SCOTTISH DRUGS FORUM

Scottish Drugs Forum Briefing:

THE RIGHT TO ADDICTION RECOVERY BILL

May 2024

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This paper provides comment on the *Right to Addiction Recovery Bill* published on the website of The Scottish Parliament on 15 May 2024.

This paper is intended to contribute to the public and media discussion about the Bill and the wider discussion of how Scotland improves its response to drug issues, the current public health emergency of drug-related deaths and The National Mission to reduce drug-related deaths.

This paper should be read along with the text of the bill as introduced available at - https://www.parliament.scot/bills-and-laws/bills/right-to-addiction-recovery-scotland-bill/introduced

Note: The language used in this paper reflects that used in the text of The Bill and is not language SDF would normally utilise. People who are receiving treatment (or trying to access treatment) are 'patients'; the person who makes a diagnosis and decides the treatment and treatment regime is a 'health professional'.

The Bill is a member's bill proposed by Douglas Ross MSP. It is for members of the Scottish Parliament to decide whether the Bill is supported as it stands, amended or rejected.

Scottish Drugs Forum has significant reservations about the Bill as drafted. These reservations are described and explained below.

1. **The Bill proposes better information collecting and reporting about treatment**

This is to be broadly welcomed. Currently there is a lack of clear publicly available information on the most basic facts around treatment. This has hindered discussion and the planning and improvement of services – both masking issues and allowing inaccurate accounts of treatment experiences to become common rhetoric. The consequences of this include the provision of services that are less efficient and effective than they would otherwise be. This has also led to a lack of accountability as well as issues in identifying better practice.

The information needs are obvious: exact numbers of people in different types of treatment; how long people are in treatment; why people leave treatment and short and longer term outcomes including returning to treatment and deaths. These should be made available and clearly reported.

The Bill specifies other data which would be reported if the Bill were implemented. These are relevant but for reasons made clear below are likely to produce data which is of very

limited use.

2. **The Bill does not confer new rights for patients**

Currently anyone presenting for drug treatment will have some form of assessment and a decision about what service (treatment) they may receive will be made. They will then be offered and receive that treatment. The Bill does not necessarily add anything new to this process.

3. **Under the proposals, the decision about treatment remains wholly with the health professional and the patient is not empowered**

If passed, the Bill would enshrine in law that:

- A health professional must have 'a meeting' with the patient
- A list of treatment options is explained to the patient and their suitability is explained
- The patient can 'give feedback, provide comments and raise concerns'

Once the options are discussed, the person best placed to determine what treatment is in their best interests is the patient themselves, not the health professional as indicated in the Bill – where the decision on which treatment is suitable and offered remains entirely with the health professional. The Bill therefore does not empower patients.

The Bill states that the treatment decision and its rationale are provided to the patient in writing and a second opinion may be sought with the patient's initiative.

There is likely to be low uptake of this. Sadly, most people who present for treatment are in desperate circumstances and have often come to a stage where they are seeking help in a personal crisis. The power imbalance between the patient and the health professional is a significant factor in the patient's engagement and experience of services. In our experience, it is unlikely that a patient in these circumstances would challenge a decision or be in a position to go through assessment twice. It is more likely that the patient's perception would be that the service cannot or will not help them – a common experience for people experiencing drug problems in engaging with services generally.

The treatment decision and its rationale being provided in writing may be helpful for some but there are issues with this which are described below in section 5.

All of the Bill's proposals described in this section would be regarded as good practice currently and the Bill simply describes what should already be common practice in services. It is worth noting that the Medication Assisted Treatment Standards go further than the Bill,

providing for the patient to make informed choices about their medication and dosage. It is disappointing that the Bill does not similarly seek to empower patients.

Whatever treatment is provided, the key to treatment success is that the patient is engaged in a therapeutic relationship with a service / its staff and this results in the patient having agency - being empowered to take decisions and actions that can have a positive impact on the issues they identify and prioritise. Empowerment is almost entirely lacking in the Bill's proposals.

4. **The decision about which treatment patients are to be offered is unlikely to be changed by the Bill**

Since the decision about treatment remains with the health professional, the decisions made will most likely not be changed by the proposals made in this Bill.

There is a disproportionate emphasis on abstinence-focussed treatments.

Those advocating for the Bill have suggested or implied that the Bill will see a rise in residential rehabilitation provision. This is unlikely.

The Bill states that the health professional's treatment decision should take into account the patient's needs, providing the optimum benefit to the patient's health and wellbeing. This is likely to be the basis on which health professionals justify their treatment decisions when they write to patients informing them of the treatment decision and the reason it was reached. In their consideration of the patient's health and wellbeing the health professionals may judge that residential rehabilitation is not the best option for many patients. Consideration of the patient's wellbeing must include, obviously, the likelihood of the person dying. It may well be that health professionals make a reasonable, defensible judgement that even if residential rehabilitation is completed and a person leaves abstinent from drugs, the elevation in their risk of dying subsequent to relapse means that this option does not provide 'the optimum benefit to the patient's health and wellbeing'. There are similar issues if the health professional makes the judgement that it is likely that a patient may leave residential rehabilitation before completing treatment.

5. **The relationship between the service / health professional and the patient is threatened by the Bill**

Key to making progress and supporting people to address their drug-related problems is the establishment of a therapeutic relationship between service staff (including health professionals) and the patient.

The Bill threatens this therapeutic relationship. As stated above, the Bill does not empower the patient to address the power imbalance between the patient and the service/health professional. However, it does make some demands on the service which may be unhelpful in their practical application. For example, given that the letter explaining the treatment determination would be required in law, a system that uses pro forma letters written with the advice of lawyers may be implemented. For some patients this may be a very formal and legalistic rejection of a treatment request they had made. This may lead to a less than therapeutic relationship.

6. **Treatment cannot be provided on the basis described in the Bill**

The Bill proposes that a patient will start treatment within three weeks. In terms of Medication Assisted Treatment, this completely undermines Standard One, same day access to prescribing.

Current providers of residential rehabilitation treatment in Scotland are unable to provide treatment to people with 'any ongoing misuse of alcohol or other substances' or 'any existing prescription for opioid replacement' as suggested in the Bill. People have to be abstinent or on very low doses of medication on the day they start their residential rehabilitation treatment.

In practice this proposal will only mean that a person would be expected to start preparations for entering a residential rehab within 3 weeks.

There is precedent for this kind of approach. The former HEAT targets stipulated that people should receive drug treatment within three weeks of first referral for treatment. What actually happened was that, broadly speaking, services did not become more accessible as a result of this measure. As services had to report to government via Alcohol and Drug Partnerships on their delivery of this HEAT target, 'treatment' came to be defined to include 'motivational and preparatory work' which was the most common coding at first appointment. This would include activities like the person keeping a drug diary and logging the drugs they took each day. For some people in some areas this would continue for months before they were provided with an actual treatment. The MAT Standards have largely addressed this for people experiencing an opiate dependency, but these proposals represent a retrograde step and the return of this poor practice and they do nothing to change this poor practice where it still persists.

The provision that someone should receive treatment without reference to 'any other matter concerning any involvement by the patient in the criminal justice system' would seem impracticable. If a patient was due to stand trial and may be imprisoned or was already

imprisoned, some treatment options would not be open to them including residential rehabilitation.

7. **The Bill does not address legitimate concerns about the quality of treatment**

The Bill's advocates have used examples of people being in long term medication assisted treatment, specifically methadone treatment, as a reason these measures are required.

It is important to acknowledge from the extensive evidence base that being in long term medication assisted treatment can keep people safe from drug-related harms including overdose deaths. It can offer stability which can serve as a platform for people to address other issues they may have with their general physical and mental health; their housing situation; their relationships and social networks; their income and meaningful occupation including learning, volunteering and working. Medication can assist people to move away from a life dominated by illicit drug dependence and make other positive changes that are important to them and their quality of life.

People should not be stigmatised because they are on long term MAT. Stigma is the basis for attitudes in public, political and media discourse that marginalise and alienate people in treatment. This makes their challenges more difficult and is to be condemned.

Under-resourced and poorly designed treatment systems that do not ensure people get the support they need to address the other issues they have in their life as well as their drug use mean that some people in long term treatment feel dissatisfied. This should be a focus of concern and should be actively addressed by improvements in policy and practice. This issue is not addressed by this Bill.

There is also poor practice around MAT treatment regimes with people sometimes unnecessarily being expected to attend local pharmacies six or seven days a week. That should be challenged and ended where it is not necessary. It should not be a default treatment regime. There are several valid criticisms of community-based services but they are not addressed by this Bill.

8. **NHS budgeting would be challenged**

The Bill says that a 'treatment …may not be refused to a patient on the basis of…the cost of the treatment'.

There are three issues here. Firstly, decisions have to be made about the cost effectiveness of all medical treatments and this involves complex decisions. It seems unsustainable to argue that an exception should be made in law for one patient group but there is a clear need

to end the inequity of health budgets that focus on treatments for conditions experienced by those in the least deprived areas.

Secondly, if implemented, this would make NHS budgeting far more difficult. Boards have a legal responsibility to effectively control their budgets and this provision would need careful consideration.

Thirdly, almost all current residential rehabilitation is provided by the third and private sectors and commissioned nationally or locally. These providers of services would potentially be able to increase the cost to the NHS and other commissioners knowing that their services were to be commissioned without question regarding funding.

9. **The Bill is not a means to expand the capacity of treatment options available**

The long term change that has seen medical treatment and care moved from institutions to communities is to be welcomed. However, that does not mean that residential services have no place.

There is a long-standing complaint that there is a lack of residential treatment services in Scotland. This is a valid concern.

Recent investment in residential treatment is to be welcomed. It would be helpful in delivering the National Mission and against other measures to also expand residential stabilisation services and community-based treatment services. This would help address the issue that barely half of the people in Scotland who could be in treatment are actually in treatment. This is a significant factor in Scotland's drug-related deaths public health emergency.

The best way to improve service provision is to expand the capacity AND make services more accessible and acceptable to patients. This should include the provision of prescribing services from 3rd sector providers. There is work to be done to make residential rehabilitation services more acceptable – existing services offer very different experiences, levels of support and standards.

For reasons explained in section 4, the choice of treatment is unlikely to be affected by the proposals in the Bill. However, if, as has been argued by proponents of the Bill, these decisions were changed and there were a greater number of referrals for residential rehabilitation would this actually mean more residential treatment services being made available? The example of homelessness legislation suggests not. Under the Homelessness etc. (Scotland) Act 2003 every person experiencing homelessness presenting to their local authority has a right to a tenancy. Although this right legally exists, Scotland has higher levels of homelessness and recently the Government declared a housing crisis.

Conclusion

If brought into law, the Bill, as drafted, would not achieve the radical change necessary to improve Scotland's drug and alcohol treatment system so that it more effectively responds to Scotland's public health emergency and to the individual needs of people with an alcohol or drug dependency facing crisis in their lives.

SDF has significant concerns that the Bill, as proposed, may be counterproductive in many areas and, through unintended consequences, may increase the harms faced by people experiencing drug-related problems.

Note: The HEAT Target was introduced in 2010 and is that 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. In practice, access to all forms of treatment, community-based and residential was largely unaffected by this measure.

Scottish Drugs Forum works to improve Scotland's approach to drug-related issues and towards a Scotland free from drug-related health and social harm.

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BRIEFING PAPER

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