Draft Charter of Rights for People Affected by Substance Use – SHAAP response

Question 1: Does the content of the draft Charter apply to you and/or the communities you're involved with? If not, why not?

Scottish Health Action on Alcohol Problems (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. The draft Charter applies to the mission of SHAAP, as well as the clinicians we represent, their patients, and the wider population.

We are pleased that the National Collaborative is committed to creating a Charter of Rights for Scotland which will build a stronger human rights culture, reduce stigma and strive towards fair and equal treatment of people with substance use problems. This Charter is a much needed opportunity to protect individuals in Scotland from the devastating effects of alcohol and alcohol-related harms by ensuring that relevant rights are protected in policy development, decision making, treatment and support.

Alcohol harms are one of Scotland's most pressing health and social issues. Deaths from alcohol in Scotland increased from 1,245 in 2021 to 1,276 in 2022.[i] Additionally, in 2022/23, there were 31,206 alcohol-related hospital stays.[ii] This means that **every day in Scotland, more than 3 people lose their lives and over 85 more are hospitalised because of alcohol**. All of these devastating harms are avoidable.

Scotland's alcohol crisis is also a major source of inequality in our society. Alcohol widens our existing health inequalities, as those living in the most deprived communities are worst affected: there are 4.3 times as many deaths from alcohol-specific causes in the most deprived communities as in the least deprived,[i] and anyone living in one of our most deprived areas is six times more likely to be hospitalised because of alcohol-related conditions.[ii]

Scotland has a long-standing history of issues with alcohol harms which were exacerbated even further by the COVID-19 pandemic and resulting changes in alcohol-related behaviours. Deaths from alcohol have risen in each of the 3 years since the pandemic by a total of 25%, and these harms are modelled to get even worse if we don't take critical action.

While these figures convey the scale of harm caused by alcohol in Scotland, they mask the damage and pain caused in the lives of people who are living with an alcohol problem, as well as that in the lives of their loved ones and in wider communities. This harm is immeasurable.

Alcohol harm also has major impacts on public services and the Scottish economy. Alcohol consumption is a causal factor for more than 200 disease and injury conditions and puts an immense strain on our overstretched NHS. Alcohol harm is estimated to cost the Scottish economy £5-10 billion every year.[iii]

Alcohol harms are rising year on year in Scotland and undermine our rights. It is also important to note that, whilst harms are rising, access to alcohol treatment services in Scotland has fallen by 40% in the last decade[iv] - and this must be remedied. A wide package of measures, supported by the Charter of Rights, is required to tackle this crisis. Individuals have a right to health and to be protected from the devastating harms which alcohol brings – particularly children and young people.

People with alcohol problems are at high risk of being marginalised, unfairly treated and of facing discrimination. They are also at a higher risk of not receiving the levels of care they require and therefore face major issues in gaining treatment and recovering from alcohol problems. Minimum standards must be put in place in order to protect and support such individuals, and the Charter of Rights – alongside the Human Rights Bill for Scotland - is an means to achieve this.

The Charter should act as a measure to bring the right to protection from alcohol harms to fruition. SHAAP is supportive of the core mission of the National Collaborative and Charter to promote substance use issues as a human rights and public health based issue, as opposed to a criminal justice issue. SHAAP is wholly supportive of the aims of the Charter to support people with alcohol problems to understand their rights in order to: access services, to support service providers and policymakers to improve services; and to support a cultural shift and to reduce the great burden of stigma which surrounds alcohol problems.

The content of the Charter is largely applicable to our aims, however SHAAP is extremely concerned by the current balance of focus on drugs at the expense of alcohol and the lack of parity of investment in current substance use policy and legislation. We have concerns that this imbalance is reflected in the Charter. Despite the Scottish Government's declaration of the 'dual public health emergency' of alcohol and drugs harms in Scotland, we are not seeing parity of urgency or resource allocation between the two emergencies. Anecdotally we are hearing this time and time again – and this is being demonstrated on the ground by the reduction and integration of specialist alcohol services into broader services. It is important that this Charter aims to address this imbalance rather than inadvertently furthering this inequality.

Question 2: What could improve the content of this draft Charter? Is there anything you would like to add?

The Charter would be improved by an explicit mention of how alcohol and drug harms/rights to access services will be upheld in an equitable manner. The Charter would be enhanced by clear signposting throughout as to which areas are intended to be applicable to alcohol and/or drugs. The Charter should include a section on addressing the inequalities present between alcohol and drug services, resources, and the differences in barriers to treatment experienced by people with alcohol to those with drug problems (or both). The Charter should mention the rapidly declining numbers of individuals accessing alcohol treatment and support: the number of people commencing specialist alcohol treatment dropped from a peak of 32,556 in 2013/14 to 19,617 in 2021/22, representing a 40% decline across Scotland. It is vital that the Charter sets out how it will support increasing access and

also how it will reduce barriers to support, in detail. The 'Starter Checklist' on the Right to Health should address this: in the 'available' section, which currently asks 'do services provide sufficient choice and person-centred support?'. Another criteria should be added which reads 'do services meet the scale of local need for both alcohol AND other substance use needs?'.

It should be made clear how the rights in the Charter are going to be communicated to different groups of varying levels of disadvantage, stigma, and need: this is essential so that the Charter does not inadvertently further inequalities. For example, how will these rights be communicated to individuals living in more deprived areas or individuals with less health literacy? Knowledge of rights needs to be equal in order to achieve the aims of the Charter and in order for individuals to be meaningfully engaged in decision making. This could be addressed through the 'accessible' section of the checklist on the right to health. Access across the socioeconomic spectrum should be included as an outcomes indicator. Similarly, the Charter should make clear how it is applicable to the justice setting, and how the rights of the Charter will be communicated and realised in the Scottish justice landscape.

It is not entirely clear how the Charter will impact any decisions around funding. However, SHAAP is concerned by the current funding of alcohol services, as explained above. Funding must be tailored to the scale of local need and areas disproportionately affected by health inequalities, especially with respect to alcohol vs other substance abuse services. The Charter should seek to address this.

The Charter also mentions at many points how it seeks to uphold people's rights to the highest attainable standard of physical *and* mental health, yet does not make clear how the current barriers to co-occurring alcohol and mental health problems will be addressed through the Charter or otherwise. Time and time again we are presented (through research, discussions with other organisations, and individuals with lived experience) with the same issue of people with co-occurring mental health problems and alcohol problems being hindered in their treatment and support by a lack of joined up approach between sectors and services, resulting in being excluded from one – usually mental health - service. This is despite there being plenty of guidance and strategies on the issue: the Mental Welfare Commission of Scotland reported finding "that the guidance and standards set out by government are not being followed at a local level. There was a clear failure to implement guidance[…] [which] is having a direct impact on the lives of very vulnerable people and their families, who need joined-up support."[v] It is not always clear for people with co-occurring mental health issues and alcohol problems which service is appropriate for them, and the system must be redesigned in such a way that there is no wrong door for people who require treatment and/or support. The Starter Checklist should seek to address this through its action and also include this as an outcomes indicator, building on existing guidance. People and services must be brought together across sectors to support prevention, treatment and recovery from alcohol problems in an integrated, comprehensive manner.

The Charter could also be improved by detailed explanation of how services will be evaluated against the aims and actions.

We are pleased to see that, alongside the Human Rights Bill, the draft Charter includes the right to a healthy environment, and an environment which is not harmful to individuals' health and wellbeing. We understand that, in its current format, the 'right to a healthy environment' presently refers primarily to ecosystems and the biosphere, however SHAAP strongly encourages the adoption of a wider definition of a healthy environment, to include other environmental factors which have a major impact on the health and wellbeing of Scottish citizens. We would encourage the essential inclusion of environmental exposure to alcohol, alcohol outlets and the branding and marketing of alcohol. The draft Charter also includes the 'right to an adequate standard of living' and 'the right to the highest attainable standard of physical and mental health'. In the current environment of Scottish society, individuals are constantly exposed to reminders of alcohol without consenting – be it through outlets selling alcohol or exposure to branding and marketing of alcohol. Alcohol prompts are pervasive and inescapable in the Scottish environment, and this has major impacts on our physical and mental health. Exposure to alcohol marketing and nudges to drink are present in our outdoor and public spaces, on TV and radio, near schools, in our sporting stadia, at events, in print media, etc. The effect which this current environment has upon our health and decision making cannot be underestimated.

It is well established that exposure to alcohol marketing is causally associated with the initiation of drinking, an increase in alcohol consumption (including binge drinking), and also an increased risk of relapse (for those in recovery).[vi,vii,viii,ix,x,xi] Alcohol companies invest billions of pounds every year in marketing, aiming to increase the consumption of their products, often through the targeting of heavy drinkers and recruitment of new drinkers.[xii]

The current environment in Scotland is designed as such to nudge individuals to drink through reminders in their daily lives. Non-consensual exposure to alcohol marketing in our daily lives is a human rights issue and is particularly problematic for children – as we know this influences drinking behaviours.

People have a need and the right to be protected from the aggressive marketing of alcohol. Exposure to alcohol and its marketing is majorly compromising to the right of individuals to a healthy environment and the right to the highest attainable standard of physical and mental health. Alcohol marketing and exposure to alcohol-related content also undermines people's rights to privacy and to be free from exploitation.

Comprehensive restrictions on alcohol marketing/promotion and availability are upheld as some of the World Health Organization's 'best buys' to reduce alcohol harms. Scottish citizens have a right to be protected from this in their daily environment.

We know that Scotland is facing a crisis with alcohol and that marketing is contributing to this. SHAAP would like to see the introduction of a comprehensive set of marketing restrictions around alcohol promotion in sporting events, in public spaces, in the retail environment, online and through TV, radio and print advertising. Scotland should continue to uphold their reputation as a world-leader in alcohol policy. The implementation of a new human rights strategy and Charter of Rights is a real opportunity for us to change the Scottish narrative around alcohol and put the wellbeing of our nation first. Consideration

should also be given to how the alcohol industry negatively impacts our environment and climate due to the resource-intensive nature of production and distribution. This is also a rights issue.

SHAAP is concerned by the major conflict of interest which the alcohol industry poses in public health policy development and would like to see the 'right to no conflict of interest' added to the Charter. The alcohol industry has a vested interested in maintaining and growing sales of their products, to maximise profits for shareholders: this major conflict of interest makes them fundamentally incompatible with the public health policy development process. People should have a right to a policy development process free from bias and conflict of interest such as this.

The Checklist and Indicators for Women section should include a right to fast-tracked treatment and support for women who are pregnant. This is essential to minimise the risk of Fetal Alcohol Syndrome Disorders.

Finally, while families of people with alcohol or drug problems are referenced in the various checklists, they are not identified as having specific rights in relation to their own health and wellbeing. This should be addressed.

Question 3: What would support you to use the Charter in practice? (e.g. training, resources, guidance, different formats)

N/A

Question 4: Can you foresee any challenges or barriers to implementing the draft Charter? How these might be overcome?

As mentioned above, SHAAP is concerned by the current focus on drugs over alcohol and see this as a barrier to implementation without clear signposting to which areas are applicable to alcohol or drugs, or explanation of how each item is transferable/translatable.

Another barrier is staffing and resourcing. It should be clear how the implementation, communication and monitoring of the Charter will be staffed and funded. The draft Charter states that "all duty bearers should be mandated to ensure their workforce are appropriately trained in rights-based approaches to service delivery". It should be clear how healthcare professionals, service staff and anyone interacting with people in their realisation of their rights will be trained on this, and how a holistic cultural shift will happen with these individuals in order to address the current power imbalance. For example, how will existing staff be trained on language and approach? Will training programmes for new staff be amended to include the content of the Charter? Will medical curriculums be changed to include this? How does the Charter see the cultural move coming to fruition as opposed to remaining aspirational?

As highlighted in the call for evidence, funding models are currently not optimum, with a short term approach to service commissioning which is limiting productivity of services and staff retention/job attractiveness. Services are also separated at local authority level, making the tackling of wider societal issues and a joined-up approach difficult. The Charter

should make clear how these issues could be addressed to improve the realisation of rights of individuals and to remove barriers to treatment and support. How will the aspirations of the Charter be implemented uniformly?

It should also be clear which actors will be responsible for monitoring and enforcement of the Charter, as well as measuring outcomes and success. Will this be self-reported/inspected? Will there be an independent regulator or services?

Question 5: Is there anything else you want to say?

N/A

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[i] National Records of Scotland (2023). Alcohol-specific deaths 2022.
[ii] Public Health Scotland (2024). Alcohol related hospital statistics.
[iii] Bhattacharya, A. (2023). Getting in the spirit? Alcohol and the Scottish Economy.
[iv] Data can be found here: https://www.parliament.scot/chamber-and-committees/questions-and-answers/question?ref=S6W-19111
[v] Mental Welfare Commission for Scotland (2023) Ending the exclusion: Care, treatment and support for people with mental ill health and problem substance use in Scotland
[vi] Booth, A., Meier, P., Stockwell, T., Sutton, A., Wilkinson, A., Wong, R., Brennan, A., O'Reilly, R., Purhouse, R. & Taylor, K. (2008). *Independent review of the effects of alcohol pricing and promotion. Part A: systematic reviews*. Sheffield: University of Sheffield.
[vii] Anderson, P., De Bruijn, A., Angus, K., Gordon, R., & Hastings, G. (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol and Alcoholism,* 44(3), 229-243.
[viii] Smith, L. A., & Foxcroft, D. R. (2009). The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. *BMC Public Health*, 9(1), 51.
[ix] Jernigan, D., Noel, J., Landon, J., Thornton, N., & Lobstein, T. (2017). Alcohol marketing and youth alcohol consumption: a systematic review of longitudinal studies published since 2008. *Addiction*, 112, 7-20.
[x] Scott, S., Muirhead, C., Shucksmith, J., Tyrrell, R., & Kaner, E. (2017). Does industry-driven alcohol marketing influence adolescent drinking behaviour? A systematic review. *Alcohol and Alcoholism*, 52(1), 84-94.
[xi] Shortt, N. K., Rhynas, S. J., & Holloway, A. (2017). Place and recovery from alcohol dependence: A journey through photovoice. *Health & Place*, 47, 147-155.
[xii] Hastings, G., Brooks, O., Stead, M., Angus, K., Anker, T., & Farrell, T. (2010). *"They'll drink bucket loads of the stuff": An analysis of internal alcohol industry advertising documents.* London, UK: Alcohol Education Research Council.
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