community where they lived.

It is also important to note that there is no suggestion that the clients accessing the FAVOR UK Advocacy Service are representative of all those accessing ADRS services or even all those in need of help for addiction problems.

This a group of individuals who all found themselves in circumstances where they felt they needed to reach out to an Advocacy service for support to engage with their local ADRS.

It is unclear if they are representative of a small group of dissatisfied service users or a much larger population. However, it would be negligent, in the midst of the drug-related deaths crisis, to be anything other than open-minded to the possibility that this is the **"tip of an iceberg"**. Our preliminary findings in this matter will be discussed later.

However, for the moment, it is also relevant to point out that the vast majority of those who did engage with our Advocacy Service had been receiving significant levels of family support, and indeed in many cases it had been a parent or a sibling who had made the referral. One common phrase that has been mentioned to us over the last few months, by clients, family members and even ADRS case workers, "How many more people are out there who don't have the support of organisations like FAVOR?", or how many more are out there who don't have family members to keep fighting for them when their hope has gone?

One common phrase that has been mentioned to us over the last few months, by clients, family members and even ADRS case workers...

"How many more people are out there who don't have the support of organisations like FAVOR?"

"How many more are out there who don't have family members to keep fighting for them when their hope has gone?"

FAVOR·UK
FACES & VOICES OF RECOVERY

FAVOR UK INTERVENTIONS

Since the start of our Advocacy project, we have found that there is a worrying disparity in how each local authority engages with FAVOR UK and our clients' wishes to have independent Advocacy involved in their case.

We have struggled in some cases to even have caseworkers within these services to respond to emails or take our calls to discuss a client's case. Even as we have struggled to connect with certain ADRS in some cases, we have still offered any support that we could to clients to try to find alternative support outwith their local ADRS; examples of this issue include:

CLIENT T

A client who has been engaging with Glasgow South ADRS had asked us to request a meeting between him, FAVOR UK and his new caseworker to discuss his treatment and ongoing care.

This request was submitted on the 4th March 2022.

There has been no positive response from this service to date regarding the meeting request, as his caseworker is off on sick leave and the service do not appear to be able to cover this absence. This client asked us to help him with an alternative recovery plan, he is interested in exploring music therapy as a way of helping him recover.

FAVOR UK have referred him to Nordoff Robbins in Glasgow, who are working to try to accommodate him within their service.

This client had previously been subject to an overdose, while in hospital, reportedly, as a result of a clerical error in his notes about his methadone dosage. This error was, reportedly, between the ADRS and the Hospital involved. Given these circumstances, we would have expected a greater effort towards patient care. Unfortunately, this has not yet transpired.

CLIENT A

A client from East Dunbartonshire who we were supporting for two months before we were able to get a response from their service, despite numerous calls and the client even telling them to contact us directly.

However, the individual caseworker involved in the client's care has still not responded to our enquiries. All contact with this service has been via a social worker who was not the lead worker and our client's GP. We eventually managed to push this service to provide a residential placement for the client after being involved in his case for three months.

A freedom of information request, published by a journalist, revealed that this local authority had made no spending of referrals to residential rehabilitation in 2019 to 2020, in the immediate run-up to the lockdown.

After we eventually persuaded the ADRS to agree to a referral to residential rehabilitation for the client, we were surprised to be asked if we could complete their financial assessment with the client on their behalf. Several weeks after the client had entered the residential setting, the ADRS contacted us to ask if we would be able to get copies of the client's bank statements for their records.

While we are aware from numerous anecdotal reports that workers have been discouraged from making referrals to residential rehabilitation in recent years, from several local authority areas, this case left us with the distinct impression that ADRS workers and managers had become so unused to making these referrals that they had become unfamiliar with how to do so. This may reveal a training need across the country's statutory addiction services.

The problems with communication in this case, and others, appears to have been created by what is difficult to describe as anything other than a culture of secrecy.
The Service Manager's email address could not be found anywhere on the internet, as with other areas.. The only way to contact the service was through the main switchboard. Numerous messages were left with the switchboard in exchange for assurances they would be passed on directly to the worker. The worker never replied to any of these requests.
Our only break-through came after contacting the local ADP Co-ordinator to request the service manager's email address (and even "who is responsible for the service in the manager's absence?"). A senior worker responded and finally we achieved some progress. But, still, we experienced clear resistance in our requests for the emails of individual workers.

Even the family identified that their calls to the worker were no longer being returned after they had approached FAVOR UK to represent their son.

FAVOR·UK
FACES & VOICES OF RECOVERY

CLIENT J

One vulnerable client who is served by Glasgow North West ADRS instructed us to write a letter supporting her desire to get assessed for residential rehabilitation. We submitted this letter in early February 2022, the service has still not provided a response to this request. Our casework team have asked on multiple occasions for a decision and has been ignored. In the meantime, we have supported this client through an increased engagement with community groups to offer her more support.

This client came to our attention after she had presented to the Drug Crisis Centre hoping to be assessed for their residential programme. After the client's ADRS worker was notified, she intervened to encourage the client to instead think about going into the Stabilisation Unit instead. The client agreed.

Several weeks later, the client had still received no word about either the Stabilisation Unit or her preference of residential rehabilitation. After we pressed further for updates, there appeared to be a rapid availability of a place in the Stabilisation Unit.

While this was not what the client wanted, she was desperate for a place of safety and accepted the only offer available. However, we reminded the ADRS team that the client retained the wish to be referred to a residential rehab in order to get off of all substitute medication.

Although her stay at the Stabilisation Unit was successful, there was no follow-up on her preference of rehab. Several weeks later the client has relapsed badly. In retrospect, it is difficult to imagine how this was ever expected to result in a successful outcome.

The client identified her preferred outcome to be free of illicit substances and opiate replacement medication. The support she identified to achieve this was residential rehabilitation. The response was to refuse her request for her preferred treatment and, instead, offer her nothing but a different intervention that she did not want. Beforehand, this alternative intervention was presented to the client as "similar to rehab". Afterwards, she would discover that, not only was Stabilisation not the same as Rehabilitation at all but, it had pushed her even further away from her preferred goal of being drug and opiate replacement free.

And after all that wasted time, effort, money, trust and hope, the client has relapsed and still requires residential rehabilitation. There are surely cautionary lessons here on the conflict between short-term savings and long-term investment in people.

FAVOR·UK
FACES & VOICES OF RECOVERY

CLIENT S

Another female client in Glasgow North West had been referred to the Stabilisation Unit instead of her preference for residential rehabilitation. Again, she took up the only offer available, but asked that her request for residential rehabilitation remain in place as her aim was to get off of all medication. This was refused, as the view from statutory services appeared to be that residential rehabilitation would be inappropriate after a stabilisation programme. The ADRS was reminded that the client was a single woman fleeing harassment from two men who she did not have the confidence to keep out of her flat whenever they appeared. Her accommodation was no longer a place of safety and relocation should have been an urgent priority.

Despite this, the ADRS refused to consider a referral from the stabilisation unit directly to residential rehabilitation. Due to the urgency of the client's situation, FAVOR managed to secure a free place at a new residential service, to everyone's relief.

Except for the ADRS. All they had to do was send the client's methadone prescription to the residential provider's local pharmacy, until their Home Office Prescibing Licence arrived. They refused. On the very day the client was to be discharged back to her flat, with the only concession being one extra night in the Stabilisation Unit.

Again, due to the unaddressed safety concerns, FAVOR contacted the client's GP to see if she would be willing to assume the methadone prescription along with her other medications, to allow the rehab placement to proceed. This was agreed.

However, still not content to allow this free referral to succeed, the ADRS spent the next 24 hours trying to persuade the client's GP to convince the client to accept a new offer they had suddenly produced, for a rehabilitation service in Glasgow that they had previously rejected. The client refused this, telling her GP that she no longer trusted the ADRS.

The client entered the new residential service the next day and has been a huge success, having already begun a detox programme to completely come off of her methadone.

This case was taken to the local MSP, Bob Doris. The situation alarmed him so much that he contacted the Drugs Minister, Angela Constance, and demanded explanations from the Heads of both Glasgow City Council and Glasgow HSCP.

This has instigated a review of all requests for residential rehabilitation, including the range of providers available that workers can refer to and the different rehab approaches available. The client also received apologies from both, via her MSP.

FAVOR·UK
FACES & VOICES OF RECOVERY

GENERAL EXPERIENCES

We have also detected patterns of similar approaches to specific problems being adopted in more than one area. These approaches are often in opposition the Scottish Government guidance, and likely shared at local authority or health board level. These include policy approaches to the handling of disagreement with treatment decisions.

The examples above are at the extreme end of the questionable practice that we have experienced from local ADRS teams. However, we have also built up positive relationships within the local authority areas where we represent clients.

South Lanarkshire Council are a particularly good example of this relationship building. Our two clients that reside within SLC have been treated fairly and have been able to express their voice as to the type of treatment that they need.

This local authority links in well with other statutory services such as mental health, social work, and community groups to provide a well-rounded service to those that need it. This statutory addiction team has stood out clearly in terms of its transparency and we have never struggled to find information for a client and are always welcome at client case reviews and meetings.

FAMILY ADVOCACY

There has been a definite trend in how we receive an initial referral for a client. All but four of our clients were referred to us by a family member. In these sixteen cases, it has either been a parent or a sibling that has asked us for support. In all cases where a family referral has come to us, the family have been trying to support their loved one to navigate a service or access any help that they could. In most cases, the family have been trying for years to get their loved one away from alcohol and other drugs. In many of these cases, the client has been waiting for years for the treatment that they felt that they needed.

We have seen remarkable efforts from families to advocate for access to treatment programmes. In some cases, the strain of this intense support has had a major impact on those supporting the individual. In one case, the client's mum had been trying support her son through an acute mental health disorder and his substance use disorder for over three years prior to FAVOR U getting involved. This had a drastic effect on the client's mum. She suffers from anxiety and stress, she had to take long term sick leave from work as she was not coping with the effects of the client's addiction on the family.

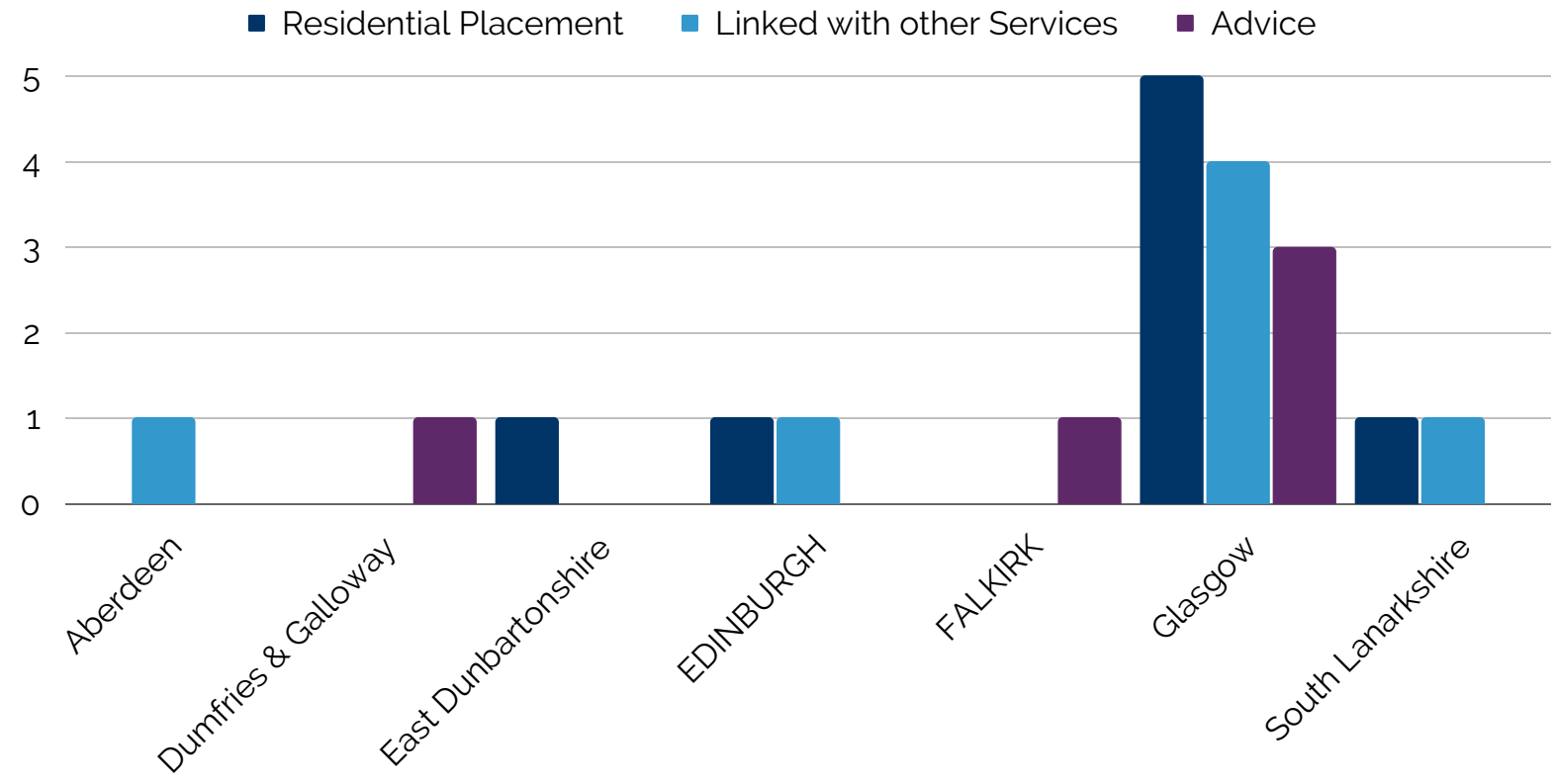
Another client's sister had been supporting her for over 10 years without Advocacy support. She had been fighting on multiple fronts to get her sister the help that she needed, with very limited progress. The client's sister advised our Advocacy caseworl that she just wanted a normal sisterly relationship with the client, but that had become impossible as she felt that over the years, she had become her carer. The sister advised us that she was "sick with worry, that she would find her loved one dead"

The two examples above are typical of the stories that we have been hearing when discussing cases with family members of our clients. In all cases the family dynamic changed due to substance misuse and the client's addiction, and lack of any meaningful progress through the system has had a detrimental effect on the mental wellbeing of family members.

Once we take on a case it gives families of those that we are advocating for a bit of breathing space and allows them to be a b more detached from the issue. With the knowledge that FAVOR UK are taking on an Advocacy role for their family member, they are able to return to focusing on relationships that are not solely formed around trying to support their loved one through their journey towards recovery.

DESTINATIONS AND EXTERNAL RELATIONSHIPS

From the start of our Advocacy project, we have worked to ensure that every client that we take on has access to the vital services that they advise that they would like to engage with. Most clients have the aim of accessing residential rehabilitation. In most cases this takes longer than desired to achieve, even with Advocacy support. We try to explore all options available for pathways through recovery for our clients. The graph below shows how we have helped all twenty of our clients so far.



We define a residential placement as anywhere a client has been placed within a secure setting for a period for drug/and or alcohol treatment. Eight of our clients have been placed within a residential setting whilst we have advocated for them.

Linking our clients in with other services out with statutory services is also a vital part of the work that we do. In most cases a client will be asked by their ADRS to engage in a period of community-based recovery treatments before residential placements are considered. We see how important this period is for a client and try to link them in with support networks and community-based organisations that will support then on their journey towards recovery.

The breakdown below shows how we have supported each client and where they currently sit within the range of the support we have offered. It is important to note that most clients have had support across all three of the subcategories. For example, we have given advice, linked most clients in with a service and advocated for further interventions.

Residential Placements

Linked with Other Services

Advice

FAVOR UK have linked in well with rehabilitation services when working with clients. Our Advocacy service has developed a number of positive partnerships with other support organisations. We have attended case review meetings for three clients who managed to get entry to the Glasgow Stabilisation Centre. We have developed very productive relationships with both the Stabilisation Unit and Crisis Centre from our engagement with them on behalf of our clients.

We have connected with Calderglen House in Blantyre, a new provider of residential rehabilitation in Scotland. This new provider gifted to FAVOR UK the opportunity of a free six-month placement in their new facility. In December 2021, after an extremely careful series of considerations, we allocated it to one of our most vulnerable clients.

Our Advocacy team have made great strides within the first six months to identify services that we can work with to ensure our clients are getting the support that they need. We have built up very good relationships with external community-based organisations. In Glasgow, we have worked with clients to access services such as We Are With You, a commissioned community rehabilitation provider. In South Lanarkshire, we have buddied a client who was too nervous to attend services on his own, until he had the confidence to go to the Beacons Centre in Blantyre alone. This service runs a full programme of activities for south Lanarkshire residents who are struggling with substance misuse.

One of our key referrers is SISCO in North Glasgow, as they recognise the importance of this type of assertive advocacy. This organisation has referred families and individuals to us since the start of our project and have provided us with room space to meet with our clients. SISCO, in turn, invited us to attend their recovery café group in HMP Barlinnie. The purpose of this visit was to help to identify the distinct barriers experienced by prisoners as they attempt to re-engage with community services upon release. We intend to follow this up to provide a clearer picture of these particular issues.

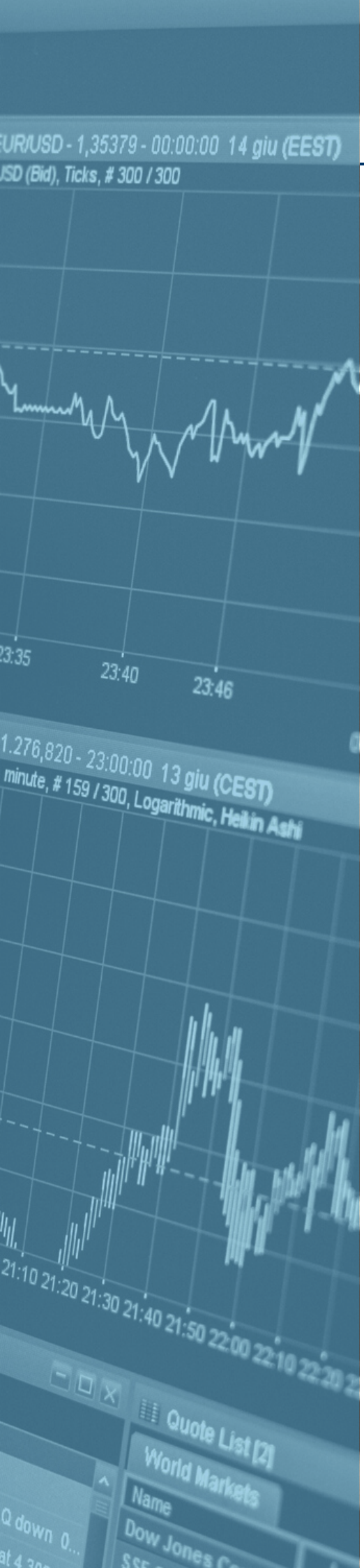
We have also built-up relationships with national organisations such as Shelter Scotland and Nordoff Robbins music therapy. One of our clients asked us to support her to re-engage with the Richmond Fellowship, with whom we managed to negotiate a new care package for her and we regularly attend joint agency meetings with this organisation and social work services to discuss and plan her care. These multi-agency meetings have also been a feature of those clients who have been referred to the Stabilisation Unit.

MOVING FORWARD

In the initial six months of the Advocacy project, we have made good progress and believe that we are learning more about the diverging drug and alcohol polices in different areas, with every client that we work with. We will continue to tackle the issues that our client's face, directly, and support them to receive the help that they ask for. Our service will promote what we do within communities to ensure that anyone who needs Advocacy support know that we are here and ready to support them.

The work that we do and the type of support that we offer will continue to evolve and we will continue to build meaningful relationships with organisations that we believe will help clients to recover. We hope that we are able to help more that 40 clients with meaningful support within the first year.

In addition to these 40 clients, we have already begun to have existing clients re-engage with the service for additional barriers. These are separate engagements and will be recorded as an added value to the service rather than buried within the numbers of individuals we claim to support. In other words, the numbers of individuals we identify in our reports will be distinct people, and additional engagements with the same people will be clearly identified.



FINANCIAL BARRIERS

It is clear that one of the main barriers to referrals to residential rehabilitation is the cost of this type of provision. While the Scottish Government are exploring top-down approaches to this problem, such as a national fund for local authorities to draw down the funds they require, FAVOR have already begun a potential grassroots solution.

We have begun discussions with Self Directed Support Scotland (SDSS) to explore how Self Directed Support can be made more accessible to those seeking treatment or support for addiction problems. SDSS have themselves identified their bewilderment at why the Addictions Sector have not engaged with Self Directed Support, and have been delighted to find that FAVOR has the same view.

There are strong parallels with the development of care homes and our current situation with residential rehabilitation. Although care homes, such as for the elderly, involve huge amounts of money, the financial costs are dwarfed by the costs of looking after every individual in their own homes. Care homes only became possible because they became the cheaper option.

The situation with residential rehabilitation is precisely the reverse. Despite the Scottish Government's pleas for more councils to send more people to residential rehabilitation, there are huge pressures in every local authority, and in every ADP, to erect more barriers because residential rehabilitation is the more expensive option.

This begs questions about why people in withdrawal or in the early stages of recovery, and whose condition is likely to deteriorate if they are left alone, are systematically left to face their nightmares on their own. If addiction was considered in the same way as dementia, then care at home would become the norm, and residential provision would soon become the cheaper option. This suggestion may become even more persuasive if we also consider that, unlike dementia, people recover from addiction if they receive the right support.

This transformation could be achieved if we changed the language of treatment for addiction away from the type of provision and towards the type of need. If a consensus could be achieved that someone in early recovery was not safe to be on their own, as with dementia, then residential rehabilitation could soon become a commissioner's favourite provision.

Self Directed Support, with individuals becoming their own decision-makers, may be the key to opening the gates to a new paradigm.

This work has already begun, and FAVOR plans to explore this as far as possible with SDSS. Both organisations are in agreement that, in the context of Self Directed Support, there is no reason why addiction needs should be considered any differently from those care and support groups where it has already been established.

From the work we have engaged with to date, there are a number of cultural practices where statutory services appear to have created barriers to their own services, and many of these appear to have been employed more frequently as a result of the pandemic.

We suggest that each of these practices are considered in the context of a public health crisis of record levels of drug-related deaths. We would also suggest a harm reduction consideration of each, on the basis of whether they are likely to reduce or augment the risks of drug related deaths.

1. Service Managers' contact details withheld from the public

Lack of public access to the contact details of the service managers of addiction services, to us, appears to be a particular barrier for family or friends who may need to contact service decision-makers. It is also a barrier to any client who may wish to make a complaint about the service.

2. Addiction teams withholding their phone numbers when making outgoing calls

Calls from addiction services have been received on lines that have "No ID". This has been witnessed by both our staff and clients. This has caused uncertainty for the clients, as many have a range of reasons to avoid answering any unknown numbers. This has also created barriers with our staff as we are unable to return calls to workers, and any other organisation. We also believe that these are obvious considerations that, had they not been overlooked, would have prevented such decision from being made at all.

3. Drift towards Abandonment of Clients

The pandemic was a problem for everyone to find new ways of working. However, those receiving support from addiction services appear to have been abandoned during this time. We have numerous clients who claim that they did not receive any support during the pandemic, and supervised methadone prescriptions suddenly became unsupervised. This was understandable and excusable, for a period of time.

However, we have clients who have still not seen their worker in months. We also have a client, who approached us to recover her deceased daughter's medical records. This mother wants answers and accountability, as she says that her daughter phoned every day for 62 days, begging for help, until she died on the 63rd day. No-one phoned her back until after her death was known.

4. Planned Abandonment of Clients

We have received claims from our clients that their ADRS operates a duty service that is staffed by a rotation of workers taken away from their caseloads for periods of two weeks at a time. During these periods, these duty workers are not permitted to support the individuals on their caseloads, unless they call the duty worker.

If true, and we believe that it is, then the drift towards an abandonment of clients brought about by the pandemic has been normalised into post-pandemic service planning.

5. Irresponsible Decision-Making

We have discovered that certain decisions, such as, referrals to residential rehabilitation, are conducted in ways that are contrary to Scottish Government guidance on effective administrative decision-making.

Our experience has discovered that these decisions can be made by "Multi-Disciplinary Teams" with no apparent accountability. The clients never meet these groups, who provide no written decisions, provide no reasons for their decisions, and have no appeal or review processes in place. When approached for clarity on these areas by FAVOR, on our clients' behalf, our requests were simply ignored.

This conduct is completely unacceptable, and we will be developing a much more assertive and robust approach to make these processes much more transparent.
We are currently considering a number of options, such as ensuring that every ADRS manager is aware of the Scottish Government Guidance; Right First Time, and making all clients aware of the option of securing a copy of their health records.

6. Irresponsible Policies

We have discovered huge variations in policy approaches in different ADP areas. Some of these policy approaches also appear, to us, as being likely to contribute to the number of people dying from drug-related deaths rather than to prevent them. One example of this is a local authority that has particularly punitive approaches to those seeking help. In particular, their policy position for referrals to residential rehabilitation includes a six-month ban from being referred again if they miss an appointments in the referral process.

As well as being an effective blanket ban that courts could strike down for failing to consider individual circumstances, this is also likely to be demoralising to many and contrary to any understanding of the crucial role of motivation in behaviour change.

We plan to conduct a policy audit of all local authorities and ADP areas, in order to identify good practice and promote these in favour of those that may undermine individual recovery.

7. Inappropriate use of Human Resource management of clients

We have experienced two local authorities who have adopted a Complaints Process approach to the management of disagreements over treatment options. In one case the client sent an email saying he wasn't happy that he'd been denied a referral to rehabilitation and tried to plead his case for the decision to be reviewed The ADRS involved interpreted this as a complaint and forwarded it to the council's complaints department, even though the client made no mention of making a complaint. The Complaints Team then interpreted their own chosen grounds from the email, in ways that would easily be defended by the Council.

Our first involvement for the client was to instruct the Council that the client had not made a complaint and wanted the matter handled informally with the relevant team. As well as being in breach of GDPR, the client did not want to engage in a confrontational process with those he was seeking help from, and the complaints proces would involve a necessary suspension of support from the ADRS. We believe these types of approaches need to be discussed in terms of whether they are appropriate ways to handle such matters, especially without the consent of the client involved. This is another area that we intend to conduct a policy audit of all local authorities and ADP areas, to share good practice and encourage decision-makers to abandon these relationship-destroying approaches.

8. Lack of accountability

Our Advocacy Casework Officer is new to the drug and alcohol recovery sector, having previously worked across other policy areas supporting people. He was shocked to learn about how unorganised and disjointed statutory services were when dealing with clients. Unified national pathways, where there is one standard in which statuto addiction services should adhere to do not exist. This gives room for those services that are failing clients and are neglecting their needs to do so without accountability.

Abuse and neglect of vulnerable individuals and a shocking disregard for their welfare is rife within this sector. Since starting to work with our clients, our casework team have been exposed to shocking stories of how they have been treated by some individuals and indeed by certain Alcohol and Drug Recovery Services as a whole.

These kinds of abusive conduct have been reported to the Operations Manager and CEO of FAVOR, such as beir shouted at, either in person (in their own homes) or over the phone. Unfortunately, clients often do not wish to name the workers involved or wish to deal with the issues, partly for sympathy for the workers involved, partly fo fear of losing all support, and partly because they have become so accustomed to such abuse that they do not consider it to be unacceptable.

We recognise that there are grounds for some form of Whistle-blowing resource, and FAVOR may be well-place to develop such mechanism. However, until such a facility is in place, FAVOR will continue to advocate for those clients who need support to overcome such power dynamics and introduce some form of accountability.

9. Contracts Before Lives

Our work in Glasgow uncovered arrangements at the city level, across three supposedly independent ADPs, to inhibit referrals to residential rehabilitation providers outside of the city boundaries. This arrangement was finally admitted to in response to our client who we secured a free place at a new residential provider outside the city.

The implications of this arrangement is that contract's with two preferred providers prevent the spot purchase of placements in other providers. This meant that people in desperate need of residential rehabilitation were told they had to wait indeterminate periods of time for a bed to become available in a contracted provider, while beds lay empty in other locations. This is an ethically unsustainable position and begs questions of how many people died waiting for residential rehabilitation while beds lay unused.

We have already secured confirmation of these practices in our support of Client S, and Bob Doris has secured promises of review from the leaders of the Council and HSCP. Now we have initiated these discussions, we plan to develop this further in our policy audit processes.

FAVOR·UK
FACES & VOICES OF RECOVERY

https://www.facesandvoicesofrecoveryuk.org