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Better adaptation of healthcare services for persons with a substance use disorder

PERSPECTIVES

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The new UN Convention on the Rights of Persons with Disabilities should also be applied to ensure better adaptation of healthcare services for those with a substance use disorder.

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The human rights of persons with disabilities have been strengthened in recent years, in particular through the UN Convention on the Rights of Persons with Disabilities (CRPD) (1–3). The CRPD does not grant new rights but stresses that human rights also apply to persons with disabilities. The committee that examined the incorporation of the CRPD into Norwegian law points out that substance use is covered by the CRPD if it has resulted in disability (4). So far, the CRPD has had little impact on the access to Norwegian healthcare services for those with a substance use disorder (SUD).

Can substance use lead to disability?

Functional ability includes physical, mental, sensory and cognitive capacities. Disability encompasses physical, mental, sensory and cognitive impairments. Someone with SUD may have a disability either as a result of the disorder or independently of it. Whether a disability occurs in a specific situation depends on both the person's functional ability and their surrounding environment. For example, in order for persons with cognitive impairment to be able to arrange a medical appointment, the booking process must be accessible and not entail barriers for them. Disabilities that hinder participation in society arise from the interplay between persons with impairments and environmental barriers (3). This is called a social relational model of disability and is applied in Norway and internationally (3, 5). The model integrates individual and social factors as well as the interaction between the person and their environment.

When assessing whether SUD leads to disability, the focus is on factors related to the individual. Does the person have physical, mental, sensory or cognitive impairments related to their SUD? However, the interaction between the

person and their environment also plays a role. For example, a person may encounter barriers when trying to make an appointment with their general practitioner (GP) because the digitalisation of the health service requires digital literacy and access to digital tools and the personal electronic identification system BankID. Not everyone with SUD has access to these resources.

We believe that substance use and SUD can lead to disability because they affect the person's cognitive functioning, somatic and mental health, self-care, and interpersonal relationships. The lifespan of individuals with both SUD and a mental disorder, known as a co-occurring disorder (COD), as well as those with SUD but no mental disorder, is 10–20 years shorter than that of the general population (6–9). Trauma, lifestyle, living conditions, access to healthcare services and the specific substance use all contribute to health inequalities. At the core of this is the interplay between the person and their environment and how the person manages their daily life. Are they able to make use of somatic and mental health services? Do they have satisfactory housing? Are they part of a local community?

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Whether SUD can be considered a disability has not yet been investigated. The Equality and Anti-Discrimination Ombud has pointed out that it is unclear whether SUD is encompassed in the term 'disability' (10). The Norwegian Institute for Human Rights recommends that the authorities assess the actual and legal need for discrimination protection for those with SUD and consider whether legislation and practices should be revised to strengthen this protection (2). If a person requires accommodation or other affirmative action to gain equal access to healthcare services, we believe it is discriminatory *not* to provide this. We therefore support an investigation into whether SUD should be understood as a disability and whether a lack of accommodation in the health service can be considered discriminatory.

From discrimination to affirmative action

Article 25 of the CRPD states the following (3):

'States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services'.

Requirements for out-of-pocket expenses to be paid can lead to financial problems for patients and feelings of shame from being in debt to their GP. This can serve as a barrier to attending necessary medical appointments and result in persons with SUD missing out on preventive measures and essential treatment. This situation increases the vulnerability of individuals with SUD. The consequence can be higher morbidity and mortality among this group, often from diseases that can currently be prevented and treated. It could

therefore be argued that applying out-of-pocket expenses and fees for missed appointments has a discriminatory effect on people in vulnerable life situations, even if that is not the intention.

In 2023, the regulations were amended to prevent hospitals from charging out-of-pocket expenses for opioid agonist treatment (OAT) (11). This means that OAT patients are exempt from paying out-of-pocket expenses, but only specifically for the OAT. If they require help for substance issues or other health problems from their GP or other parts of the specialist health service, or if they are not receiving OAT, they are required to pay out-of-pocket expenses. If this hinders equal access to healthcare services, exemption from such expenses could constitute an individualised accommodation that enhances access to health care for SUD patients.

> ***«Exemption from out-of-pocket expenses could constitute an individualised accommodation that enhances access to health care for SUD patients»***

Norwegian Medical Association must do more

The Norwegian Institute for Human Rights has addressed the human rights of individuals with SUD in two recent reports, both of which reference the CRPD (1, 2). The reports note the importance of investigating the actual and legal need for discrimination protection for those with SUD. One of the recommendations of the report on substance use and human rights (*Rus og menneskerettigheter*) is to strengthen housing and healthcare services, with a particular focus on access to physical and mental health care for those with COD (1). The second report calls for an assessment of whether our statutory framework is sufficient for protecting those with SUD from discrimination (2. 67).

In our opinion, the most recent of the two aforementioned reports from the Norwegian Institute for Human Rights (2) should have implications for the organisation of healthcare services for SUD patients. The report points out that SUD patients are protected from discrimination under international conventions (2. 10), and makes specific reference to the CRPD.

The Norwegian Medical Association established a working group to address the topic of physical health in patients with severe mental health problems and/or substance use problems They submitted their report (*Bedre helse og lengre liv*) (12), but did not draw on the CRPD in their work. The mandate was threefold: identifying areas with potential for improvement and the need for additional efforts, proposing standards for somatic assessments, and devising procedures for collaboration between the different levels of the health service. According to the second author of this article, who was a member of the working group, the human rights perspective was not considered.

«From a service user perspective, it can appear that the rights of SUD patients are being violated in their interactions with healthcare services»

A greater focus on human rights and discrimination in the field of substance use has led to various surveys and reports that have revealed violations of fundamental civil rights. From a service user perspective, it can appear that the rights of SUD patients are being violated in their interactions with healthcare services. We believe that the Norwegian Medical Association has a particular responsibility to contribute to good-quality, accessible healthcare services for vulnerable groups. The lack of engagement with the CRPD in the report by the Norwegian Medical Association demonstrates the need for more knowledge about the rights of persons with disabilities among doctors and in the health service in general. The CRPD serves as a human rights framework for affirmative action through better individualised adaptation of healthcare services (13). It should therefore be more widely applied as a point of reference for providing good services for substance users.

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