BECAUSE PEOPLE MATTER

Proposed Right to Addiction Recovery (Scotland) Bill
TPS Key Messages

Turning Point Scotland works with adults who are experiencing a range of support needs in relation to problematic drug and/or alcohol use, involvement in the criminal justice system, homelessness and mental ill-health. We work from the belief that people matter, that they are the experts on their support needs and that it is for us to work creatively with them and with partners to ensure that those needs are met.

We play a significant role in the delivery of treatment and recovery services across Scotland. Our range of services in Glasgow offer people a pathway from crisis, through residential stabilisation and on into moving-on support, and in Edinburgh we provide recovery focused support as part of the North East Recovery Hub. Our North Ayrshire Prevention, Early Intervention and Recovery (PEAR) works in partnership with local statutory services to support people in their recovery, and we are one of the main third sector providers working across Aberdeenshire. We have developed innovative approaches to support that integrates work around problematic drug and alcohol use with homelessness services (Housing First, Glasgow Homelessness Service) and with criminal and community justice services (218, Turnaround).

We welcome the opportunity to work with Douglas Ross and the Scottish Conservative Party in their efforts to improve access to treatment and support.

1. Our overall position

We share the sentiment expressed in this proposal that we must do more to prevent unnecessary and avoidable drug related deaths, to reduce the harm associated with problematic alcohol and other drug use and to support people in their recovery.

We believe in a rights-based approach to treatment and support that empowers people to understand what they need and ensures the provision of a wide range of evidence based responses to those needs.

We do not believe that there is any single, right or wrong way to recovery, but that recovery depends on identifying, understanding and addressing the drivers of problematic alcohol and other drug use, drivers that are unique and personal to each individual. In our experience, that is supported by the evidence base, people will often require support in relation to mental health, housing, involvement in the justice system, education and employment, poverty, social isolation and disconnection. Our treatment and support services must be positioned within a holistic, multi-agency Recovery Orientated System of Care.

While we believe that the right to treatment already exists, we do not object to further solidifying that right.

We welcome the opportunity to challenge stigma and misperception by positioning problematic alcohol and other drug use as a medical condition requiring and deserving of treatment, and not as an individual failing. However, we would welcome greater recognition of and action on the social, cultural and systemic drivers of problematic alcohol and other drug use.

We agree that we should have "*standards and guidance in place to help people find the support that is right for them*"[1]. We agree that that funding mechanisms should be more transparent and, along with decision making structures, be more focused on individual choice and control. They should be designed to enable a co-production approach that maximises communication, discussion and informed decision making.

We are fully supportive of the need to do more in order to prevent deaths, to prevent harms and to empower people to live the lives that they choose. However, we do not agree that the steps proposed in this Bill are the only, nor the best way to achieve these aims.

[1] Foreword to the Proposal, Pg. 4

2. A narrow view of 'treatment'

'Treatment' is used seemingly interchangeably with residential-rehabilitation. In his foreword, Douglas Ross says that he believes "*that many people across Scotland would benefit from addiction treatment, but they aren't able to access it*", and then refers to evidence of waiting times for residential rehabilitation and legal cases where people "*were denied access to drug treatment*", when what it appears is that they were denied access to residential rehabilitation (Page 11 of the proposal).

The list of treatments that would be included under this proposal given on Page 6 is welcome, but so much focus is given to residential-rehabilitation services throughout the document that we believe it presents an imbalanced picture of what treatment in Scotland should look like.

If this proposal is intended to improve access to treatment, then we cannot ignore, nor undermine, methadone or other medically assisted treatment. This is a fundamental tool in reducing harm – in keeping people alive – and in supporting people towards their own recovery goals. We absolutely agree that there are real weaknesses in our current approach, and we welcome the Scottish Governments' MAT standards as an important step towards strengthening this response; this proposal should seek to support the delivery of those standards as a key, evidence based[2] route towards its stated goals.

We should also take this opportunity to promote and raise awareness of newer, less understood, evidence based[3] approaches like Heroin Assisted Treatment. We need to show how we will open up routes in to treatment for those furthest away from it, by engaging with people where they are through evidence-based models such as Safer Consumption Facilities[4] and drug testing services[5] that have been shown to not only encourage engagement in treatment, but also to reduce harm and keep people alive.

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[2] "*There is review-level evidence that the health of individuals with opioid dependence is safeguarded while in substitution treatment. Optimum dose is critical and retention in treatment essential to achieving positive outcomes*" http://www.healthscotland.scot/media/1609/drugs-related-deaths-rapid-evidence-review.pdf

[3] "*Over the past 15 years, six RCTs have been conducted involving more than 1,500 patients, and they provide strong evidence, both individually and collectively, in support of the efficacy of treatment with fully supervised self-administered injectable heroin, when compared with oral MMT, for long-term refractory heroin-dependent individuals*." https://www.emcdda.europa.eu/system/files/publications/690/Heroin_Insight_335259.pdf

[4] *"The evidence is strong that safe injection sites reduce the transmission of HIV and hepatitis, prevent overdose deaths, reduce public injections, reduce the volume of shared or discarded syringes, and increase the number of drug users entering treatment programs"* https://www.cato.org/sites/cato.org/files/pubs/pdf/pa-858.pdf

[5] "*We found that individual outcomes matched earlier intentions and that service users followed the harm reduction advice they received at the festival. Over ½ disposed of substances identified as other than what they had bought or expected, thereby reducing the risk of poisoning. Nearly ½ reduced their dosage and extended their consumption periods, thereby reducing the risk of overdose. This was particularly the case for those whose sample was stronger than expected substance, with nearly ¾ taking less or not taking the substance at all."* https://transformdrugs.org/blog/drug-checking-works-new-evidence-from-the-loop

3. An over-emphasis on residential-rehabilitation as the only/best treatment model

We recognise that access to this model has been restricted and decisions have not been made on the basis of what is best for the person. These issues were identified in David McCartney's work[6], but he also identified that there is much work that has to be done in ensuring quality, consistency, efficacy and efficiency within the residential-rehabilitation provision in Scotland.

This proposal should be based on evidence of the models that are most effective in supporting people reduce harm and work towards recovery, and encourage investment there.

We have seen that, for people who we support, residential-rehabilitation in the wrong circumstances can be harmful, and put them at greater risk of harm and of death. Residential-rehabilitation has high dropout rates (although difficult to quantify because of different models and different KPIs), and we know that people's tolerance is reduced following a stay in rehab, thus if someone leaves in an unplanned way their risk of overdose is that much higher[7]. Going into rehab when not ready, particularly when the sole measure of success is abstinence, can set people up to fail. Although it is the treatment model that has in fact failed the person, that 'failure' can be internalised, adding to self-stigma and a lack of hope, and reducing the likelihood of that person maintaining contact with treatment services, which is in itself a key protector against overdose.

Even when it is the right time, people need support before (to stabilise, detox and otherwise prepare) and afterwards (to resettle, re-establish or make and maintain positive links and patterns in their community).

We agree that residential-rehabilitation offers an important opportunity, and that budgets, availability and accessibility should not be the barriers that prevents a person from engaging with the support that is right for them.

However, promoting this model as the only or best option for treatment ignores the reality that people need different types of support at different stages of life and of recovery, and investing in one preferred model will inevitably mean disinvestment in other options. Further, it maintains the idea that it is the person themselves who needs to be removed and

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[6] https://www.gov.scot/publications/residential-rehab-scotland-status-report-current-levels-capacity/

[7] *"It has been found that overdose deaths are more likely to occur in specific situations, for example the period shortly after prison release, hospital discharge or completing a course of residential detoxification or recovery treatment"* https://www.emcdda.europa.eu/publications/topic-overviews/prevention-drug-related-deaths_en

'fixed', excusing us from considering the wider social, cultural and systemic drivers of the problematic alcohol or other drug use that they will return to.

4. Informed Choice

We fully agree that people themselves are best placed to decide what treatment and support that they need, and this is why we must invest in a wider range of treatment and support options rather than prioritising one preferred approach.

Most people have an idea of what residential-rehabilitation is, and the opportunity to get away from the drivers and stresses of life for a while to allow the space to do the work that needs to be done is attractive. We need to ensure that people are also aware of other treatment options that are available to them, and of the evidence on what is most likely to work for them in their circumstances, before they make their choice.

We should learn from the Self-Directed Support approach in adult social care which aims to give people choice and control over how to best achieve their aims and aspirations, and includes a duty to ensure that choice is informed and options are understood and considered.

People should be supported to identify their own priorities – what do they want to address? What do they want to achieve? – and then to consider what the evidence tells us is the best way to achieve those aims. There are times when it is right to challenge a person's view that residential-rehabilitation is the right choice.

5. How do we measure success?

We push back against the view that abstinence is the only measure of success. We disagree with the claim on Page 11 that "The key aim of treatment must be to wean those who suffer from addiction off the substance which they are dependent on" – our treatment and support services should aim for more. We should aim to address the drivers of problematic alcohol or other drug use, to reduce harm, to stabilise, to establish Medically Assisted Treatment, to address physical and mental health needs and establish a sustainable treatment programme.

Abstinence may be what people want and we can and should support them towards that goal, but we must recognise those steps along the way.

We must also challenge the stigma that underlies the view that being 'drug free' is the only goal; it is not an expectation made on the rest of society. Often people seek abstinence-

based treatment because of internalised stigma and the moral view of alcohol and other drug use.

6. We do not believe that this proposal will deliver the change that we need to see

Ultimately, while we can support much of what the proposed Bill aims to achieve, we do not believe that it is the most effective way to reduce deaths, to prevent harm or to encourage recovery.

Establishing a legal right would help draw attention to a neglected issue, but we already have the attention.

Even if this act was passed and we established the legal right to treatment, work would then still need to be done to make that right a reality. We believe that that work is already underway, and that our time and effort would be more productively spent on ensuring that work included all that it needs to.

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