NATIONAL CARE SERVICE CONSULTATION: COMMON WEAL BRIEFING

2. DRUGS & ALCOHOL ISSUES

SEPTEMBER 2021

The Scottish Government have invited response to their proposals for the establishment of a National Care Service. The document is divided into sections with 95 questions seeking responses – some with a simple YES or NO and most inviting comment and suggestion. You can find it here:

https://consult.gov.scot/health-and-social-care/a-national-care-service-for-scotland/consultation/

These briefings are to help people who would like to make a submission to these consultations. This one is about drugs and alcohol issues.

What are the drawbacks of Alcohol and Drug Partnerships (ADPs)?

— Since the inception of ADPs in 2009, drug deaths have skyrocketed whilst alcohol deaths have increased steadily. ADPs run on target culture. This means certain targets are created either centrally or locally, but are not necessarily relevant in all areas of a certain locality. For example, a target of one ADP is to distribute X amount of naloxone within their area, despite opiates not being the main harmful drug in all areas they are responsible for. When you are a doctor saying cocaine is creating harm in your area, and you are provided with a naloxone kit by the ADP your trust in the ADP can erode. Targets during COVID were also inflexible, with the third sectors still being expected to deliver targets for face to face recovery groups during a time when it was illegal to do so. Target culture politicises healthcare by removing the focus from compassion and care. The integration of ADP functions within broader social work services would lead to improvement.

Are there other ways that Alcohol and Drug services could be managed to provide better outcomes for people?

— Why not look at prescribing practices by GPs (largely ignored) but which sometimes start people on their addiction journeys? These are known to vary from practice to practice.

— Funding cycles for third sector support organisations inevitably focus scarce resources on making a case for continued funding – rather than services themselves. Mainstreaming services within local authorities or finding more secure funding mechanisms for third sector services of proven value would result in continuity and security.

— Different psychological therapies should be provided as part of a clear therapeutic structure. For example, many services only provide Cognitive Behavioural Therapy(CBT) where the introductory questions can be very past-orientated and focused on relationships, past experiences and abuse. This, however, is counterproductive and creates a disengagement as people are asked to bring up painful memories which they don't discuss in depth later on due to the nature of CBT. Having a range of therapy would be beneficial for people who do not take to CBT. Additionally, individual focused CBT and social focused recovery are two

very different theories. If mental health and recovery services are to integrate, the theories themselves will also need to integrate, so overly focusing on structure and strategy will mean these practice barriers to good care will be missed.

— Create a policy presumption that families affected by alcohol and drugs, who are often sharing the same stigma, trauma and burden as the individual living with addiction, are included in treatment plans and ensure resources are also devoted to them.

— Assertive outreach to be totally integrated and not a pilot: we know it works. Fund it.

— A separate policy for rural drug and alcohol services as they run on less money and more diluted expertise.

— Be far more transparent and analytical about the data and encourage curiosity. Proactively ask why poverty is contributing towards addiction. It is incredible the amount of council-based strategy that is created that is not based on very much evidence.

— Opiate replacement therapy needs to remove the 'methadone and that's it' mentality. Instead of providing a service we are giving people ORT and putting them on a waiting list. This is not an intervention (the same is happening with mental health and antidepressants.

Could residential rehabilitation services be better delivered through national commissioning?

— Yes, in principle, so long as this is informed by local needs and understanding, whether from people with addiction problems, their family and friends, or professional staff. A range of services and practices are required: recovery and abstinence need to be considered that can provide for large numbers of people and these should include spiritual components if this is what the person needs. It would also mean that commissioning of third sector charity-based rehabilitation should not cease if they can evidence good practice for the group they cater for. National commissioning need to include a diverse but inclusive approachs to rehabilitation.

What other specialist alcohol and drug services should/could be delivered through national commissioning?

— Family services: there is a national strategy for local services to provide support for families but this is patchy. A better focus by preventatively-orientated, supportive- and relationship-based mainstream social work services might help identify gaps where commissioned third sector organisations stemming from local community initiatives could enhance supports. The emphasis here should be on local commissioning to meet local variations and needs rather than national commissioning that hands responsibility to large third sector organisations.

Are there other ways that alcohol and drug services could be planned and delivered to ensure that the rights of people with problematic substance use (alcohol or drugs) to access treatment, care and support are effectively implemented in services?

— Replace target cultures with compassion and empathy. This sounds very simple, but it's completely overlooked. An anecdote from a frontline worker: "I once visited a recovery service where the social worker offered his wisdom that perhaps maybe they should offer service users a cup of tea as an act of kindness. I assumed that this was a joke, because I thought they would have already done this since I could see the canteen from the waiting area. I was taken aback when told this was not the case, that the visible canteen was for staff only and that a cup of tea was seen as a pioneering example of kindness, rather than just basic care."

— For care to be successfully implemented it needs to be at the centre of everything. This might mean having people with lived experience working to deliver support: to care is to readdress power imbalances too.

— A better understanding on how drugs and alcohol affect not just the individual, or even the wider economy, would help services become more community focused and less stigmatised. Scotland is suffering an epidemic of sadness: deaths from alcohol, drugs and suicide are causing a totally different bereavement process for those these deaths leave behind.

Anything else?

— The consultation itself admits (p80) that there are issues with governance and accountability: this raises questions of leadership, and there is evidence that lack of responsibility at all levels in the public sector can result in poor care – personal and collective responsibility needs to be a priority within the NCS. The consultation does not acknowledge clearly enough that experts by experience can also be successful leaders. Often a 'professional' person who is university educated and is well paid and trained to manage a team is described as a 'leader'. Contrastingly an expert by experience who has the same leadership qualities but gained through hardship rather than enablement is described as 'resilient'. We do not see them as potential leaders and by ignoring this potential, we do not go far enough to address power imbalances.

— An important issue with the integration of mental health and recovery services concerns lack of ownership for a person's care. There is ample research that tells us that mental illness and addiction go hand in hand, but it's so often the case that people within the system are pushed from one service to the other. They aren't falling through the gaps as the consultation suggests – they're in the system, they're there. They're aren't getting missed – they're being pushed out of the door. A named social worker, who was there for a person whatever specialist services they are receiving, would help alleviate these problems.

(With thanks to Heather Still)