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Submitted to Right to Addiction Recovery (Scotland) Bill - Call for Written Evidence
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Organisation

Organisation details

Name of organisation

Name of organisation:
Royal College of Psychiatrists in Scotland

Information about your organisation

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Question 1

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

Disagree

Question 2

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?

Please use this textbox to provide your answer:

We agree with the sentiment of addressing Scotland's drug and alcohol crisis and the aspiration to provide patients with easier access to treatment and support for addictions. However, we have major reservations about the proposals as outlined in this Bill – and the unintended consequences which would likely occur should this Bill be progressed.

Scotland is facing a public health emergency in relation to alcohol and drugs, which requires a proportionate multi-sector response. Investing and upscaling quality, trauma-informed and person-centred treatment and support services for people facing addictions is a vital part of this. However, simply introducing a legal right to treatment will not address this crisis on its own. Instead, we should look to tackle the drivers of addiction, and the significant barriers people with addiction face in relation to accessing treatment and support. Poverty and deprivation have been identified as key drivers of addiction in Scotland, with the likelihood of dying from a drugs-related death being nearly 16 times higher for those from the most deprived areas than the least deprived areas in Scotland. The mortality disparity is 4.5 times between the most and least deprived areas of Scotland in relation to alcohol. We must also look to our environmental drivers of addiction, and address issues such as the commercial determinants of addiction: for example, the pervasive marketing of alcohol, as well as affordability and availability. We must also social drivers of addiction, such as inadequate housing. It is clear that without confronting the full context of Scottish addiction, and drivers such as those outlined above, a legal right to treatment alone is extremely unlikely to be effective in tackling Scotland's drug and alcohol crisis.

We must also focus on the significant barriers that individuals with addiction experience in accessing treatment and support for addiction. Many individuals face stigma, poor mental health, or a lack of awareness about treatment options, which prevents them from seeking help. A legal right alone does not attend to these underlying barriers.

Without addressing these barriers, introducing a legal right to treatment could unintentionally exacerbate health inequalities. Those with greater health literacy and fewer barriers may be better positioned to utilise their rights, leaving those who already struggle to access treatment no better off under the proposed legislation. Addressing these barriers is essential to ensure that any new legislation benefits everyone equally and does not inadvertently deepen existing disparities.

Additionally, introducing a legal right to treatment with no plans to address these barriers to treatment or drivers of addiction risks diverting attention and resources away from systemic issues.

As outlined in our answer to Question 1 – simply introducing a right to addiction treatment does not address the drivers of addiction, not the current barriers individuals face in accessing treatment and support. We therefore do not support the introduction of this legislation as a sole measure to address Scotland's drug and alcohol crisis. We also reiterate our concerns outlined in our answer to question 1 that simply introducing a right may actually inadvertently widen the health inequalities present in relation to drug and alcohol harms.

The proposal makes it challenging to understand how a "Right to Recovery" would function in practice. Specifically, it lacks clarity on what is meant by an "enforceable right" to treatment under Scots law. Key details, such as whether this right would be legally justiciable, who would hold the rights, who would bear the duties, and who (if anyone) would be held accountable for ensuring the right is realised, remain undefined.

As an overarching comment: the Bill does not necessarily introduce new rights. Currently, individuals seeking drug or alcohol treatment undergo an assessment, during which a decision is made regarding the appropriate service or treatment. This process is carried out through the NHS, and the individual is subsequently offered and provided with the recommended treatment. As such, the Bill largely reflects the existing procedures without significantly altering them.

We are concerned that enshrining the right to treatment for one patient group undermines the existing care provided by the NHS and could in fact increase stigma for this group. One group having a legally binding right to treatment (and potentially a diverting of resources) could lead to societal resentment and an unintended consequence of increased stigma.

We are also concerned by the feasibility of some of the proposed items to be enshrined in law. Treatment, in clinical reality, likely cannot be provided as outlined in the Bill. For example, the Bill sets out that people will have the right to rehabilitation and cannot be refused on the basis of currently being in receipt of substitute prescribing services or currently still undertaking alcohol and/or drug misuse. Current residential rehabilitation providers in Scotland are often unable to offer treatment to individuals who are still using alcohol or other substances, or who are on opioid replacement prescriptions, as the Bill suggests. This restriction presents a challenge for treatment providers, as residential rehab typically requires patients to be abstinent or on very low doses of medication before starting treatment.

We are also extremely concerned by the risks to patient-clinician therapeutic relationships that may occur consequent to the introduction of the Bill. As currently proposed, the Bill risks creating conflict between patients and healthcare professionals. Instead, a preferred approach is to adopt a trauma-inform, person-centred, human rights-based framework for service delivery. Building trusted relationships between patients and clinicians is essential for effective shared decision-making. While disagreements may still arise, the Bill's legal right and proposed clinician justification process could increase both the frequency and the complexity (or cost) of resolving disagreements, potentially straining the healthcare system.

There is no focus on quality of care, person-centred care or trauma-informed care provided throughout the Bill, and this is a major issue which requires addressing through each element proposed in the Bill.

We are also concerned by the patient safety impacts which the Bill may convey. Allowing patients with addiction to choose a preferred treatment option, and for them to receive that option unless deemed harmful by a medical professional could result in worsened patient outcomes. Specialist addictions clinicians are experts in deciding the appropriate treatment course for people with alcohol and/or drug addictions and enshrining the right to the treatments as outlined in the Bill risks patients pushing for courses of treatment which would not usually be considered the safest and most effective (for example, there may be an increase in people requesting residential rehabilitation – which is not appropriate in all cases). There is a reason why medical professionals have their expert opinion within current structures. Flipping this on its head risks people requesting treatment not of the best course for their outcomes and against expert opinion. There is limited acknowledgment that the treatment and support needs can differ significantly between patients – e.g. from those with alcohol vs drug issues. For instance, alcohol detoxification requires careful management, as it can be life-threatening if handled improperly. The Bill is also overly abstinence focussed.

Concerns exist regarding the prevention of treatment refusal based on the outcome of a mental health assessment. If the assessment determines that someone is not eligible for addiction treatment, it is typically to safeguard the patient's well-being and avoid unnecessary suffering or medical complications. Overriding these safeguards could introduce significant risks.

Additionally, the Right to Recovery Bill would likely have major clinical implications for psychiatrists. This could lead to an increased demand for diagnosis and treatment for a workforce which is already absolutely stretched to its limit. Despite a doubling of demand for adult mental health services in the past decade, there has been no corresponding increase in our workforce – which has remained stagnant. Additionally, there has been an unprecedented rise in demand for neurodevelopmental condition assessment and support – with demand increasing by 500%-800% across Scottish health boards. Our workforce is therefore in a critical condition. If the Right to Recovery Bill is to move ahead – it must be clear how workforce will be expanded and funded to provide for increased demand.

Question 3

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

Please use this textbox to provide your answer:

We have several significant concerns about the current treatment proposals outlined in the Bill, specifically regarding the implications for clinical practice and patient safety.

The separation of “any other treatment the relevant health professional deems appropriate” from other categories raises significant concerns. This phrasing is vague and lacks clarity, potentially sending a confusing message about the scope and nature of available treatments. It is crucial that all treatments offered to patients are both clinically appropriate and evidence-based. The current language is too ambiguous and creates a clinically unworkable list of potential treatments, which risks undermining the quality and consistency of care.

For the safety of patients, it is essential to define what is meant by a “relevant healthcare professional.” Not all healthcare professionals have the specialised knowledge and training required to make decisions about addiction treatment. This ambiguity could lead to inappropriate treatment decisions and undermine the delivery of safe, effective care. The Bill must explicitly clarify who is responsible for determining treatment plans, ensuring these decisions rest with qualified addiction specialists.

The lack of specificity in the Bill could lead to requests for a wide range of treatments, some of which may be unsuitable or ineffective. This would place an increased clinical burden on healthcare providers and escalate costs for the NHS, further straining already limited resources.

The current proposals could also inadvertently lead to an increase in repeated detoxifications. This is a known risk factor for unnecessary harm, including heightened chances of relapse and overdose. It is critical to emphasise stability and continuity of care in treatment planning to avoid these detrimental outcomes.

We are deeply concerned about the potential role of unregulated rehabilitation services. These facilities often destabilise individuals, leaving them in a dangerous state of withdrawal without proper coordination with statutory services. There is an urgent need for regulation and oversight of these providers to ensure patient safety and treatment efficacy. Issues surrounding private providers and their practices require careful consideration. There is a risk that private facilities may prioritise profit over patient welfare, leading to inconsistent standards of care. It is essential to establish robust oversight mechanisms to ensure that all providers meet stringent clinical and ethical standards. This is also why an person-centres, outcomes-based approach to the Bill must be implemented.

While the Bill aims to enhance access to addiction treatment, its current provisions raise significant worries about clinical feasibility, patient safety, and resource allocation. We recommend revising the Bill to address these issues, ensuring that treatment pathways are clear, evidence-based, and subject to rigorous oversight to protect the well-being of individuals seeking recovery.

The proposal to allow individuals to choose treatment options (e.g., residential rehabilitation) without a robust assessment process could lead to inefficient use of limited resources. Ensuring access to a range of services—from brief interventions to residential rehabilitation—requires strategic investment and planning, not merely a legal right.
Again, the treatment section of the proposals does not follow a trauma-informed, person-centred approach: this must be included.

Question 4

4 Do you have any comments on the procedure for determining treatment?

Please use this textbox to provide your answer:

This seems to be an explanation of the best practice system already in place through current NHS structures. It is unclear how this procedure would change outcomes. We urgently require outlining at each stage how this Bill seeks to improve quality of care and patient outcomes.
The term “addiction” can be interpreted in various ways, and its use in the context of the Right to Recovery Bill may inadvertently exclude certain groups. For instance, individuals whose alcohol use is problematic but who are not classified as dependent drinkers could fall outside the scope of the proposed rights. Problematic alcohol use, even without a formal diagnosis of dependency, often requires intervention and support to prevent escalation and harm. Additionally, many people who need help for alcohol or drug-related issues may never receive a formal diagnosis under current structures. The Bill does not clarify how existing protocols and systems will be updated to address this gap. Without such updates, individuals who do not meet strict clinical criteria for "addiction" could be excluded from accessing treatment, despite their clear need for support.
This lack of clarity raises concerns about accessibility and inclusivity in treatment provision. It is crucial to ensure that the definition of addiction within the Bill encompasses a broader range of substance use issues and does not solely focus on dependency. By doing so, the legislation could avoid unintended consequences where individuals with significant but less traditionally defined needs are left without adequate support.

Question 5

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

Please use this textbox to provide your answer:

There are significant concerns about the proposed timescales for providing addiction treatment as outlined in the Bill.

Mandating rapid access to treatment, particularly for complex interventions like detoxification, is clinically unfeasible. Detox requires careful planning, medical supervision, and stabilisation to ensure patient safety. Accelerating these processes without appropriate preparation could compromise the quality of care and lead to adverse outcomes.

The proposed timeframe could be unsafe, especially given the stipulation that treatment cannot be refused based on current alcohol or drug use. Starting treatment too quickly for individuals actively using substances, without proper assessment and stabilisation, increases the risk of complications such as withdrawal, relapse, or medical emergencies during detox.

While timely access to treatment is essential, the quality and appropriateness of care should remain the priority. Rushing individuals into treatment to meet arbitrary deadlines may result in mismatched or suboptimal interventions, undermining long-term recovery outcomes. Treatment plans need to be tailored to individual needs rather than driven by inflexible timelines.

In summary, while improving access to addiction treatment is vital, the proposed timescales pose challenges for clinical feasibility, patient safety, and the delivery of high-quality care. It is critical to balance timely access with the need for safe, evidence-based, and personalised treatment approaches.

Again, we re-iterate that there needs to be a person-centred outcomes-based approach to addiction treatment and support – acknowledging that treatment and support for addiction is a nuanced issue – with timeframes for optimum outcomes varying by case. Quality of care needs to be addressed here – not simply mandating a timescale.

Question 6

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

Please use this textbox to provide your answer:

Items as outlined in other answers to consultation questions.

Question 7

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

Please use this textbox to provide your answer:

The Bill could lead to increased costs for the healthcare system without ensuring that essential services are expanded to meet heightened demand. Key areas such as the recruitment and training of specialised staff, development of infrastructure, and fostering cultural change within the system are critical for the Bill's success but appear to be inadequately addressed. Without targeted investment in these areas, the Bill risks creating an unfunded mandate, placing undue pressure on existing services.

Currently, many addiction treatment services already operate under severe financial and capacity constraints. Without addressing these systemic issues, the Bill may fail to deliver its intended outcomes of improving access to treatment. If resources are spread thin, the quality of care could deteriorate, further frustrating patients and overburdening healthcare professionals.

The increased demand for treatment, driven by the enforceable right to recovery, could create significant strain on existing services. This includes longer waiting times, reduced availability of specialised care, and the diversion of resources from other critical areas. A lack of clear financial planning to meet this demand exacerbates these risks.

Question 8

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

Please use this textbox to provide your answer:

Consideration must be given to how the centralisation of addiction treatment under the Right to Recovery Bill could impact existing issues of siloed working and the overall quality of patient outcomes. Currently, a lack of coordination between services often leads to fragmented care, with individuals falling through the gaps between mental health, addiction, and social support systems. These gaps frequently leave patients without the comprehensive, integrated care they need to address the complexities of their condition.
Centralising addiction treatment may risk further entrenching these silos, particularly if clear mechanisms for coordination between services are not established. For example, patients with dual diagnoses or complex needs may struggle to navigate between centralised addiction services and other critical care providers, such as mental health teams or housing support. Without a robust framework for collaboration, this fragmentation could worsen, undermining the goal of improving access and outcomes.

Moreover, the focus on centralised systems must include strategies to address regional disparities in service availability and ensure that local needs are not overshadowed by a one-size-fits-all approach. Failure to account for these variations could exacerbate inequalities, leaving some communities underserved.

To mitigate these risks, the Bill must include provisions for fostering a joined-up approach that encourages collaboration and integration across all relevant sectors. This includes shared protocols, integrated care pathways, and mechanisms for accountability to ensure that patients receive seamless, holistic support. By addressing these systemic challenges, the Bill can avoid exacerbating existing issues and instead contribute to a more coordinated and effective care system.