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Submitted to Right to Addiction Recovery (Scotland) Bill - Call for Written Evidence
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What is your name?

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Are you responding as an individual or on behalf of an organisation?

Organisation

Organisation details

Name of organisation

Name of organisation:
Royal Pharmaceutical Society Scotland

Information about your organisation

Please add information about your organisation in the box below:

We are the Royal Pharmaceutical Society, the professional membership body for pharmacists and pharmacy.

Our mission is to put pharmacy at the forefront of healthcare.
Our vision is to become the world leader in the safe and effective use of medicines.
Since RPS was founded in 1841 we have championed the profession, and are internationally renowned as publishers of medicines information.

We promote pharmacy in the media and government, lead the way in medicines information, and support pharmacists in their education and development.

Question 1

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

Neutral

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:

The Right to Addiction Recovery Bill, in response to the increasing numbers of people dying from a drug-related death, is one approach to addressing this issue and the principle behind such an approach is noble. Anyone diagnosed as having a drug and/or alcohol addiction should receive timely, high quality, person-centred treatment.
However, as stated in the Bill explanatory notes, the current work already in place to establish treatment in this area is correct (namely Medication Assisted Treatment (MAT) Standards), however, it requires more investment to make the necessary impact. The Bill will only be successful if additional investment accompanies the legislation.

One potential disadvantage of the Bill, and the requirements within for adhering to proscribed timescales and reporting, is that resource is diverted to manage the requirements of the Bill away from the service capacity to provide treatment.
The MAT standards advocate for a range of treatment options tailored to individual needs, as reflected in the draft legislation. The Bill's legal framework might inadvertently limit flexibility by enforcing specific timelines and treatment protocols, potentially reducing the ability to customise care based on patient preferences and clinical judgment.
Furthermore, in order to tackle this public health emergency, investment is required to address the contributory socio-economic factors and prevent people becoming addicted to drugs in the first place. This is not addressed in the Bill.

Question 3

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

Please use this textbox to provide your answer:

The glossary describes a drug as including any intoxicant other than alcohol. There are drugs where no evidence-based treatment options are available and may require an alternative or combination of approaches to those listed in the Bill e.g. novel psychoactive drugs. We recognise that these may be covered by the "any other treatment the relevant health professional deems appropriate". In addition, for cocaine addiction, detoxification and psychological support is the mainstay of treatment and may require residential treatment.

Question 4

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

Please use this textbox to provide your answer:

"A healthcare professional must explain treatment options and the suitability of each to the patient's needs";
This full discussion will take time, with a skilled professional with specialist knowledge and skills. Will the discussion about treatment options be carried out, potentially, with a separate healthcare professional to the professional who makes the treatment determination? Does this separate out the treatment options discussion with the in-person determination of treatment discussion? Does this offer a way of circumventing the 3 week period? E.g. treatment discussion happens at one appointment, treatment determination takes place at second appointment (indeterminate time period after first appointment) and then the 3 week clock starts?
We are not convinced that this is factored in fully to the financial memorandum in terms of workforce impact.
"that the patient is allowed and encouraged to participate as fully as possible in the treatment determination";
We suggest that the Bill sets out how adults with a temporary or permanent incapacity might be impacted/protected from discrimination within this process.

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:

We recognise that the 3-week timescale for providing treatment was derived from work to implement the Medication Assisted Treatment standards. Before this timeframe is written into law, we would encourage a robust review of the evidence base for the 3-week timescale.
The draft legislation provides for a letter to be sent to the patient outlining the reasons for the treatment determination decision, should no suitable treatment be identified or if this does not meet the patient's expectations, and this sets a precedent as this is not required for other illnesses where there are a number of treatment options.

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:

Healthcare Professional definitions include a pharmacist independent prescriber, however, pharmacists who do not hold a prescribing qualification provide many services and pharmaceutical care for patients affected by addiction and already contribute to services described within the Bill – this Bill should be amended to accommodate that.

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:

In terms of process, we do not feel the impact of the healthcare professional's time to fully discuss the treatment options with the patient is reflected in the financial memorandum. In practice, we anticipate that in some services the treatment option discussion may be held at a separate time to the treatment determination. These may be held with different healthcare professionals and this type of model will require additional resource to the one-stop model.
In addition, the Bill financial memorandum must include costs of dictating, typing, printing and sending the letter of the treatment determination to

patients. This will need to be in an accessible format meeting the individual patient's needs and has not been costed in the financial memorandum.
The costs of training additional specialist healthcare professions to address the workforce, and therefore service, gap across all settings has been underestimated. This will include prescribing qualifications for non-medical healthcare professionals. For the pharmacist workforce this may reduce over time as newly qualified pharmacists will be prescribers from 2026.

Question 8

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

Please use this textbox to provide your answer:

Code of Practice
How will the code of practice align with professional standards and guidance from healthcare professional regulators, healthcare regulators and healthcare professional body standards and guidance? Another consideration is the integration and alignment of the Code of Practice with Government and Health organisations delivery plans and strategies. We would like to see this considered within the Bill.

National Care Service
The Bill does not mention the potential impact of the National Care Service whose Boards will oversee community health services and Alcohol and Drug Partnerships.

Reasons to refuse treatment
The draft legislation places restrictions on the professional autonomy of the healthcare professional and could put patients at risk. The goal should be about ensuring the right treatment is available at the right time for the patient, rather than beginning an agreed treatment within 3 weeks as a priority.
The draft legislation also describes the reasons that cannot be used to decline a patient's request for a certain treatment, but this does not include the zero tolerance policy to violence against healthcare staff – there must be a risk assessment in place to ensure that healthcare professionals are protected while providing care.
The draft legislation must also allow for the provider of the treatment to refuse to deliver the care if they felt that there was a risk in doing so. E.g. in a scenario where a healthcare professional prescribed opioid substitution therapy, the community pharmacist, on assessing the patient at the point of dispensing or administration and concluding it would be unsafe to continue. This option must be available for the protection of the patient and the healthcare professionals involved. In these scenarios, the healthcare professionals would be acting in the best interests of the patient.
Currently, the Bill as drafted, describes the reasons to refuse treatment with a perceived assumption that these reasons are discriminatory, when in practice, these decisions are part of the safeguarding of patients who are suffering from an addictive illness.