Response to consultation on Right to Addiction Recovery (Scotland) Bill

About SHAAP

SHAAP is a partnership of the Medical Royal Colleges in Scotland and the Faculty of Public Health and is based at the Royal College of Physicians of Edinburgh (RCPE). SHAAP provides the authoritative medical and clinical voice on the need to reduce the impact of alcohol-related harm on the health and wellbeing of people in Scotland and the evidence-based approaches to achieve this.

Questions

1. The Bill focuses on drugs and alcohol addiction. Do you agree or disagree with the purpose and extent of the Bill?

   There is an urgent need for investment in and upscaling of quality, person-centred treatment and support services for people with alcohol problems to ensure easier, quicker access.[1] Despite the number of people dying because of alcohol increasing for the last four years, and despite the Scottish Government's recognition that alcohol harms are a public health emergency, there has been a decline in the number of people being referred to structured alcohol services by around 40% over the past decade.[2] We therefore believe that the aim "to ensure that everyone has access to the necessary drug and alcohol addiction treatment they need" is laudable, but that it requires investment, resource, training, systems change and a cultural shift – a right in itself won't necessarily drive all the systemic action required. We also believe that if the Bill is to make a substantial difference, it would need to be extended significantly to ensure all people who would benefit from alcohol services and treatment have a right to treatment, not just people who are diagnosed as "addicted" or dependent. People who are dependent on alcohol make up a relatively small proportion of people with alcohol problems in Scotland, for instance, in 2022/23 there were 28,000 alcohol related hospital admissions and 3,855 of these were due to alcohol dependence syndrome, which is just over 13%. While it is likely some people would be dependent on alcohol but were admitted for other reasons (and in many cases will have Alcohol Use Disorder, a term which includes hazardous and harmful drinking patterns, as well as dependence)[3], this still demonstrates that the burden of alcohol health harms is not restricted to people who are dependent, and as the Bill is currently drafted these people would be excluded.

[1] We will limit comments in this response to services aimed at people with Alcohol Use Disorder, given SHAAP's area of expertise.

[2] https://www.parliament.scot/chamber-and-committees/questions-and-answers/question?ref=S6W-19111

[3] This is defined by the World Health Organization as hazardous or harmful drinking or dependence AUDIT : the Alcohol Use Disorders Identification Test : guidelines for use in primary health care

The criteria for diagnosis must be clearly and consistently set out within the Bill. The terminology used in the World Health Organization's International Classification of Diseases is "dependence" rather than "addiction" or "dependency".[4] While the distinction between these terms may not be immediately apparent, if the Bill is to be limited to people who are dependent it is important that one term is used consistently throughout the Bill so that a future right is applied unambiguously and that a definition including diagnostic criteria is provided. Throughout this response SHAAP will use the term "dependence". However, it is our clear view that limiting the right to people with alcohol dependence and not including all people with Alcohol Use Disorder would not be appropriate. This would risk skewing service provision towards dependence and away from treatment services for other people with Alcohol Use Disorder, which in turn could result in more people suffering greater harm including developing dependence.

The most recent version of the WHO international Classification of Diseases (ICD 11) identifies three central features of alcohol dependence, impaired control over alcohol use, alcohol use as an increasing priority in life and physiological features of neuroadaptation specifically the development of increasing tolerance to alcohol and the experience of withdrawals or taking alcohol to avoid withdrawal. All of these features have a spectrum of severity and the diagnosis of dependence is a clinical judgement. There are several other diagnostic categories for alcohol use disorders including Harmful Pattern of Alcohol Use and Hazardous Use as well as many diagnoses for alcohol related diseases such as liver disease, pancreatitis and neurological diseases. We note that the financial memorandum uses a definition from Drinkaware, an alcohol industry funded organisation. We would recommend the use of WHO diagnostic criteria.[5]

Many people currently in treatment with structured alcohol services in Scotland will not have a diagnosis of alcohol dependence. This could be because staff in the service are not qualified to diagnose or because the person's problems with alcohol, which may be substantial, do not meet the criteria for dependence. Medical staff are less likely to be involved in alcohol treatment and support than in drug services and this is one of the many differences between services for alcohol and drugs, particularly opiates.

More generalist treatment services (tiers 1 and 2 – see below) and specialist alcohol treatment (tiers 3 and 4) can all be provided by statutory services or by providers commissioned by the Alcohol and Drugs Partnership under the auspices of the Integrated Joint Board. The Bill as it is currently drafted seems to suggest the right applies to commissioned services but is less clear in relation to statutory services such as treatment sometimes provided by GPs, practice nurses, addictions nurses, hospital-based Alcohol Care Teams, addictions psychiatrists, and addictions workers (although these could be captured under the "any other treatment" clause). Given the mixed nature of the provision of these services, and the fact that someone may benefit from more than one treatment option as their recovery progresses, potentially concurrently, it could be a complex process in which to

[4] The Bill uses the term "addicted", but this is the standard definition in relation to alcohol dependence: "The characteristic feature is a strong internal drive to use alcohol, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use alcohol. Physiological features of dependence may also be present, including tolerance to the effects of alcohol, withdrawal symptoms following cessation or reduction in use of alcohol, or repeated use of alcohol or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if alcohol use is continuous (daily or almost daily) for at least 3 months." ICD-11 WHO 2024

[5] Our Funding | Drinkaware

engage for anyone seeking to use the legal right outlined by the Bill. It is not clear how the right proposed would interact with the reality of complex treatment journeys.

While the need to improve treatment is extremely apparent, we also need to see action on prevention. As well as population-wide preventative measures such as restricting alcohol marketing this includes alcohol services that prevent further harm but for which it would be difficult to have a right. For instance, screening and identification of people who consume alcohol at hazardous and harmful levels in the community or in hospitals, who can then be given advice or referred into other services depending on individual circumstances is a vital service which potentially benefits more people than any other but it is difficult to envisage how a right to such a service would be enacted.

The Bill as it is currently drafted does not make provision for adequate support for families and carers of people with alcohol problems, which is a significant shortcoming given the role families have in supporting people living with alcohol problems and the implications this has for their own health and wellbeing.

2. What are the key advantages and/or disadvantages of placing a right to receive treatment, for people with a drug or alcohol addiction, in law?

In our view, the Scottish Government's forthcoming National Service Specification for alcohol and drug services will provide an opportunity to set out what services should be available with a range of models for their provision. This is due to be followed up by standards, to help ADPs commission and work with partners to ensure the provision of structured services that meet local need. Introducing a legal right via this Bill risks diverting focus away from the opportunities that the service specification and standards afford in providing a comprehensive and holistic approach to treatment and recovery pathways. In effect it is likely to place the horse before the cart by introducing a right to a narrowly defined group of people without those services necessarily being in place. However, that is not to say the Scottish Government's plans will be successful. Commitment, leadership, commensurate resourcing and a new system of governance and accountability are all required if they are to ensure access to treatment and support and ultimately create a "no wrong door" system for people with alcohol problems. Any changes to service provision will only work if we have an accurate picture of the level of need across Scotland, so before either this Bill progresses or the Scottish Government expects ADPs to deliver against future standards, a thorough needs assessment must be carried out to inform local decision making about scaling up service provision, and this must be resourced.

There is a need to focus on the quality of services and treatment that people should be able to access – quality of care is not currently addressed by the right being proposed – which could be compromised if providers and practitioners are focused on delivering a right to treatment. There is currently no standardisation or measurement of quality and a mechanism for this should be developed as part of the Scottish Government's intention to deliver a national service specification and standards.

The Bill does not propose setting up a mechanism to make the right enforceable, or to ensure sanctions are taken when the right is not upheld. The Explanatory Notes state that if someone feels their right is not upheld they would have recourse through the NHS complaints procedures, and failing that, raise a petition in the Court of Session. Resting on the annual report by Scottish Government on use of the right as the means to make it a reality seems misplaced, given the experience of the Charter of Patient Rights and

Responsibilities which sets out a right to planned treatment within 12 weeks[6] but increasing numbers of patients are not being treated within this timeframe[7].

3. Section 1 of the Bill defines "treatment" as any service or combination of services that may be provided to individuals for or in connection with the prevention, diagnosis or treatment of illness including, but not limited to:

   - residential rehabilitation,
   - community-based rehabilitation,
   - residential detoxification,
   - community-based detoxification,
   - stabilisation services,
   - substitute prescribing services, and
   - any other treatment the relevant health professional deems appropriate.

   Do you have any comments on the range of treatments listed above?

   There are many other services and treatments that could and should be available to people with alcohol problems, so with the catch-all statement "any other treatment the relevant health professional deems appropriate" we would suggest the list of treatments is not necessary on the face of the Bill.

   The workforce within alcohol and drugs services, and anywhere else in our health and care system that people with alcohol and drugs problems engage, should be adequately resourced and skilled to be able to provide people using their services with the information they need, in a clear and transparent way, to foster shared decision-making.

   There are four tiers of support available for people with alcohol problems.[8]

   Tier 1 interventions include provision of: identification of hazardous, harmful and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions.

   Tier 2 interventions include provision of open access facilities and outreach that provide: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.

   Tier 3 interventions include provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.

   Tier 4 interventions include provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.

   The list of services in the Bill suggests the right is to tier 3 and 4 services, i.e., more specialist services. However, different tiers will be appropriate for individuals depending on the extent of their alcohol use, their personal circumstances including factors such as employment

[6] FAQs on NHS waiting times in Scotland – SPICe Spotlight | Solas air SPICe
[7] Stage of treatment waiting times - Inpatients, day cases and new outpatients quarter ending 30 September 2024 - NHS waiting times - stage of treatment - Publications - Public Health Scotland
[8] Models of Care for Alcohol Misusers

status and caring responsibilities, as well as their own personal choice. There is also a mix of providers, some being statutory and some being commissioned by ADPs from the third or private sectors.

A more positive, holistic and person-centred approach should be taken to service provision whereby people are made aware of all their options, including those from each tier as appropriate. Highly specialist services may not be suitable for people who are dependent but not wanting to be abstinent in their own personal journey, or who are not dependent, or for very practical reasons such as being a parent of school aged children or being in employment. However, other options from other tiers such as brief interventions through to structured psychological interventions could be more appropriate. Services across all tiers should be adequately resourced so that people who need them are able to readily access them. Currently alcohol treatment and support provision in Scotland falls well short of this ambition.

There is a substantial mutual help network for alcohol problems in Scotland, of which Alcoholics Anonymous is the most frequently used organisation. By their nature, it is difficult to measure activity of such organisations, and impossible to give people a right to such groups, but the facilitation of engagement with recovery groups including mutual aid groups is a key component of treatment for Alcohol Use Disorder.

4. Section 2 of the Bill sets out the procedure for determining treatment. It states that:
   - A healthcare professional must explain treatment options and the suitability of each to the patient's needs;
   - that the patient is allowed and encouraged to participate as fully as possible in the treatment determination and;
   - will be provided with information and support.

   The treatment determination is made following a meeting in person between the health professional and the patient and will take into account the patient's needs to provide the optimum benefit to the patient's health and wellbeing. Do you have any comments on the procedure for determining treatment?

   There is no one set pathway for diagnosis and some people will not receive a formal diagnosis of alcohol dependence as this is not currently necessary to gain access to services and can be a fluctuating condition. Usually pathways follow this general structure, although this varies on a case-by-case basis, dependent on needs and local service provision:

1. Initial assessment and identification of alcohol problem: often primary care (usually GPs) is the first point of contact. Hospital emergency departments can also be the first point of contact, and the clinician involved may identify Alcohol Use Disorder including dependence.
2. Referral: after assessment, the individual with an alcohol problem may be referred to a specialist alcohol treatment service or community-based service. ADP-commissioned structured services provide support at a local level. There is a shortage of such services and engagement with these has been declining in Scotland over the past 10 years[9].
3. Comprehensive assessment and care plan: Once the referral is received, there is a standard that treatment is to begin with three weeks which will begin with a comprehensive assessment. Here a care plan tailored to the individual's specific needs is produced. It is far from common for people with alcohol problems to be assessed by a medical professional, so a diagnosis of dependence or other AUD is not likely to be formally made. The assessment

[9] Audit Scotland: Alcohol and drug services, 2024

usually results in a combination of medical detox[10], psychological support etc, depending on need and circumstances.

4. Access to different support structures: inpatient and/or outpatient treatment may be provided.

Specific pathways vary between localities and whether the patient requires inpatient treatment. The procedure described in the Bill and Explanatory Notes does not necessarily reflect the reality of access to treatment on the ground which often involves expertise from a multi-disciplinary team. The Bill would potentially require an entirely new approach given the expectation would be that medical practitioners – in particular GPs – nurse prescribers and pharmacist prescribers make the diagnosis which would currently happen – if at all – after someone has been referred to treatment services. If patients qualify for referral to alcohol services, they should be able to choose appropriate treatment, informed by guidance from staff involved in a person's care, and then receive it. Requiring a formal diagnosis of dependence to begin treatment would be incredibly restrictive.

The Bill suggests that a medical professional can refuse a treatment if it's deemed harmful so would not totally prevent treatment being refused. As it is currently proposed, the Bill risks pitting patient against healthcare professional so our preferred way forward would be to take a collaborative approach to treatment and support in line with Realistic Medicine[11] and to upscale and resource that provision. It is very important that a trusted relationship is established between service users/patients and the professionals providing their care, thus allowing shared decision-making. Of course there will still be disagreements, but a legal right as proposed by the Bill could make this both more likely, and more difficult and costly to resolve.

The process for diagnosis and then a discussion of treatment options and referral requires clarification. The Bill as currently drafted would shift diagnosis from the specialist services to GPs, some other medical practitioners, nurse prescribers and pharmacist prescribers who would then be responsible for discussing and agreeing treatment options and referral. This would be a significant shift in workload, knowledge and responsibility at a time when GPs in particular report being under intense pressure[12] and the number of whole-time equivalent GPs continues to decrease.[13]

The proposed procedure for determining either that no treatment is appropriate or that a treatment requested by the patient is not appropriate for the patient is that "the relevant health professional must provide the patient with a written statement of reasons for that decision in a form prescribed by the Scottish Ministers in a code of practice under section 6".

[10] How and where individuals attempt detoxification will be determined by their level of alcohol dependency. In mild cases, they should be able to detox at home without the use of medication as withdrawal symptoms should also be mild. If consumption of alcohol is high (more than 20 units a day) or withdrawal symptoms have previously been experienced, detox at home with medication to help ease withdrawal symptoms may be provided. A tranquiliser called chlordiazepoxide is usually used for this purpose. It is dangerous to take chlordiazepoxide along with opiate-based medicines, such as methadone, or illegal opiate drugs, such as heroin. Doing so can lead to severe breathing difficulties, coma, and even death. If dependency is severe, detox in hospital or clinic may be necessary. Alcohol misuse - Treatment - NHS

[11] One of the main aims of Realistic Medicine is for people using healthcare services and their families to feel empowered to discuss their treatment fully with healthcare professionals, including the possibility that a suggested treatment might come with side effects – or even negative outcomes. Everyone should feel able to ask their healthcare professional why they've suggested a test, treatment or procedure, and all decisions about a person's care should be made jointly between the individual and their healthcare team.

[12] Retaining our GP workforce in Scotland - Executive Summary

[13] General Practice Workforce Survey 2024 | Turas Data Intelligence

If the current system is to be changed so this responsibility would sit primarily with a GP, nurse prescriber or pharmacist prescriber there would need to be a significant amount of training, and protected time, put in place for these healthcare professionals who would normally refer into alcohol services if an AUD was identified. If the healthcare professional does not agree to the treatment a patient requests, and the reason is not excluded by the list outlined in section 3 (2), resource would also have to be put in place to allow the healthcare professional the time to complete the required paperwork. Furthermore, if a person seeking a particular type of treatment has been refused it and they seek a second opinion, if this opinion is different it is not clear whose opinion should be acted upon. The way the Bill is currently drafted could potentially mean a second opinion could be sought from a healthcare professional who is less familiar with the patient's medical background and personal circumstances. It would be informative to consider the arrangements in place for obtaining second opinions under Mental Health legislation as an indication of the infrastructure which could be required for this element of the Bill.

The Bill also states that treatment may not be refused on the basis of any medical history of or ongoing misuse of alcohol or other substances. However, in practice, the medical history of an individual, including the use of prescribed and non-prescribed drugs, including alcohol, will be key considerations when devising a safe and effective treatment plan. For instance, some treatment options would not be safe or appropriate if someone is still consuming alcohol.

5. Are there any issues with the timescales for providing treatment, i.e. no later than 3 weeks after the treatment determination is made?

   It is assumed that three weeks has been chosen as the most suitable timescale for starting treatment because of the Scottish Government Standard that 90% of people referred for help will wait no loner than three weeks for specialist treatment[14]. However, three weeks is not a suitable timescale for certain treatments. For example, people entering residential rehabilitation may be expected to have not been consuming substances for a period of time before entry.[15] It also seems a short timescale if a GP or healthcare professional outside of the current treatment service system makes the diagnosis of dependence, determines the appropriate treatment and then refers them to a service commissioned by an ADP. It is also not clear at what point after diagnosis the discussion about treatment options takes place and the treatment is determined – is this all on the same day or over a set time period prior to the three week time period for starting treatment?

   Finally, it is not clear from the Bill or associated documents what the process and timings would be for someone who is being referred into more than one treatment. Would this be possible under the current wording, and if not, what would the process be for obtaining second, third or fourth treatments and what would happen when those treatments would work best if they are provided concurrently?

6. Is there anything you would amend, add to, or delete from the Bill and what are the reasons for this?

   As we have outlined in this response, there are risks associated with a legal right to treatment, namely that it could create challenges for the therapeutic relationship between

[14] National drug and alcohol treatment waiting times - 1 January 2023 to 31 March 2023 - National drug and alcohol treatment waiting times - Publications - Public Health Scotland

[15] Pathways into, through and out of Residential Rehabilitation in Scotland: Results from the Residential Rehabilitation Providers Survey

healthcare professional and patient, and that patients who have not been diagnosed with alcohol dependence could be excluded from treatment. As currently drafted it would also require very different and additional ways of working for healthcare professionals outside the current provision of specialist treatment options. If the Bill is to go ahead it should be amended to address the following:

- the many different pathways into treatment
- people who have not been diagnosed with alcohol dependence but have Alcohol Use Disorder
- clarification of who can diagnose alcohol dependence (or Alcohol Use Disorder, as is our preference) and how this is going to be resourced
- the process for obtaining and acting upon a second opinion
- a new process for using the right in practice

7. Do you have any comments on the estimated costs as set out in the Financial Memorandum?

The financial memorandum describes the aim of the Bill as to establish a right in law to treatment for addiction for anyone in Scotland who is addicted to alcohol and/or drugs. It includes the figure from the Scottish Health Survey 2022 that 22% of people drink at harmful or hazardous levels (defined as more than 14 units of alcohol per week)[16] but then states that the Bill specifically relates to those who have been diagnosed as having a drug or alcohol addiction. As in our response to Question 1, the issue and relevance of a diagnostic process in alcohol treatment and support services as they are currently configured in Scotland is not a straightforward one. Needs assessment exercises for Scotland show a considerable unmet need for help for alcohol problems at all levels of severity and it is likely this situation is deteriorating.[17][18]

We would argue that a much more realistic cost should be calculated based on a robust needs assessment not only of people who are dependent but everyone who has potential Alcohol Use Disorder. The following factors would also need to be taken into account when developing costs:

- Any new roles for medical practitioners (mainly GPs), nurse prescribers and pharmacist prescribers to address the time spent in upskilling and engaging in new processes on top of current workloads
- New ways of working for alcohol treatment services
- Process and workload for obtaining second opinions
- Use of the NHS complaints procedures
- Use of the Court of Session to enact the right

However, there could be some cost savings associated with the Bill if it resulted in more people accessing treatment and support services, which would in turn reduce health and social harms. This is likely to be a longer-term consequence of the Bill and would only result if there was investment in quality service provision.

We strongly support action to provide accessible, acceptable and good quality alcohol treatment and support services in Scotland. Accessibility depends on services being of adequate capacity. The investment which will be required for this has not been estimated,

[16] Alcohol - The Scottish Health Survey 2022 – volume 1: main report - gov.scot
[17] Scottish Alcohol Needs Assessment
[18] 24408-AssessingTheAvailabilityOfAndNeedForSpecialistAlcoholTreatment.pdf

but modelling of the cost benefits of good quality alcohol services shows a high benefit cost ratio.[19]

8. Do you have any other comments to make on the Bill?

Overall, while we agree with much of the analysis of the problem made by the Bill, we do not feel the introduction of a right is the best way to address this, without having a clearer idea of the scale of the problem. For instance, one study has estimated that for every one person who is accessing a specialist alcohol treatment service there are a further eleven in need who are not[20] while another which uses different methodology estimates that approximately one in four adults with alcohol dependence accessed treatment in 2012[21]. These figures are out-of-date and do not necessarily cover the whole spectrum of Alcohol Use Disorder so we would urge the Committee to establish current needs before taking the Bill any further.

The reasons for not accessing services are diverse and can range from stigma through to poor mental health, trauma, lack of knowledge of where to turn, lack of acceptance of an alcohol problem, unavailability of services, or a poor relationship with health services. Giving a right to services or treatment won't address all of the barriers to treatment. Instead, in addition to more resources, more work needs to be done to identify the barriers to accessing services and where necessary they need to be redesigned to provide holistic and individualised treatment and support pathways, for everyone who has an alcohol problem. The forthcoming UK-wide Alcohol Treatment Guidance should go some way to address this, but there will be a need to ensure the Guidance is followed and makes a difference for people with alcohol problems, which we believe should be done via the introduction of standards and indicators.

We are expecting a review of the decline in alcohol treatment referrals to be published by Public Health Scotland in the coming months. The findings of this review should be used to shape any future legislation or frameworks on the provision of alcohol services including this Bill.

Better monitoring and scrutiny of access to care and treatment for alcohol use disorder in Scotland would be welcome. Examples of information which should be collected and reported include referral sources into structured specialist care, waiting times for assessment, waiting times for care and treatment, interventions offered, retention rates in services, patient satisfaction and patterns of healthcare use. There is currently relevant data that could be analysed in relation to people with alcohol dependence that are in structured services. However, there is a pressing need to collect data on needs assessment and the scale of harm among people who are not accessing services. This information should be the basis for work to take a strategic approach to improving alcohol treatment and services, and in our view would be more effective in improving care than introducing a right to addiction recovery.

In summary, while we agree with the much of the rationale behind this Bill, we believe there would be a much more effective way to address problems accessing alcohol treatment in Scotland, if the Scottish Government puts in place the necessary resources. This would involve:

- Carrying out a robust national needs assessment as a first step

[19] https://www.bmj.com/content/331/7516/544.long
[20] Scottish Alcohol Needs Assessment
[21] Assessing the Availability of and Need for Specialist Alcohol Treatment

- Using this, informed by the PHS review of decline in alcohol treatment referrals, to calculate the costs of upscaling provision to meet unmet need for all people with AUD
- Resourcing alcohol services to meet this need by investing in workforce and providing funding for commissioned services
- Developing standards and indicators for alcohol treatment with a focus on access and quality of care

Introducing a right to treatment without carrying out the steps above first, risks putting in place a right to treatment that is not properly resourced nor of sufficient quality, and as a result is not effective and lets down the very people the Bill wishes to better support.