FAVOR·UK
FACES & VOICES OF RECOVERY

ANNUAL REPORT 2022

Blueprint to Save Lives

Ignoring the drug death crisis is the status quo for Scotland's politicians.

Foreword

In the middle of the economic cost-of-living crisis that we're all facing, we need to make sure as a society that we don't forget about Scotland's drug death crisis.

But it won't surprise me if our political elite do exactly that. It's entirely predictable that the Scottish Government and Scottish Parliament will not pay enough attention to the scale of the tragedy that is devastating our communities.

Maybe I sound cynical. But it's for a good reason. Ignoring the drug death crisis is the status quo for Scotland's politicians. For years, they were detached from the reality on the ground, out-of-touch with the real world on the streets of Glasgow, Dundee and countless other towns and cities.

The First Minister, Nicola Sturgeon, was perhaps the most honest I have ever heard a politician be when she admitted that she had 'taken her eye off the ball' on Scotland's drug death crisis. That's exactly it - the government overlooked what was happening.

Look at the consequences on our streets. The political elite's lack of interest is the reason why we're in this awful mess, where we have the worst drug death rate than anywhere in the United Kingdom or any other country in Europe.

The drug death crisis gets shunted to the back of the queue when something comes along that is deemed to be more important.

Of course, the cost-of-living crisis is vitally important. Millions of people are struggling to get by. It's the defining issue of 2022. I don't dispute that. But the economic crisis doesn't mean the drug death crisis is put on hold. If anything, it makes it even more tragic and acute.

And I don't think anybody, least of all the politicians, should feel it's ok to forget about those suffering drug addiction just because there is a wider economic crisis impacting more people. The Scotland I know is better than that.

FAVOR and our allies will keep working as hard as we can to help people on the ground and make sure that the Scottish Government and Scottish Parliament remember we have a crisis on our hands that needs to be tackled.

The problems in our communities have not gone away. So FAVOR won't go away either. We'll keep working to get people the help they need and deserve.

Yours Sincerely,

Annemarie Ward, FAVOR SCOTLAND CEO

Executive Summary

There is a 'postcode lottery' of treatment. Residential Rehabilitation referral processes are still inconsistent across the country, with some areas refusing access to facilities outside of their area.

Some people have been waiting years for appointments with recovery services. Engagement with Alcohol & Drug Recovery Services are inconsistent in their provision of support to service users. In many cases, people have not been provided with appointments for several months, and sometimes years.

People seeking treatment are being sent to pretend rehab services. In some cases, clients are misinformed when referred to a stabilisation service instead of their request for residential rehabilitation.

Treatment for too many people is solely pharmaceutical with no mental health support at all. Medical Interventions have become the only support provided to many clients using ADRS services, which now focus only on managing substance dependence. Psychosocial Support is not being provided to many clients, failing to support for their attempts to resolve their addiction, contrary to UK Guidelines on Clinical Management for Drug Misuse and Dependence.

People seeking treatment often have no agency in their own treatment. Decisions for referral to residential rehabilitation are often made without any opportunity for the client to meet with the decision makers, denying them the opportunity to express their individual circumstances. Some ADRS services provide only a commissioned advocacy service rather than provide clients with the opportunity of choice.

Some services have introduced complaints management processes. Management of ADRS services have in some areas introduced complaints processes to manage disagreements over treatment choices.

The Scottish Government MAT Standards have been a let down for people seeking treatment. MAT Standards have failed to be implemented as and when intended, with some clients having to wait months for methadone prescriptions.

Services are not always engaging in ways that work for people suffering addiction. Means of communication with clients are often counter-productive, such as the use of withheld phone numbers.

Six key recommendations

1. Introduce a clear definition of a residential rehabilitation place, so that nobody is sent to pretend rehab facilities that are really stabilisation or detox services.

2 Introduce a centralised referral and funding system to end the postcode lottery, provide a more consistent approach across the country, and allow for rapid sharing of best practices across services.

3. Introduce guidelines to ensure that psycho-social and mental health support is provided alongside substance management and pharmaceutical treatment.

4. Introduce statistics to measure the number of people waiting more than six months, 12 months and 24 months for residential rehabilitation places and other forms of treatment too.

5. Introduce a Right to Recovery Bill to ensure that the Scottish Government MAT Standards are actually implemented and people seeking treatment can actually get it.

6. Return to community not centralised services. All of the evidence confirms that the centralisation of services has not worked and a return to community-based rehabilitation and recovery services would be beneficial.

Background: FAVOR and drug deaths in Scotland

In July 2019, it was revealed that there were 1,187 drug-related deaths in Scotland the previous year. That fact shocked and embarrassed the country. Various theories were put forward to try and explain the catalyst of the situation. The suggested causes included the impact of poverty, the ongoing effect of stigma, an ageing population and many others.

However, while these theories may explain in part why drug deaths have increased, they do not explain why Scotland's drug death figures have rapidly become worse than every other country across the UK and Europe.

At this time, FAVOR UK was asked to help. In August 2019, a candle-lit vigil was held in George Square, to commemorate not only those who had died, but also the bereaved families. One person after another spoke for the first time of their loss, while finding some comfort in the knowledge that they were not alone. These people spoke not only of their own losses, but also of the huge scale of deaths in their communities. As the evening drew to a close, the mood turned to action, and FAVOR were asked repeatedly to find a way to change what was happening.

Over the next six months, FAVOR immersed itself in the areas of Glasgow most impacted by the increase in deaths. The aim was to hear from those most affected about what the problems were from their perspectives and how things could change. This engagement with the public included a series of community consultations in Possil, Maryhill and Springburn.

It provided the evidence to produce a report that included 23 recommendations. which were passed to the Scottish Government and the newly launched Scottish Drug Death Task Force.

FAVOR continued to meet interested parties across Scotland for the next 18 months, and continues to work with communities to tackle this crisis.

FAVOR's mission

As drug-related deaths rose, FAVOR decided to extend its operations from its traditional group advocacy in the form of campaigning and towards individual advocacy. With the support of funding from the Corra Foundation, the Advocacy Service was launched in October 2021 on a pilot basis for one year. This was tasked with supporting 40 people across Scotland, with the aim of supporting those most at risk from drug-related deaths to overcome barriers in accessing the treatment of their choice.

A second aim of the service was to seek to understand the barriers to treatment identified by our clients and to highlight any areas that may inadvertently contribute to the numbers of drug related deaths. Most of the theories put forward to explain the situation attributed the cause to societal factors; none seemed to question the addiction service system itself. We felt this was important.

In 2022, the Scottish Drugs Death Taskforce was discontinued at its final report revealed that the latest levels for drug related deaths for 2021 was 1330. This was 12% higher than the 2018 figures that were so horrific that the taskforce was launched, with its mission to turn around the situation.

In September 2022, FAVOR were grateful to find that its plans to progrezz with the Advocacy service had been continued with another four years of funding beyond the pilot phase. A preliminary report was released in April 2022, covering the service's activities in its first 6 months. This report details the support provided over that full pilot year, from October 2021 to September 2022, and explores some of the issues we found lying behind our clients' experiences.

Background: our report on our first six months of activity

In April 2022, FAVOR produced a report detailing progress during our first six months of activity. In that report, we highlighted several significant case studies. Most of these clients continued to be supported after the period of the report, so we will provide an update on how these cases have progressed, before moving on to discuss the full year and our activity during that time.

Client A

This person had been subject to a clinical error by staff involved in his case and felt he was being completely ignored by his local ADRS.

We helped him engage with the service, had him assessed for CBT, and accessed other services.

Update

Unfortunately, the delays involved in this case have seen the client relapse and now seeking more intensive support than originally sought.

Client B

This person had been waiting for three years for a referral to residential rehab and felt completely "palmed off" by the ADRS. This was having a huge impact on the mental wellbeing of him and his family.

We assisted him to put forward his case and he was soon referred to residential rehabilitation.

Update

The client successfully completed his residential rehabilitation and progressed to a community recovery service, where he is now engaged as a volunteer.

Client C

This person felt abandoned by the ADRS and was heavily medicated, isolated, and vulnerable to financial exploitation. Supported only by her family, she was desperate to go to residential rehab.

We assisted her to make her case for residential rehab, but this was declined in favour of the Stabilisation Unit. The client agreed to this, purely to escape from the pressures she was facing.

Update

Client C soon regretted her agreement to go to the Stabilisation Unit after she realised that it would not assist her in achieving her goal of abstinence. Shortly after completion she relapsed and is now, a year later, seeking once again to be referral to residential rehabilitation.

Client D

This person had seen her drug use escalate, partly as a result of coercion from two men in her local community. After serious health complications and a referral to the Stabilisation Unit, she sought to go on to residential rehabilitation.

Due to her request being declined and being left with no option but to return to her flat where she would not be safe, FAVOR managed to source a free place at a residential rehabilitation in another local authority. The ADRS refused to support the placement and refused to forward her prescription on the basis she was unsuitable and the revelation of a policy not to refer outside the area. After this was resolved, an apology was issued to the client and the referral was supported.

Update

The client successfully completed her residential rehabilitation programme and is now engaging successfully as a volunteer in a community recovery service.

Client E

This person had recently been in residential rehab funded by her family. She had successfully completed the programme, but some time afterwards had experienced a relapse. She believed that a methadone detox of around a month would be enough to re-establish her recovery.

We engaged in December 2021, after she had been told that she would have to wait for several months and, with money running out, this meant resorting to criminal & dangerous forms of income.

Update

Despite the hopes of same day prescribing being implemented in her area, she still had to wait until June before receiving her prescription. Fortunately, she had managed to cling on until then, but for six months she was, unnecessarily, left with no option but to continue to engage in illicit drug use and illicit income for the full 6 months.

Client F

This person had waited for almost a year for a referral to residential rehabilitation and his family were as terrified as he was that he may not survive.

FAVOR became involved just as the local authority had decided to interpret a frustrated email as a formal complaint. We instructed them that this was not his wishes, as he neither wanted to embark on an adversarial process, nor have his treatment suspended for 20 days as a result of the process.

Once this was settled, and his assessment to rehab had been completed and agreed, he was unable to attend a meeting to sign-off the paperwork due to illness, he was immediately instructed that he had been assessed as unmotivated and would have to wait another 6 months. This was policy.

Update

After several more delays, the client eventually managed to start his residential rehabilitation service, and FAVOR agreed to transport him from his home to the facility.

On that journey, it became clear how much he was still wound up by the shifting processes that he had to jump through. In his words, "They shouldnae be allowed to treat people like that".

While the client commenced his rehab programme, he decided to leave after several weeks to pursue a different recovery path.

Overview of previous case studies

While the numbers involved above are obviously far from significant, the outcomes do point to a couple of simple truths.

If you give people what they need they are much more likely to engage in it than if you give them something they don't want.

And if you provide treatments as soon as they are needed then they are much more likely to be successful, than if it is provided several months later.

These case studies are real examples of these truths that we already know.

"They shouldnae be allowed to treat people like that".

The full year report

Who we advocate for and where

In our first year, we have worked with 54 individual clients from 11 different local authority areas and 14 different Alcohol and Drug Partnership areas.

Of these people, 41 were individuals seeking help for themselves, while the other 13 were family members or friends who had, in many cases, been advocating for their loved one for prolonged periods of time, to the detriment of their own lives and wider family.

The majority of our clients were from Glasgow, particularly North Glasgow. This is mainly due to word-of-mouth recommendations communicated through the local fellowship communities.

Of those accessing support for themselves, 17 were female, while 25 were male. For those seeking support for a friend or family member, all 13 were female.

Beyond direct support, the main reasons for people accessing support included; seeking a referral to residential rehabilitation, engaging more effectively with the local ADRS, engagement with other NHS services, challenging unfair and potentially discriminatory decisions, asserting rights to influence decisions, housing issues, and a number of less common requests.

Some clients were happy to engage fully with the services involved, while seeking advice and guidance from FAVOR as they proceeded. Others were less confident and preferred that FAVOR acted on their behalf at each stage. In most cases, though, there was a mixture of both and, encouragingly, a tendency for the client to gradually shift from the former to the latter.

Repeat support

Of the 54 clients that we have represented in the first year, we have found that some have come back to us for additional support a second time, and several also came back a third time for help with outstanding problems that they faced.

In total, 54 clients asked for our support. Of these, 31 clients asked us to help resolve a second issue. In addition, 11 clients approached us once again for a third issue. These combined to a total of 96 interventions.

While some of our most demanding and lengthy engagements are around requesting referrals to residential rehabilitation, it can be seen that many more clients approached us in order to support them in their general engagements with their local ADRS. These will be discussed after the case studies presented below.

New case studies

Client G

We received a referral to help **G** with her desire to enter a residential rehabilitation programme in late April 2022. **G** had experienced long-term problems with both alcohol and heroin and had multiple issues impacting upon her ability to fully function within her community. She had just been released from prison when she was referred to FAVOR UK.

Our Advocacy casework officer first met with **G** at her flat along with her community justice social worker. **G** was living a chaotic life, and her flat was in a state of disrepair. Her community justice worker had arranged a community care grant and cleaners to make the flat fit for habitation.

At this initial assessment with **G**, she advised that she was dealing with issues around re-engagement with her ADRS service and was also experiencing extreme physical pain due to an unresolved ankle injury. **G** also needed help sorting through letters that she was receiving which were related to everything from doctor's appointments to her benefits.

Our first action was to assist **G** to re-engage with her local ADRS service. Our initial contact with them was to find a resolution around a dispute that **G** had, where she believed that a promise of residential rehabilitation was made prior to her prison sentence.

Although it was unclear if any such commitments were made, we started to attend regular casework meetings with **G**, we were welcomed into the service and they fully engaged with us regarding the case. We advised her caseworker that FAVOR UK would send a letter on **G's** behalf to formally request access to residential rehabilitation. **G's** caseworker was receptive to this and advised that she would forward it to be considered by the service management team. After a couple of meetings her caseworker planned to arrange individual support sessions.

However, this did not happen as **G** was remanded in custody shortly before these could take place. While **G** was in custody, we assisted instead on pursuing the Prison to Rehab route, and she was released straight into a private residential programme. We met **G** upon release and accompanied her directly to the residential rehabilitation service, which offered the opportunity to resolve any uncertainties and ensure she was able to arrive without any distractions. **G** is currently still in the residential rehabilitation service she joined directly from prison but is now preparing for a longer-term residential stay at a partner rehab.

This partnership between the private and voluntary sectors is a source of both inspiration and innovation and to be commended, and it has been made possible by the Scottish Government acknowledging the needs of some for longer term support. This partnership approach from prison to rehab involving both the private and voluntary sectors should be replicated wherever possible.

We also helped **G** in trying to get her physical condition addressed. Our caseworker arranged a doctor's appointment to have her ankle assessed. Although there is no further update on when she is likely to be referred.

As a result of this engagement and the relationships developed in supporting **G**, we have since received several other referrals directly from the ADRS involved.

Client H

We initially met **H** in December 2021 when he called our caseworker for advice on funding for residential rehab. We advised **H** that he would have to start engaging with his local service, as this was the pathway that individuals must take if they are looking for a local authority to fund their residential stay.

Initially that was our only involvement with **H** until June 2022, when his friend contacted us to advise that **H's** condition had become so concerning to her that she feared he would be unsafe within the community and had expressed thoughts of taking his own life. At this point our caseworker tried to source immediate secure residential support for **H**. This was not possible as the current system does not seem to be reactive to placing individuals within a secure residential setting. The only advice we received was to take **H** to hospital.

We immediately started to work with **H** and his friend to try and get him the help that he wanted. **H** was reluctant to engage locally as he was well known within the local service sector, having worked in the addiction field for many years. However, he finally agreed to a referral to his local service.

H's case was complicated as the numerous services involved were not consistent in the advice provided for who was responsible at each stage of the process, such as who was supporting him and who would make the relevant decisions on eligibility and access to rehab. Our caseworker gained a clear insight into the experiences of service user as he was passed from one service to another on multiple occasions whilst trying to gain information regarding the status of H's case and his desire to get a residential stay.

Eventually, after several weeks, we were able to find out that **H** had been allocated a social worker and that he would receive an assessment for residential rehab. **H** did not want to do his rehab in the local area due to his personal involvement in the local addiction field and had requested a stay within a rehab in a different local authority. This request seemed to cause the service a degree of difficulty, and it was explained that there might be a hold up in getting him his first choice due to the structure of funding.

Once the service had agreed on his funding, **H** was advised of his entry date. However, on the day that he was supposed to enter the facility, he was informed by his ADRS that there might be a delay, due to a hold up in paperwork. This obviously caused **H** a great deal of anxiety. After several hours of communication with the relevant services, the problem was resolved. However, given that it was resolved in such a short space of time, it raised concerns over how such potentially devastating oversights are allowed to happen and a scramble for our casework team to try and find out what was going on and how it could be fixed.

H was able to enter later that afternoon and is currently halfway through his treatment and is doing exceptionally well in the programme

.Client J

J was referred to us from a professional in the field who had been supporting **J** on a personal level to an appointment for his Buvidal treatment. It was reported that **J** had been on this opiate replacement for eight months and he attended the ADRS service once a month for his injection.

J reported that he didn't want to continue with the medication as he no longer used heroin and hadn't for several months. J said that he had tried to explain this to his addiction worker, but he felt had simply been palmed off. Therefore, J explained that he had simply not gone to his last appointment of the previous month. J advised that he had gone to his most recent appointment after being urged by his addiction worker to do so, and that is why he had gone with moral support. When he explained again his intentions, and what he had done about it, he was warned that if he didn't take his Buvidal then he wouldn't get his Diazepam. J said that he felt threatened and manipulated and the referring professional who witnessed the conversation described it as coercive control.

J asked us to communicate with his ADRS service to seek clarity and ensure that his wishes were respected. We wrote to the ADRS to explain the situation and received a fairly rapid response from the service manager to agree that there certainly had been a misunderstanding, that **J's** wishes had been registered, and that his assessed needs and treatment (and prescription) for one issue would not be affected by his decisions on another.

Although this was the clarity that J was looking for, it is unfortunate that this incident (and others) has made him distrustful of future service engagement.

Client K

K was referred to from a third sector organisation who were deeply concerned that he was not receiving the care or support that he needed and required an advocate to represent him.

K has been on methadone for over 30 years and uses heroin daily. He has been under the care of the local ADRS for approximately three years. At our initial meeting, **K** reported that he last received a meeting with his caseworker roughly six to eight weeks prior to our meeting. He advised that the only time he sees his caseworker is when he drops into the service; there are no planned appointments.

However, a meeting had been arranged at his ADRS for the Wednesday that week, in response to the third sector service raising their concerns with the ADRS.

Our caseworker called the service and advised that **K** had asked us to accompany him to the meeting. However, on the day of the meeting we found out that the meeting had originally been arranged for a different time, and it would have been impossible for our caseworker to get to it. After making numerous calls to try and get confirmation it was agreed that the meeting would take place at the time that our advocacy worker was advised originally.

K had made it clear to us that he wanted a few things to be discussed at the meeting. He wanted a sleeping aid. This request had been continuously denied as his doctor and the ADRS referred him back and forward. **K** also wanted a full case review to take place as he had never had one before. The most important issue for **K** was to argue for a place in the stabilisation unit, but he did not want his Methadone to be increased, only to be stabilised in a safe environment.

At the ADRS meeting the caseworker advised that he and **K** could "thrash it out" our advocacy worker challenged this use of language as not particularly appropriate when dealing with someone so vulnerable. We were also aware of an earlier incident when the same caseworker had initiated a previous meeting by asking if he had come to "play the victim again", even in the presence of a third party.

During the meeting the caseworker advised that he would take the request for stabilisation to a complex case review. But he could not make any assurances that this review would result in **K** receiving his preferred pathway. We also asked for a case and medication review to be set up for **K**, and a copy of his recovery plan. The caseworker advised that he would organise all of this.

In the weeks since this meeting, we have yet to receive confirmation of any action, despite seeking clarification. We will continue, as before, to follow up on any outstanding issues.

Client L

L was referred to us by his aunt. She explained to us that **L** had been in crisis and was at risk of overdose as he had had some form of emotional breakdown and could no longer cope in the community.

He was described as emotionally immature and easily influenced in normal circumstances. However, in his current state, neither he nor his family believed that he was safe to survive without help.

L had presented at A&E, saying he couldn't cope in the community and needed help. He was feeling strange and paranoid, and although he said he "didn't want to be here", he was terrified he was going to die. His family explained that he was very impressionable and easily coerced into using drugs and being financially exploited to purchase drugs. However, there was something seriously wrong as he was "talking like a child".

He was admitted and a nurse agreed that he was vulnerable and sent off an AP1 form. The family were told he would be detained under the Mental Health Act until he was well again. Within only a few days, it was clear he was no longer welcome. As discussions turned to discharge, there were mentions of other patients feeling uncomfortable and receiving complaints.

We engaged with **L** and his aunt in the ward and sought clarification about **L's** stay in hospital. We were initially told that **L** had capacity and that he would be discharged soon, without any clear date. However, as we enquired further, that position seemed to change.

When asked about the section, it was explained that this is just a maximum period of care, it doesn't mean that he cannot be assessed as regaining capacity and discharged before that time. When asked if the assessment would involve the views of the client and his family, we were told that this was a clinical decision.

When asked about the AP1 form, we were surprised to discover that, even after 3 days, the social work team had still not received it. We asked one of the psychologists whether there was a duty to place any discharge on hold, on the grounds that they had knowledge that an AP1 form had been submitted and that this would trigger an independent investigation by the social work team. He said he wasn't sure.

We then asked if, at a minimum, that **L** would have to remain in hospital until the detox they had implemented had come to an end. This was agreed to.

While we were still in **L's** room in the ward, he was visited by the Addiction Liaison Nurse who was arranging a referral to the local ADRS. We updated the nurse on **L's** background, including that he had ADHD but that his medication had been stopped by his GP when he moved home, and that he had recently been diagnosed in prison as having PTSD but that this had never been treated. The nurse proceeded to tell **L** that he needed to start making better decisions. It appeared to us that there is a clear need for trauma training in generic medical settings.

Unfortunately, **L** was discharged before his detox had been completed, and without any communication with his family (as had been requested and agreed to). We provided an update and a formal request for residential rehabilitation to his local ADRS. As far as we know, the AP1 form was never received.

Client M

M was referred to us by a support service that had serious concerns about **M's** well-being and safety. He had relapsed shortly after being prematurely discharged from a residential setting and as well as being suicidal, was experiencing delusions where he believed that there were insects crawling about under his skin.

Attempts to refer **M** to a suitable setting had been unsuccessful, as both his care worker and a local crisis service had refused to assess him as, in their view, he should go to Accident & Emergency. When the support worker accompanied **M** to the A&E, they were assured that he would be admitted, not only because of his psychological state, but because he had bleeding from one of his ears. The nurse assured the support worker that they would be safe and that, with it being in the evening, they could leave **M** in their care.

Within an hour, the support service received a call from **M** who said he was standing on a bridge outside the hospital and didn't see the point in trying any longer. He said that shortly after the support worker had left, another nurse asked him what he was in for and, as soon as he explained, he was sent away. They hadn't even explored the bleeding from his ear.

The support service made sure he was safe that night and we engaged the next day, where along with the support service, **M** had an emergency appointment arranged with mental health services. The CPN immediately arranged for a referral that day to an in-patient mental health ward.

This time and space allowed for his support service to arrange for a referral to be made to residential rehabilitation to coincide with the completion of his stay in hospital.

Family support

During the first year of our project, we also worked closely with some of the family members of our clients. In all the cases presented here, these family members have struggled for years to advocate for support for their loved ones. These are the words of our clients' loved ones regarding FAVOR UK's involvement

Sister N

"The service that our family has received for X has been beyond our wildest dreams. This advocacy service is needs based, and complete focus has been put on X and her desires to get the help that she wants.

FAVOR mean what they say, they have walked beside my sister, putting their heart where their mouth is. The advocacy team are upfront, honest and are principled. They have been a consistent presence in my sister's life since the initial assessment that they carried out.

This organisation sees past my sister's addiction and treat her like a human being. This has meant that they have been able to fully understand her trauma. The relationship that they have built with X is based on trust and is non-judgemental.

FAVOR UK getting involved in my sister's life has taken a huge weight of pressure away from me. I do not feel as stressed as I did when I was supporting her on my own. As a family we are no longer alone in trying to help X, we have back up now. I have never had any issues in discussing X's case with her caseworker. He is always available to chat, or just listen and most importantly he is reliable.

I do not feel like X's carer now I have got a bit of my life back knowing that X has professional support. My sister and I no longer have a co-dependent relationship, and I feel safe in the knowledge that we are getting open and honest support."

Mother O

"My son has been struggling with his mental health and addiction issues since the age of 15. For years we have worked and struggled to help him. For years he has been risking his life and being hospitalised, no doubt costing the NHS a fortune to patch him up until the next week or two. When he would repeat the same behaviour.

Thankfully we found information from Alan McCrone and others at FAVOR UK that gave us hope. It's important to be able to fund rehabilitation programs tailored to meet the needs of those like X who have health problems they were unable to help themselves with.

Thanks to all the people at FAVOUR, especially Alan. Only with their intervention did we finally receive a place on a rehabilitation program. X has been there for 3 weeks now, and says it is helping him tremendously. I hope FAVOR is further supported by funding to continue to help those families of forgotten loved ones who are going through the heartache of addictions with their family members"

Mother P

"You have been a great support not only to X but the family too. X waited 3 years to get a funded placement at a residential rehab and within 3 months of you being involved you pushed for the service to provide a funded residential placement that X had been fighting for, for a number of years. This shows the commitment you had to helping him.

You took a lot of the pressure off myself and X by following up with the addiction team when things continued to stay at a standstill because of the services not doing what they said they would do and were able to request certain procedures were followed as you had experience in this field whereas I did not.

I was off work long term sick due the stress and anxiety that services were causing X which then had an impact on my mental health and wellbeing, I felt that it was a constant battle and the services who were suppose be helping X were making things worse for all involved.

As a result of you intervening to help not only X but his family and supporting us, this relieved a lot of the pressure. To this day we can't thank you and your service enough for all the help and support you have given X and our family.

We were never given guidance that a service like yours existed from the addiction team X was involved with as if we had been made aware sooner this would have made a huge difference to X.

We feel that if we hadn't contacted your services when we did, things would most definitely be no further forward or in fact a lot worse due to the state of X's mental health and the way he had been treated.

In my option this service is vital to the support of the individual and families and must continue as not everyone has someone to fight for them and even those that do are worn down by the constant battle with those involved, albeit the addiction team, mental health team and hospital and lack of communication, commitment and incorrect procedures being followed by these listed services"

Mother Q

"I am writing this statement to support Favour UK after by finding them by chance, which I believe needs more exposure is needed in order that more people are aware of who they are and what they do. They have helped myself, though predominately my son, with the issues that he has been having with no one to help him until Favour UK became his voice.

We had a meeting with Alan McCrone from Favour UK and he constantly keeps in touch. Now he is trying to set a meeting up and has been trying to do for some time as the other party are trying to avoid the issue. Alan has made more progress in the short time of being involved than the other party who are supposedly to help have done in years. I sincerely hope that Favour UK grow and evolve in order that more people can be helped and be heard by Favour UK."

Mother R

"When our son decided he was ready to recover from addiction we wished to support him with this but felt overwhelmed by the complicated criteria and pathway to recovery and obtaining funding for rehab as this was essential for our son's recovery to begin. We felt we were going round in circles and getting absolutely no further forward.

Thankfully after some months of getting nowhere, we decided to approach FAVOR UK (who I had found out about through social media) and they kindly offered to advocate for our son, this was a godsend and turning point as it alleviated some of the pressure on our family as we knew the advocate was doing everything in his power to help our son secure rehab and most importantly our son had confidence and complete trust in him as this was someone who only had his best interests at heart. I am delighted that our son is now in rehab, which may not have happened without the help of Dougie McMillan at FAVOR and our family will be forever grateful for this. I would strongly recommend that this service be available to all people suffering from addiction"

Positive Developments

During our first year we have witnessed some good practice from caseworkers who are working hard to achieve the best possible outcome for their clients. These caseworkers fully embrace working with a client and our advocacy workers.

An example of positive engagement with our service is in the work that we have done within Renfrewshire. Renfrewshire ADRS. Their criminal justice team fully embraced our service when we contacted them about our first client who had engaged with their service. We were welcomed into every meeting that they had with our client, they arranged regular weekly meetings and tried to work towards the outcome that our client had asked for. Although our client presented with a complex case, we witnessed a compassionate team doing their best under challenging circumstances.

The work of this service meant that our client was able to achieve her wish of getting into residential rehabilitation a couple of months after we became involved in her case.

The positive contact that we have with Renfrewshire ADRS has now extended to them referring three more clients to us. We were also invited to join an adult protection case review for one of these clients. The transparency with client's cases that we have had from this particular service is far removed from what we have experienced from the vast majority of the services that we have tried to open up dialogues with over the last few years.

In Glasgow we have seen a real commitment from the south ADRS to address issues for one of our clients as and when they come up. Anytime we have contacted the head of service in this ADRS to discuss issues around a client's situation, she has responded quickly on every occasion. This service has also been extremely proactive in addressing concerns before they escalate.

Connections and Relationships

Since the start of our project, we have engaged with Alcohol & Drug Recovery Services and NHS facilities in 11 of Scotland's 32 local authorities: Aberdeenshire, Argyll & Bute, Dumfries and Galloway, East Dunbartonshire, Edinburgh, Falkirk, Glasgow, Inverclyde, North Lanarkshire, Renfrewshire, and South Lanarkshire. A crucial element of our first-year work has been to ensure that we identify organisations and build relationships with a range of statutory and third sector actors within this field. We believe that through our work with clients that we have covered good ground doing this.

We engage regularly with rehabilitation providers regarding clients who are enquiring about their services or who are receiving treatment. We have regularly attended meetings for clients within the stabilisation unit in Glasgow. Our advocacy team regularly supports clients engaging with services such as we are with you who are a commissioned community rehabilitation provider. Our advocacy worker has accompanied some clients to community-based organisations such as the Beacons Centre in Blantyre.

During our work we have built up strong referral networks and relationships with a few organisations. Two organisations where this has been most prominent has been Shelter Scotland and SISCO in North Glasgow. We continue to proactively reach out to organisations that persist in trying to address the drug crisis in Scotland.

In July 2022 FAVOR UK was invited by Public Health Scotland to be part of a working group to explore how best to measure MAT Standard 8 and define best practice. We are pleased that we can contribute to such an important body of work.

Shortly after this, we received confirmation that the Corra Foundation had agreed to fund our advocacy service for another four years. This has led to us being invited to engage with a number of other strategic groups, including; the Workforce Expert Delivery Group, and Professor Alan Miller's National Collaborative team. These invitations to become involved in these groups appear to be acknowledgements of the work that we are carrying out to promote the rights of individuals and our campaigning to change the landscape in Scotland in regard to how those with addiction problems are treated.

Underlying Issues that must be addressed

From our work with clients, we have identified a number of issues throughout the system as a whole.

Residential Rehabilitation

In one quarter of our cases, the client's wish was to be referred to residential rehabilitation. They had approached us because this request had either been refused, agreed but never progressed, or restricted geographically to create excessively long waiting times.

In some areas we found that there is an effective postcode lottery, where no referrals will be made to residential rehabilitation services outside the local area. This has created a situation where some of our clients had to wait for many months for a referral to local facility, while they were aware that beds lay empty elsewhere. This was reported by one local authority to be due to their obligations to existing contracts with local providers. Unfortunately, the preservation of such a local policy appears to have resulted in resistance from one ADRS to support a client who had received the opportunity of a free place in a residential rehabilitation service in a neighbouring council area. After initially refusing to refer directly to the facility, the ADRS then refused to send the client's prescriptions to the chemist used by the rehabilitation service. This was despite the facts that several other local authorities had no difficulty in doing so, and that the ADRS service had previously made the same arrangements for the same client when she was staying for a prolonged period of time with her family.

One client had asked to be referred to residential rehabilitation for over three years and although this had never been refused, it was continually put off until he had given up. His family had taken over his plight with the ADRS but they, too, believed that they were also being strung along. By the time he was referred to our advocacy service, even his GP had written to the ADRS to express his belief that his patient would benefit greatly from such a referral, but there was no progress.

One client had been assessed for residential rehabilitation and found to be suitable. With the assessment process complete, all that was left was some paperwork to be signed off. Due to a delay in receiving his methadone in another part of town, he failed to make the appointment. He was then notified that his referral had been cancelled due to an arbitrary, flawed judgement that he was not sufficiently motivated.

Another client had his referral to residential rehabilitation approved by his prescribing GP. However, when it came to selecting which service to go to, he was astonished to hear his worker declare that she didn't agree with residential rehabilitation and that in 20 years she had only seen a handful of cases where it had been successful.

While the Scottish Government has committed more funding for residential rehabilitation, and encouraged more councils to make more referrals, this is clearly not having enough impact.

Local ADRS cultures often remain hostile to the concept of residential rehabilitation, with workers freely (and inappropriately) expressing inaccurate personal views on the subject matter. This leaves individuals vulnerable to arbitrary decision-making and often erodes community confidence in the ADRS services.

We believe that many of these problems could be resolved with a centralised referral and funding system to remove financial pressures from councils and provide more consistent information.

There was little discussion about their addiction, far less their plans for recovery.

Engagement with Alcohol and Drug Recovery Services

In over one third of our cases, the main purpose for seeking support was to assist in their engagement with the local Alcohol and Drug Recovery Service. There were a number of reasons identified for this.

In many of these cases, the clients had not been provided with any appointments for months at a time; in several instances these periods were in excess of a year, even while receiving Methadone or Buvidal prescriptions.

In other cases, there were no structured arrangements to their support; clients were not given any planned appointments, and only ever saw their worker if they dropped in when they were in crisis. Of those who did see their worker, it was identified that the meetings would only be to administer and monitor their medication. There was little discussion about their addiction, far less their plans for recovery.

None of our clients were aware of having a recovery plan in place with their ADRS. Some of these clients identified that they did have recovery plans with other services, and often had their own copy, but not with their ADRS. One client commented; "How could they? They've never seen me."

Other cases related to clients' wishes to reduce their opiate substitute medication being refused or ignored. One client observed that she had never seen any of the GPs that had prescribed her Methadone, and therefore none of them had ever seen her. However, when she identified she was ready to reduce she was told that the GP didn't believe she was ready. Another client identified that when his wish to reduce had been refused by the prescriber, he had asked the chemist to give him less. However, he was told by the chemist that either he took it all or he would not get any at all.

Several clients expressed their sympathy for their worker, or at least an understanding of the pressures they were under. Many identified that their workers had disclosed that they were working with caseloads in excess of 80 per worker. The clients understood that it was simply not possible for their worker to do much more. Clients also identified the inevitable consequence of the strain that their workers were under, with appointments being cancelled because of staff sickness.

Unfortunately, out of this sympathy, many of our clients preferred to suffer their own problems in silence rather than to risk creating problems for their workers. Our clients tended to have neglected their own needs for significant lengths of time before accepting that they needed to seek advocacy support. This suggests that, at any one time, there is a large number of clients who are in need of support but not presenting for help, either because they feel the service won't be able to help, or simply because life has left them holding little value over their own needs. We would suggest that this group contains many of those most at risk from drug-related deaths, yet there appears to be no strategies in place to re-engage.

Some problems of engagement with ADRS relate to difficulties in simply communicating with them. Many services do not publish the contact details of service managers which is a barrier to anyone wishing to raise concerns or seek advice for themselves or others.

Many clients have told us that they can phone the service number all day and never get through. We have experienced this ourselves and found that messages taken are often never responded to. When they do respond, it is often by phone using withheld numbers. Clients have told us that they don't like answering unknown numbers, and often don't, in case it's someone with wish to avoid. Clients don't like these systems, they create barriers, and better approaches should be adopted.

Psychosocial Support

For those who have worked in the addiction field for any length of time, we are aware of some changes in how services are delivered. One of these areas is in the delivery of psychosocial interventions. This is not necessarily appointments with a psychologist, but ongoing appointments with a named worker to explore how their clients are coping, generally, and working collegiately in a therapeutic relationship to find a path for the client to gain control over their addiction and plan a route towards recovery.

Medications like Methadone or Buvidal cannot resolve addiction any more than they can lift someone out of poverty, but what they can do is to alleviate the physical dependence on opiates. The main advantage of this is that it can allow someone who is not yet ready to confront their addiction to cease any involvement in the risks of illicit drugs, and the frequent need to engage in illegal activities to acquire them.

Today, Methadone and Buvidal are often referred to as Medical Assisted Treatment (MAT). The clue is in the name. The medication is not the treatment, but it is used to assist the treatment. The wording is no accident. In the words of Johann Hari, "The opposite of addiction is not sobriety, the opposite of addiction is connection." Likewise, the treatment for addiction is not medication, the treatment for addiction is psychosocial.

MAT Standard 6 identifies that that the system should not only be psychologically informed, but that it "routinely provides evidence-based low intensity psychological interventions", and "supports individuals to grow social networks".

However, in common with many anecdotal accounts, we have found that none of our clients were receiving psychosocial support at all, and many had not received anything of that nature since before the Covid-19 lockdown. When one client who was receiving appointments was asked if these would constitute psychosocial support, he responded "No, they don't have time. They don't ask you how you're feeling. They just tell you what you should do."

THE MAT STANDARDS

Standard 6: The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier2); and supports individuals to grow social networks.

Servies recognise that for many people, substances have been used as a way to cope with difficult emotions and issues from the past. Services will aim to support people to develop positive relationships and new ways of coping as these are just as important as having the right medication.

We couldn't understand why prescribers in Scotland would be issuing prescriptions for Methadone or Buvidal in the absence of psychosocial support. So we had a look at the SIGN guidelines:

"Buvidal is indicated for the treatment of opioid dependence within a framework of medical, social and psychological treatment."

While, in FAVOR's view, this clearly provided guidance that Buvidal can only be used in conjunction with psychosocial treatment, we could see that there could be room for misinterpretation in terms of the frequency or priority. Our clients reported that the mainstay of treatment was the medication, with psychosocial interventions being, at best, an optional extra.

In the absence of any other clear guidance produced in Scotland, we turned to the UK Guidelines on Clinical Management for Drug Misuse and Dependence; the Orange Book. The message couldn't be clearer.

"Drug misuse treatment involves offering a range of psychosocial treatment and support interventions, ***not just prescribing."*** (Page 15 - our emphasis)

"Treatment for drug misuse ***should always*** *involve a psychological component to help support an individual's recovery."* (Page 47 - our emphasis)

"For drug problems, for which medication is usually a necessary component of treatment, psychosocial interventions ***need*** *to be offered alongside the medication."* (Page 48 - our emphasis)

The National Institute for Clinical Excellence also states that "psychosocial and behavioural therapies play an important role in the treatment of drug misuse. They aim to give people the ability to resist drug misuse and cope with associated problems. For opioid-dependent people, these therapies are often an important adjunct to pharmacological treatments. Maintenance programmes vary in the quantity of psychosocial support delivered in addition to the medication, and in the degree of supervision of methadone consumption."

We can see no legitimate reason on how the properties of internationally standardised medications should be different in Scotland than the rest of the UK. We can see no legitimate reason why clinical guidelines on the management of these drugs should require psychosocial interventions to be in place before they are prescribed in the rest of the UK, but that this is somehow unnecessary in Scotland. We can see no legitimate reason why people in the rest of the UK must have guaranteed access to support for their addiction, while people living in Scotland can simply have their dependence managed without any support to address their addiction.

In short, we see no legitimate reason why prescribers in Scotland should be permitted to ignore the UK Guidelines on the Clinical Management for Drug Misuse and Dependence. We would urge the Scottish Government to explore this issue as a matter of urgency.

Workforce development

Over time, the culture of the workforce in England changed. The workforce now knows, believes and offers hope that permanent recovery from alcohol and other drug-related problems are not only possible, but a reality in the lives of hundreds of thousands of individuals, families and communities.

In the UKs biggest drug treatment charity, at least 40% of the workforce are people in recovery. Some would argue against this but perhaps it was exactly what the workforce needed.

Staff with lived experience, in many cases, were just as qualified as those who went before or are working their way to being so.

Now, in England, most of the workforce have a greater depth of understanding and professionalism than their counterparts in Scotland because recovery is embedded through the culture of services, the workforce and (most importantly) staff without lived experience.

This culture change in the workforce meant one of a permanent revolving door, where people are transformed by transformed people. This transformation can only happen when your workforce believes and does not take recovery for granted. That can only happen when you have enough people who have experienced recovery, witnessed recovery for themselves and know how to offer and guide their fellows to walk beside them on the path that leads to it.

In England they did two things to change the culture within the workforce. Not only did they strategically employ people in recovery at every level, operationally and at the very top of their systems and structures, but they also introduced operational and strategic guidance that let their current workforce could build a bridge to the recovery community from prisons, residential rehab and community services.

We would urge the Scottish Government to follow a similar pattern of cultural change.

Management

We reported in our six-month report some of the issues that we had faced when advocating for clients. Unfortunately, we are still seeing most of these issues. We reported that we were experiencing stonewalling on a massive scale when trying to contact certain services. Communication and a lack of willingness to discuss cases with our advocacy team is frustrating. We continue to struggle to identify a direct communication link to some caseworkers, and in some instances our clients don't have a clear idea who they are linked in with at an ADRS.

We link in with other third sector providers within Alcohol and drug addiction field who work with our clients too, some have reported to us that the communication issue is not a unique issue that we are facing.

In one case we approached a manager of a service via email for a copy of our client's case notes. This request has not yet been responded too. Not only does the client have a right to see their recovery plan, this is also recognised good practice to do so transparently.

We have become aware of an apparent trend where ADRS services have implemented complaints processes as a mechanism to handle disagreements with the client over treatment decisions. We believe this is completely inappropriate. This indicates an abandonment of therapeutic relationships as the basis on which treatment should be developed. Where such investment is made in pursuing a collegiate approach there would be limited occasions in which disagreement would occur, as each decision would be a joint one between the case worker and their client. More importantly, the client's wishes become redundant when a service take the position of saying "We have made OUR decision; if YOU don't like it, you can make a complaint."

However, this use of complaints procedures is also an abandonment of the commitment to deliver trauma-based practice. We understand that a large proportion of our client group have experienced significant trauma in the childhood, and because of their addiction. The abandonment of conciliatory measures in decision-making through the adoption of a complaints process creates an adversarial dynamic that is as unnecessary as it is harmful. Those who have had experience of abuse from figures of authority or power over them will have little confidence that such a development will be fair or reasonable, and clients are more likely to be silenced or even disengage.

Referrals to residential rehabilitation are decided by many ADRS team through the use of a Complex Case Review. These bodies are far from transparent, and it is difficult to even discover who sits on the group. However, we understand that they are normally comprised of the ADRS Operational Manager, the Commissioning Team, Pharmacy, Psychology, and Psychiatry. Referrals are made by the case worker, who attends on behalf of their client to plead their clients' case. The group make a decision there and then, and the case worker is left to communicate the decision to the client. Our clients have never been able to meet with this group directly, never received written reasons, and never received formal notification of the decision or how it can be appealed. We believe that this process is unfair and liable to challenge. We have clients who have been subject to unreasonable decisions and without any transparency in these processes they invite recourse to elected officials or even the courts. We believe these processes have to be reviewed and replaced by mechanisms that are much more effective, transparent, and fair.

We also question why commissioning teams are involved in clinical decision processes of this nature. Financial decisions should be handled completely separately, otherwise evidence of demand is likely to be suppressed.

MAT Standards

There is no standardisation in approach between different ADP areas where national policy needs to be implemented. We have witnessed this first hand when advocating for treatment and using the MAT Standards as a reference point. New standards for medical assisted treatment came into force in April 2022. The Scottish Government describe these Standards as something that will "transform the treatment and care of people who have a drug problem across Scotland". We have found that some standards are not being implemented or are completely ignored by some ADRS.

We advocated for a female in south Edinburgh, who had to fight for a methadone prescription for twenty-six weeks. This should not have happened and the woman in question should have had the option of same day prescribing according to MAT 1.

We have multiple clients who have expressed concern around the type of medication that they are receiving and the complete refusal of some services to reduce dosages and consider a change to their prescription. MAT 2 clearly lays out that the individual should decide what medication they would like to explore.

One example of this not happening is one of our current clients having to fight to receive stabilisation without having to increase his methadone prescription when he is awarded a place. We have also had another client threatened that if they did not abandon his wish to discontinue his Buvidal injections then he would have his diazepam prescription removed.

We have yet to see evidence in most of our clients' cases that their prescribed medication and dispensing arrangements are being reviewed regularly with full client involvement. It is difficult to see how a medical review could be done in some client's cases due to the irregular, unplanned and sporadic nature of the scheduling of appointments with services. Most of our clients report that they do not receive regular appointments at all. This problem also applies to the provision of psycho-social support. MAT 6 outlines the need for the system to be psychologically informed. Most clients that we work with do not receive psycho-social support from the ADRS in which they are involved with.

Mat 8 clearly lays out the rights of individuals to access independent advocacy support. Although we are unaware whether any of our clients have ever been dissuaded from using our service from any third party. However, in certain cases once the ADRS knew of FAVOR UK's involvement the client was signposted towards their locally commissioned advocacy service.

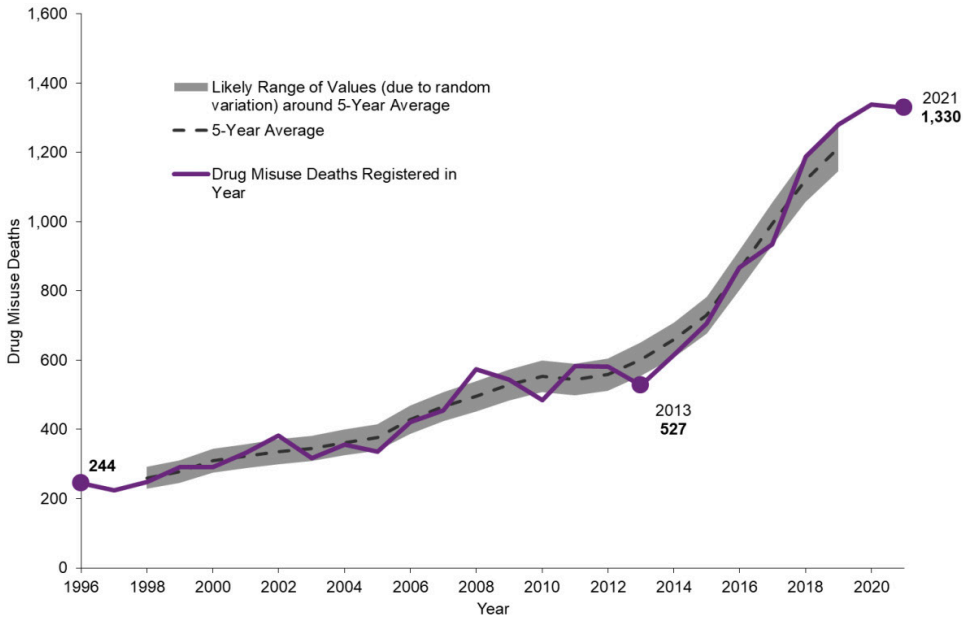
This is also highlighted in information provided by ADRS services. An example of this is a Complaints Procedure provided to us by a local ADRS. At the end of the document, it identifies that the individual has the right to access advocacy and it provides the contact details for the independent advocacy service that they commission, but not others. This would appear to us to be contrary to the Spirit of the MAT standards, which are based upon the principles of awareness of options, and that their wishes are respected. In recommending other type of independent services, local authorities often provide a list of local organisations or providers, specifically to avoid making a narrow recommendation. It would seem appropriate, and consistent with MAT standards, for ADRS communication of this nature to provide their clients with choice by providing such a list of options.

We are also experiencing a bit of resistance to advocate from some ADRS in the form of being stonewalled and experiencing major issues with the timeframes in some communications when advocating for clients.

Conclusions

The graph below demonstrates the pattern of escalating drug related deaths in Scotland since shortly before devolution.

Figure 1. Drug misuse deaths in Scotland, 1996-2021



In July 2022, Dave Liddell of the Scottish Drugs Forum said, in response to the latest yearly total of drug related deaths,

"The tragedy is that each of these preventable deaths represent an on-going systemic failure to address poverty and support vulnerable people and their families."

That there has been systemic failure is beyond dispute. However, the question that FAVOR has been exploring over the last three years is whether it is enough to seek answers for these problems at societal levels.

It is also beyond dispute, in our view, that poverty is a major determinant in the numbers of people who will experience drug-related problems and that some of those people will succumb to drug-related deaths. However, as harsh as the economic climate has been, poverty does not seem to explain the rapid increase in drug-related deaths in Scotland over the last few years.

As with the initial response to the figures for 2018, aiming the spotlight at society in general or at the responsibilities of central government, diverts us all from looking closer to home.

In focusing our attention on wider society, and away from ourselves, the addiction treatment sector has ignored what is going wrong in our own services. For example, over the last three years an inordinate amount of time and energy have been devoted to the provision of naloxone and the argument to devolve powers to permit drug consumption rooms. However, the levels of drug-related deaths continued to rise, in spite of greater availability of naloxone, and we have never had drug-consumption rooms nor the powers to implement them, so this cannot explain why the numbers of deaths have increased.

Although there has been acknowledgement that the figures in Scotland are worse than anywhere else in Europe, and between three and four times the levels of our neighbours in England, there has not been any real exploration of why we are in such a worse position.

The graph below places Scotland's situation in stark contrast with a number of other European nations.

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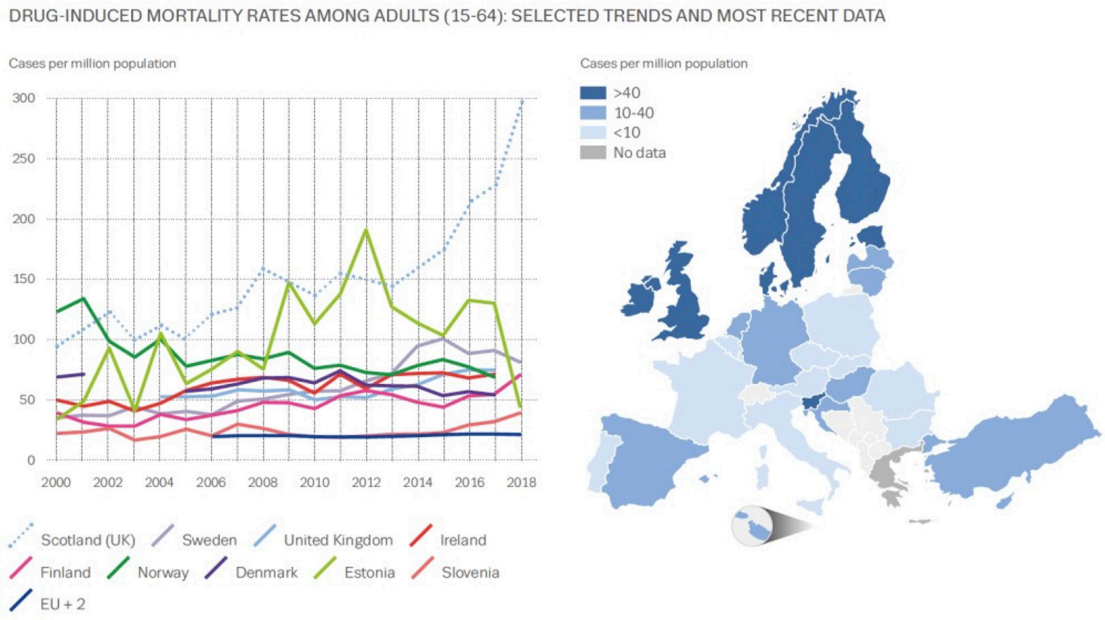
The graph below places Scotland's situation in stark contrast with a number of other European nations.



This direct comparison makes it immediately clear that Scotland is not simply in a worse position than other nations, but it is going in the opposite direction.

As a sector, we work with people who are beset by life-threatening problems and need another person with the skills to guide them to a position where they are take control of the situation. We often refer to the lack of appreciation of the scale of the problem as being "in denial". We often take an approach that requires a searching analysis of the problem, as no-one can solve a problem without understanding. Most importantly, we encourage in individual to take responsibility for finding and implementing solutions to the problem.

Ironically, the addiction treatment sector has failed to apply any of the steps to the problems it faces. We have, collectively, looked elsewhere for the causes of the problems, and have effectively been in denial for the last three years. It's time to have a fearless look at ourselves.

For FAVOR, the graph above screams loudly that we have taken the wrong turn, to disastrous effect. Rather than arguing that we need to do more of the same, or bring in new approaches, we should firs try to understand why our services have rapidly deteriorated in their core responsibilities.

If we believe in human rights, then the primary role of addiction services is to keep people alive. The systemic failure is in our addiction services. It's time to take responsibility.

An inherently flawed system

In previous years, when the levels of drug related deaths were much lower, we had a system that was built upon helping people to change themselves.

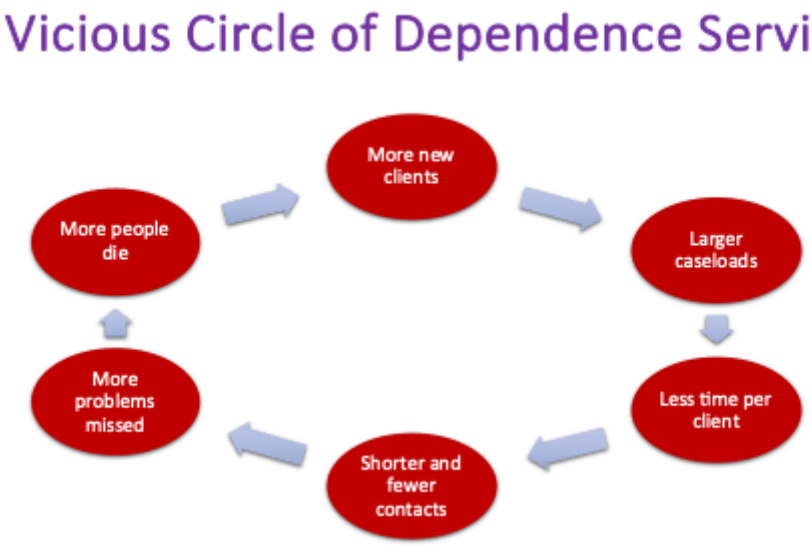
The addiction field in Scotland grew out of Urban Aid funding in the 1980s, in response to fears of an HIV epidemic. This saw the emergence of a plethora of community-based services across Scotland, often located in the areas of highest poverty, or deprivation. These were mainly grassroots charities that were created by people with lived experience, or family members or friends of those affected.

This soon led to an industry, where the workforce was trained in counselling by the Scottish Council on Alcohol and educated in the study of Addiction by our universities. Scotland was struggling to come to terms with this new challenge, but it was engaging with the latest research and implementing best practice.

This was a system designed to empower people to understand the causes of their addiction and to support them to change themselves.

Medical interventions, like Methadone, were deployed to allow people to refrain from the physical dangers of unsafe injecting and disengage from criminal activity while, or until, they engaged in the psychosocial supports that would address their addiction. However, our system has flipped from one focused on psychosocial interventions into one that is directed by prescribers, who have either no appreciation or interest in ability of people to recovery.

The inevitable consequences of such a system are characterised in the diagram below.



Each of these stages is evidenced by our clients and apparent to everyone in the field. Without sufficient resources dedicated to supporting people out of the system (psychosocial interventions) the number of clients continue to grow year after year.

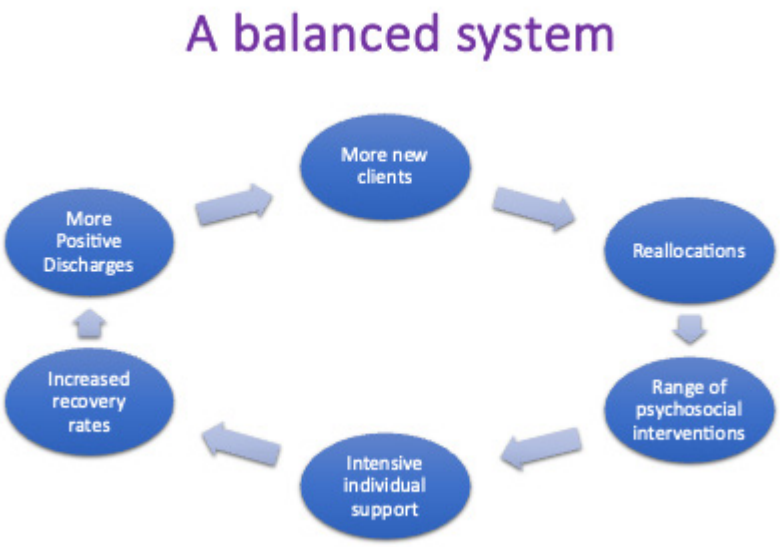
More clients, without a proportionate increase in resources, inescapably leads to larger caseloads per worker. As there are only so many hours in a working week, larger caseloads inescapably lead to less time per client. This leads, inescapably, to shorter and fewer contacts. More problems are missed and, theoretically, more people die.

Most importantly, this system cannot improve. In certain parts of the country, we are already seeing staffing levels and sickness levels deteriorate as workers buckle under the increasing pressure. This pressure on the system, comes in the form of clients retained in the system, with the ground-level caseloads placed upon each worker.

The only way to relieve this pressure, other than pumping in more and more resources, with ever increasing staff teams in larger buildings, is to safely guide clients out of the system.

In our view, that in understanding our problem of drug related deaths, we need to be prepared to look at the system itself, and at ourselves. We need to accept that we have moved away from a system that used to work much better than it does now. We need to appreciate that the international comparisons that show Scotland on a completely different trajectory from other countries means that the problem is not a result of changing trends or patterns.

We believe that the quickest and surest ways of turning around this situation is to re-discover the evidence-based approaches that worked for so many of those employed in the field today, many as managers.



These approaches will open up, again, the routes out of the system and reduce the pressure on services and individual workers, many temporarily, and many permanently.

Increased referrals to residential rehabilitation will relieve pressure on services and keep people safe. Rather than workers being afraid to mention residential rehabilitation for fear of a lecture about budgets, they should feel enabled to recommend referrals in the knowledge that their client will at least be safe for the next 3 or 6 months.

Re-investment in community addiction charities, in the most deprived areas, will keep people safe. The local charities that were once much more common than now can easily be replicated with specific funding, such as through the Corra Foundation. In the past, Scottish Enterprise were tasked with supporting charities with organisational capacity building, which could also be considered for securing the long-term impact of initial investment.

Increased training in psychosocial interventions, across the board, will help more people recover. This will free up demand on services and upon individual workers.

All of these measures, and others, in reducing the demand on services, will allow workers to invest more time in each client, allowing greater job fulfilment, but more importantly, being aware of more clients in crisis. This will reduce deaths more successfully than more investment in more medical approaches.

From everyone at FAVOR, thank you to the people we serve, the families we work with, the Corra Foundation, and Robertson's Trust for all their support.

Our work would not be possible with you.

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