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Health, Social Care and Sport Committee

Stage 1 report on the Right to Addiction Recovery (Scotland) Bill

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Health, Social Care and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Social Care.


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Membership changes

1. The following changes to Committee membership occurred during the Committee's scrutiny:

   - On 30 October 2024, Elena Whitham MSP replaced Ruth Maguire MSP as a member of the Committee.
   - On 21 May 2025, Patrick Harvie MSP replaced Gillian Mackay MSP as a member of the Committee.

2. The following declarations of interest were made during the Committee's scrutiny:

   - Dr Sandesh Gulhane MSP declared an interest as a practising NHS GP.
   - Emma Harper MSP declared an interest as a former NHS Scotland and NHS England employee and as a registered nurse.
   - Clare Haughey MSP declared an interest as holding a bank nurse contract with NHS Greater Glasgow and Clyde, as being registered with the Nursing and Midwifery Council, and as having commissioned the Scottish Mental Health Law Review when she was a Minister.
   - Elena Whitham MSP declared an interest as a former East Ayrshire councillor and COSLA spokesperson.
   - David Torrance MSP declared an interest as a Trustee of Fife alcohol support services.

Executive summary

3. This report sets out the findings of the Health, Social Care and Sport Committee's scrutiny of the Right to Addiction Recovery (Scotland) Bill at Stage 1.

Interaction with existing legal framework

4. The Committee notes concerns about the way the Bill might interact with the existing legal framework governing the rights of people suffering harm from alcohol or drug use. Some have argued that the Charter of Rights for People Affected by Substance Use is more collaborative and less medicalised in its scope and use of language. However, others have pointed out that the rights set out in the Charter are not legally enforceable whereas the rights created by the current Bill would be. Should the Bill be approved at Stage 1, the Committee calls on Douglas Ross to consider further ways of ensuring that the Bill would operate in a manner that is consistent rather than in conflict with existing policy and legal framework.

Prevention and early intervention

5. The Committee recognises the fundamental importance of prevention and early intervention in tackling harmful drug and alcohol use. It notes widespread concerns that there is a risk that passage of the Bill could result in investment in this area being de-prioritised. It therefore calls on Douglas Ross, should the Bill be approved at Stage 1, to consider how the Bill might be amended in order to address these concerns.

Setting a precedent for other areas of treatment

6. The Committee has heard strong evidence about the precedent and expectation that could be created for the treatment of other conditions by providing a right to treatment in legislation, as the Bill proposes to do. The Committee is concerned that this will need to be carefully considered in determining whether and in what form the Bill progresses to become law.

A whole-family approach

7. The Committee notes the disappointment of families and carers of individuals experiencing harm from drug or alcohol use that the Bill makes no reference to the crucial role they play in supporting an individual through their treatment and recovery journey.

8. It therefore welcomes Douglas Ross' preparedness to re-examine this issue should the Bill progress to Stage 2 to ensure the role of families and carers is appropriately recognised and they are suitably involved in the processes set out

in the Bill.

A trauma informed approach

9. The Committee does not share Douglas Ross' assessment that the narrow scope of the Bill prevents him from ensuring that its provisions embed a trauma-informed approach to the processes it sets out. Should the Bill progress to Stage 2, it calls on Mr Ross to consider further how trauma-informed practices can be properly reflected in the wording of the Bill.

A multi-disciplinary approach

10. The Committee recognises the crucial importance of a multi-disciplinary approach to supporting individuals experiencing harm from drug or alcohol use. While accepting that the Bill is intended to cover a particular stage of an individual's treatment and recovery journey, it nonetheless shares concerns that the focus on a medical practitioner making the determination of treatment risks overmedicalising that stage of the process. It therefore calls on Douglas Ross, should the Bill progress to Stage 2, to give further consideration to how the wider multidisciplinary team might be appropriately involved in the procedure for determining treatment set out in the Bill.

Impact on priorities

11. The Committee notes widespread concerns that implementation of the Bill could result in priorities within drug and alcohol services being refocused towards delivering a relatively narrow suite of treatment options and other aspects of drug and alcohol support being deprioritised.

12. Should the Bill progress to Stage 2, the Committee calls on Douglas Ross to consider the inclusion of additional safeguards within the Bill to ensure this is not the practical effect of its implementation.

Impact on workforce

13. The Committee notes the estimate of costs of training associated with the Bill as set out in the Financial Memorandum. It has heard evidence that substantial additional training to that budgeted for in the Financial Memorandum would be required to enable the sort of cultural change that would be necessary for the Bill to be effectively implemented.

14. The Committee further notes the Financial Memorandum's conclusion that any additional costs in staff time will be offset by a reduction in repeat appointments from individuals who, in the absence of the Bill, would have experienced an

unsuccessful journey towards treatment.

15. The Committee recognises the scepticism of many stakeholders that this offset in staff time will be realised in practice. For example, contributors have cited the need for longer appointments to allow proper assessment of individuals seeking to exercise their rights under the Bill. The Committee further notes concerns that staffing requirements associated with the Bill may have a knock-on impact on recruitment for other multi-disciplinary roles.

16. The Committee has heard substantial evidence of the significant strain those working in drug and alcohol services are currently under and concludes that the Bill's potential impact on the workforce must be carefully assessed in that context.

Cost and resource

17. The Committee notes assumptions from the Financial Memorandum accompanying the Bill that the number of residential rehabilitation beds in Scotland will increase significantly over the coming years in line with recent Scottish Government commitments and that the marginal cost implications of the Bill's implementation should be relatively limited and manageable in that context.

18. At the same time, many stakeholders are concerned that the costs of implementation set out in the Financial Memorandum are a significant underestimate.

19. In assessing the case for or against the Bill, the Committee concludes that further work is required to account for a range of potential associated costs, including redesigning services as well as infrastructure and IT costs associated with the reporting provisions of the Bill.

20. The Committee further notes concerns that the Bill may result in resources being diverted from addressing the needs of individuals and towards achieving legal compliance with the Bill.

Risk of litigation

21. The Committee notes concerns that the Bill may have the unintended consequence of a significant rise in litigation. It remains to be persuaded by Douglas Ross' counter-argument that an increase in availability of treatment resulting from the Bill will counteract this risk. The Committee takes the view that legislation does not necessarily lead directly to an increase in availability of treatment. However, this Bill will create a legal right to access treatment which, if unmet for whatever reason, could be subject to legal action on grounds of clinical negligence. The Committee is sympathetic to concerns that such actions could place additional strain on already constrained resources for drug and alcohol services.

Enforcement

22. The Committee acknowledges Douglas Ross' view that the act of creating certain statutory rights in legislation will, in itself, send a signal that those rights should be upheld and the need for individuals to realise those rights through legal challenge would therefore, in many cases, be negated. However, the Committee has also heard multiple concerns that creating such rights in law fails to address the underlying obstacles to access to treatment, namely culture and a lack of capacity and resource. The Committee has also heard concerns that the available routes for individuals to enforce their rights would be prohibitively onerous and expensive. Should the Bill progress to Stage 2, the Committee calls on Douglas Ross to explore developing alternative routes from those currently envisaged that would make access to justice for individuals simpler and less costly.

Language and definitions

23. The Committee notes a range of concerns about the language and definitions used in the Bill and calls on Douglas Ross, should the Bill progress to Stage 2, to give careful consideration to how these concerns might be addressed through an alternative use of terminology.

Requiring a diagnosis of addiction

24. The Committee notes Douglas Ross' acknowledgement that individuals experiencing harm from drug or alcohol use who had not received a diagnosis of addiction would not be able to exercise the rights to access treatment conferred by the Bill. The Committee further notes concerns that focusing the Bill in this way risks ignoring the harm from use of alcohol or drugs experienced by many individuals who are not technically addicted to or dependent on the substance causing them harm. The Committee has also heard substantial evidence that the Bill's focus on "addiction" and "diagnosis" risks creating stigma and discouraging many individuals from putting themselves forward for treatment.

25. The Committee shares the view that individuals receiving a diagnosis of addiction under the terms of the Bill should retain an absolute right to anonymity.

26. The Committee also highlights suggestions that a more appropriate alternative term to "addiction" would be "substance use disorder", as defined by the "Diagnostic and Statistical Manual of Mental Disorders" (DSM-5).

27. The Committee further welcomes Douglas Ross' willingness, should the Bill progress to Stage 2, to reconsider use of the term "diagnosis" in the Bill to ensure its use is not inadvertently exclusionary.

Advocacy

28. The Committee notes Douglas Ross' acknowledgement of the importance of independent advocacy in supporting individuals through their treatment and recovery journey. It further notes Mr Ross' intention that the role of advocacy be addressed by the code of practice to be prepared by Scottish Ministers once the Bill has become law. Nonetheless, it regrets that the importance of independent advocacy is not really reflected in the wording of the Bill itself which makes no direct reference to advocacy. Should the Bill progress to Stage 2, the Committee calls on Douglas Ross to reflect further on how the role of independent advocacy can be properly integrated into the processes set out on the face of Bill. The Committee considers that this will be particularly crucial to addressing the existing power imbalances that it fears will otherwise persist

Requirement for in-person appointments

29. In light of the evidence it has received that it could act as an unnecessary obstacle to individuals exercising their rights under the Bill, the Committee welcomes Douglas Ross' willingness to re-consider the requirement for in person appointments should the Bill progress to Stage 2.

Abstinence versus harm reduction

30. The Committee notes concerns that the Bill places a particular emphasis on abstinence-based types of treatment over harm reduction. It further notes Douglas Ross' acknowledgement that there is a perception that the Bill is "heavily reliant on an abstinence-based approach". The Committee has heard extensive evidence that abstinence-based treatment pathways will not suit every individual at every stage of their treatment and recovery journey, and that, in those circumstances, many individuals will benefit more from harm reduction interventions.

31. In this context, the Committee questions the value of including a list of treatment options on the face of the Bill when such a list can never be exhaustive.

Timescales for accessing treatment

32. The Committee has heard multiple concerns about the proposed three week timescale for individuals to commence treatment under the terms of the Bill. These included concerns that the timescale and the statutory nature of the Bill's provisions might result in quality and choice of treatments being restricted; would be unrealistic for certain types of treatment and could increase the risk of relapse, particularly in the case of residential rehabilitation; would place further strain on an overstretched workforce; and could result in the unintended consequence of individuals having to wait much longer for an initial treatment assessment.

33. Should the Bill progress to Stage 2, the Committee calls on Douglas Ross to give further consideration to these concerns and whether a rigid three-week timescale

is appropriate in all circumstances or whether a more flexible approach that distinguishes between different types of treatment might be preferable.

Recommendation on the general principles of the Bill

34. The Health, Social Care and Sport Committee draws its conclusions and recommendations on the Bill to the attention of the Parliament.

35. The Committee recognises the strength of evidence it has seen and heard throughout its Stage1 scrutiny of this Bill of a high level of dissatisfaction with current availability of and access to support services for those experiencing harm from drug or alcohol misuse.

36. The Committee notes that Douglas Ross has himself acknowledged the need for the Bill, should it progress to Stage 2, to be significantly amended to address those concerns raised during Stage 1.

37. Some Members of the Committee have concluded that, were it to progress beyond Stage 1, the Bill would require such significant amendment that there would be a need for substantial additional evidence to be taken at Stage 2.

38. Having concluded its scrutiny of the Bill at Stage 1, the Committee is unable to recommend that the general principles of the Bill be agreed to.

Introduction

39. A draft proposal for a Member's Bill to enable people addicted to drugs and/or alcohol to access the necessary addiction treatment they require was lodged by Douglas Ross MSP on 6 October 2021.

    A consultation on this proposal ran from 7 October 2021 to 12 January 2022 and received a total of 195 responses. Of these, 35 were from organisations. 159 were from individuals, including academics, professionals and members of the public.

40. A summary of responses to the Member's consultation was published along with a final proposal on 30 May 2022.

41. Douglas Ross MSP introduced the Right to Addiction Recovery (Scotland) Bill in the Scottish Parliament on 14 May 2024. In preparing the Bill and its accompanying documents, Mr Ross was supported by the Parliament's Non-Government Bills Unit.

42. The Health, Social Care and Sport Committee was designated as lead committee for Stage 1 consideration of the Bill on 21 May 2024.

43. Under the Parliament’s Standing Orders Rule 9.6.3, it is for the lead committee to report to the Parliament on the general principles of the Bill. In doing so, it must take account of views submitted to it by any other committee. The lead committee is also required to report on the Bill’s Financial Memorandum, taking account of any views submitted to it by the Finance and Public Administration Committee

Overview of the Bill

44. The Policy Memorandum accompanying the Bill describes the Bill's aim as being:

> (...) to establish a right in law to treatment for addiction for anyone in Scotland who is addicted to alcohol and/or drugs.

45. The Explanatory Notes accompanying the Bill describe the purpose and scope of the Bill as follows:

> The Bill provides for a right for anyone diagnosed as having a drug and/or alcohol addiction to receive a treatment determination and for the person to be provided with that treatment as soon as reasonably practicable and no later than three weeks from the date of the determination. The Bill provides that the Scottish Ministers must secure the delivery of all of these rights and obliges them to make regulations setting out how they will fulfil that duty. In doing so, it gives the Scottish Ministers the power to confer functions on health boards, special health boards, the Common Services Agency, local authorities and integration joint boards. The Bill also requires the Scottish Ministers to prepare a code of practice to go alongside these regulations.
>
> The Bill enables a person who has been diagnosed as having a drug and/or alcohol addiction to participate in the decision-making process about their treatment and for that treatment to commence no later than three weeks from the date of the determination.
>
> The Bill also requires the Scottish Ministers to report annually to the Parliament on progress made towards achieving the provision of the treatments under this Bill.
>
> The Bill requires the Scottish Ministers, before preparing a report, to consult representatives of patients and people with lived experience of drug and/or alcohol addiction, as well as health boards, special health boards, the Common Services Agency, local authorities and integration joint boards.

46. The Bill is divided into 11 sections. Sections 1 to 3 focus on a right to recovery. Sections 4 to 6 place duties on Scottish Ministers and sections 7 to 11 include the final provisions.

47. Further details on the Bill and its accompanying documents can be found on the Scottish Parliament website.

48. The Scottish Parliament Information Centre (SPICe) published an in-depth briefing on the Bill on 25 February 2025.

Background to the Bill

Legal position

49. The main legal framework for the NHS in Scotland is the National Health Service (Scotland) Act 1978. This places a duty on Scottish Ministers to promote health improvement and to provide a range of services via health boards.

50. Generally, legislation in Scotland does not specify a right to a particular service or treatment. There is provision in the National Health Service (Scotland) Act 1978 for health boards to provide specific services on behalf of Ministers (such as primary care, pharmacy services) but neither the 1978 Act nor the Patient Rights (Scotland) Act 2011give people a 'right' to treatments as specific as drug or alcohol rehabilitation.

51. Under the Patient Rights (Scotland) Act 2011, Scottish Ministers are required to publish a Charter of Patient Rights and Responsibilities that summarises the rights and responsibilities of people who use NHS services and receive NHS care in Scotland. This includes:

> I have the right to safe, effective, person-centred and sustainable care and treatment that is provided at the right time, in the right place, and by the most appropriate person.

52. Under the Charter of Patient Rights and Responsibilities, people also have the right to ask for a second opinion before making a decision about their care and treatment. They also have the right for their needs, preferences, culture, beliefs, values and level of understanding to be taken into account and respected when using NHS services. At the same time, health boards must also consider the rights of other patients, medical opinion, and the most efficient way to use NHS resources when assessing a patient's rights under the Charter.

53. However, it is worth noting that section 20 of the Patient Rights (Scotland) Act 2011 restricts the potential for legal action relating to the Act's provisions. Although the rights within the Act are not legally enforceable, a patient can seek judicial review. This is an authoritative statement that stipulates that an individual or body has a specific right or duty. It can be useful in cases where the patient seeking the review wants to establish that a particular right exists, or that a particular status applies, and that this has been doubted or denied.

Alcohol and drug services in Scotland

54. Treatment and support services for drugs and alcohol are devolved to Scottish Ministers. Integration Authorities receive around 70% of their funding from the NHS and have delegated responsibility for providing local alcohol and drug services, coordinated by Alcohol and Drug Partnerships (ADPs).

55. There are 30 Alcohol and Drugs Partnerships (ADPs) in Scotland. ADPs are a partnership of health and social care partnerships, health boards, local authorities,

Police Scotland, the Scottish Prison Service, third sector, community groups and people with lived and living experience. They are responsible for commissioning and developing local strategies for tackling problem alcohol and drug use and promoting recovery, based on an assessment of local needs.

56. In 2019, the Scottish Government and COSLA agreed to a Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs. This set out a shared ambition for ADPs and indicated that local areas should have:

- A strategy and clear plans to achieve local outcomes to reduce the use of and harms from alcohol and drugs
- Transparent financial arrangements
- Clear arrangements for quality assurance and quality improvement
- Effective governance and oversight of delivery.

57. The Scottish Government has set a standard that 90% of people referred for help with problematic drug or alcohol use will wait no longer than three weeks for specialist treatment that supports their recovery. The three-week period covers the time between referral and commencement of treatment, and includes the completion of an initial assessment.

58. A recent Audit Scotland report found waiting times for specialist treatment vary across Scotland. It also highlighted that four of the 14 NHS territorial boards missed the three-week waiting time target in at least five of the ten quarters to June 2024.

59. In evidence to the Criminal Justice Committee, Health, Social Care and Sport Committee, and Social Justice and Social Security Committee (Joint meeting) on 14 November 2024, Maggie Page from the Scottish Government said:

> We do not have robust data or statistics on the number of people who have requested residential rehab. I think that, once we started to unpick that, we would find it quite difficult to measure it accurately.

60. The Scottish Government publishes information on funding allocations to NHS Boards to support the delivery of alcohol and drug services.

61. The Scottish Government also funds a cross-government action plan intended to address increased residential capacity, public health surveillance and research, operating costs, alcohol harms and the work of the National Collaborative. It also provides funding to the Corra Foundation which then distributes funding to local grass roots and third sector organisations that provide services, as well as other third sector partners.

Scottish Government work

62. In August 2022, the Scottish Government published the National Drugs Mission Plan: 2022-2026 which included six outcomes:

1. Fewer people develop problem drug use
2. Risk is reduced for people who take harmful drugs
3. People at most risk have access to treatment and recovery
4. People receive high quality treatment and recovery services
5. Quality of life is improved to address multiple disadvantages
6. Children, families and communities affected by substance use are supported

63. The Scottish Government has noted that the work of the mission was previously supported by the Drug Deaths Taskforce, and is currently supported by the Residential Rehabilitation Development Working Group and a National Collaborative representing the views of those with lived and living experience, the National Mission Oversight Group and a number of working groups.

64. The National Collaborative is aimed at developing a human rights-based approach and involve people with experience of problem substance use, as well as people responsible for delivering support services. According to the Scottish Government, the purpose of the National Collaborative is:

- to empower people affected by problem substance use to enable their voices – and, critically, their rights - to be acted upon in policy and decision-making concerning the design, delivery and regulation of drug and alcohol services at a national level;
- to set out how the rights to be included in the forthcoming Human Rights Bill can be effectively implemented to improve the lives of people affected by problem substance use

65. An annual report was published in August 2024, which included an update on progress towards meeting cross cutting priorities and achieving each of the outcomes, including meeting the Medication Assisted Treatment (MAT) Standards, as well as in relation to community-based opioid substitution therapy and residential rehabilitation.

66. In an evaluation of the policy, Public Health Scotland concluded that the national mission on drug deaths had made a positive impact in providing additional funding, making progress towards strengthening treatment systems, improving accountability and increasing visibility of the needs of individuals affected by drugs. Unintended negative consequences from the national mission included a loss of focus on alcohol-related harms and creating unhelpful pressure in the system, as well as a risk of undermining the potential for a genuine learning and improvement culture around drugs in Scotland to be developed. Missed opportunities included insufficient focus on resourcing, a lack of support for the workforce, insufficient focus on prevention and wider system determinants, non-opioid drug use and polydrug use, and a failure to pursue a fundamental rethink of models of working.

67. In January 2023, the Scottish Government responded to the final report of the Scottish Drug Deaths Taskforce, Changing Lives. Since then, a number of reports

have been produced including:

- A caring, compassionate and human rights informed drug policy for Scotland
- Whole Family Approach: rapid review of literature
- National Collaborative Call for Evidence – Analysis Report
- Analysis of the progress made against the National Mission in the Annual Monitoring Report 2022-23

68. A Safer Drug Consumption Facility ('The Thistle') opened in Glasgow in January 2025. This is a supervised healthcare setting where people can inject drugs, obtained elsewhere, in the presence of trained health and social care professionals in clean, hygienic environments.

69. Standards for services providing drug treatment came into force in April 2022. An independent report entitled Medication Assisted Treatment (MAT) standards: access, choice, support concluded:

> There is good evidence that the health of individuals with opioid dependence is safeguarded while in substitution treatment. Evidence also indicates that it is important to consider medication choice and that optimum dose for an individual is critical to achieving positive outcomes.

70. The 10 Medication Assisted Treatment (MAT) standards are:

> 1. All people accessing services have the option to start MAT from the same day of presentation
> 2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose
> 3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT
> 4. All people are offered evidence based harm reduction at the point of MAT delivery.
> 5. All people will receive support to remain in treatment for as long as requested
> 6. The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social networks
> 7. All people have the option of MAT shared with Primary Care
> 8. All people have access to independent advocacy and support for housing, welfare and income needs
> 9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery
> 10. All people receive trauma informed care.

71. The Scottish Government's 2023-24 annual report on implementation of the MAT standards concluded that all local areas reported good progress against their implementation plans. Public Health Scotland also publishes a regular benchmarking report on implementation of the standards. The most recent report found that for 2024/25:

- For MAT standards 1–5, 91% had been assessed as fully implemented
- For MAT standards 6–10, 75% were assessed as fully implemented and 16% were assessed as being partially implemented.

The report also includes some experiential feedback on implementation of the standards.

72. The Scottish Government's Residential Rehabilitation programme, launched in 2021, is intended to improve access to residential rehabilitation. The Scottish Government's aim in launching the programme was to ensure that residential rehabilitation is available to everyone who wants it, and for whom it is deemed clinically appropriate, at the time they ask for it, in every part of the country.

The programme sets two targets:

- to increase residential rehabilitation bed capacity in Scotland by 50% to 650 beds by 2026
- to increase the number of individuals publicly funded to go to rehabilitation by 300% to 1,000 per year by 2026.

73. Public Health Scotland published a first evaluation report into the programme in February 2024 and subsequently produced information on the number of individuals starting a residential rehabilitation placement between 2019 and 2023.

The report found that implementation of the residential rehabilitation programme (in the period until 2022-23) had coincided with a substantial increase in access to publicly funded residential rehabilitation in Scotland and a slight increase in the total number of individuals accessing rehabilitation, noting that the main change (in the period until 2022-23) had been the source of funding. In December 2024, Public Health Scotland concluded that, based on available data, the Scottish Government had reached its target of 1,000 individuals going into publicly funded residential rehabilitation in the financial year 2022-23.

74. The Scottish Government also published a stigma action plan in January 2023 which provides the following definition of stigma:

> Stigma can involve negative assumptions, prejudice and discrimination against someone based on a characteristic, condition or behaviour. It is not based on fact or evidence. In the case of substance use, it is often rooted in moral judgements about the 'wrongness' of what is assumed to be a choice.

75. The National Collaborative launched its Charter of Rights for People Affected by Substance Use and Toolkit on 11 December 2024. These aim to support people affected by substance use to realise their human rights. They also aim to support service providers to understand and implement these rights, to achieve a shift in the balance of power in favour of service users, and to change the culture from one that

reinforces criminalisation and stigma towards a public health and human rights -based approach.

The rights set out in the Charter of Rights for people affected by substance use are:

1. Right to life
2. Right to the highest attainable standard of mental and physical health
3. Right to an adequate standard of living
4. Right to private and family life
5. Right to a healthy environment
6. Freedom from torture and other cruel, inhuman, or degrading treatment or punishment
7. Freedom from arbitrary arrest or detention.

The Charter also outlines people's right to give positive or negative feedback about their care and support, to have this listened to, and to be able to complain about services.

Current public health situation in Scotland

76. There are long-standing and serious issues associated with drug and alcohol use in Scotland. These problems are often concentrated in the most deprived communities, where health inequalities and social exclusion impact on the experience of people and access to services.

    As set out in a 2018 report, the Scottish Government has six public health priorities. Priority 4 is "A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs".

77. Audit Scotland described alcohol consumption and binge drinking as a "deep seated part of the Scottish culture", with Public Health Scotland estimating that 22% of adults drink at levels that increase their risk of cancer, stroke, heart disease and type 2 diabetes.

78. The Rapid Action Drug Alerts and Response (RADAR) quarterly report (July 2025), identified the following key trends in drug use in Scotland:

    - *Polysubstance use* continues to drive the majority of harms, with high-risk combinations frequently involving cocaine, gabapentinoids, benzodiazepines (notably diazepam and bromazolam) and opioids, with the average numebr of controlled drugs detected per sample being six in hospital and four in post-mortem toxicology,
    - Benzodiazepines, or benzos, available on the street continued to change, with ethylbromazolam detected six times in Scottish WEDINOS samples (March to May 2025), following no previous detections and a continued decrease

inbromazolam detections was observed in post-mortem toxicology, from 24% (January to March 2023) to 6% (January to March 2025),

- *Emerging synthetic drugs* such as potent nitazene-type opioids and xylazine are increasingly reported in harms,
- *Cocaine* was the second most common substance in post-mortem toxicology (after heroin), with powder cocaine being the most commonly reported main drug among people who had an assessment for specialist drug treatment.
- *Contamination* of drugs remains prevalent, with substances often not containing what the purchaser intended; this spans across drug types including adulteration of heroin, benzodiazepines and oxycodone with nitazene-type opioids. Half of all Scottish samples submitted for testing to WEDINOS tested positive for more than just the purchase intent.

79. Public Health Scotland has also estimated that, as of 2022/23, there were 43,400 people with opioid dependence aged 15 to 64 years (a prevalence of 1.23%).

80. In its 2024 report on Alcohol and Drug Services, Audit Scotland stated:

> The number of people dying in Scotland because of alcohol or drug use remains high compared with other parts of the UK and Europe. This is despite improved national leadership and increased investment in alcohol and drug services.

81. Official drug misuse death statistics are published annually by National Records of Scotland (NRS). In 2024, NRS reported that 1,017 people had died due to drug misuse, a 13% decrease from 2023. This is the lowest number of drug misuse deaths recorded since 2017. However, drug misuse deaths are still much more common than they were in 2000 when that number was 292.

82. In 2022, the rate of drug poisoning deaths in Scotland was more than double the rates in other UK countries. Statistics show that Scotland had the highest rate of drug poisoning deaths (22.7 per 100,000) followed by Wales (11.0), Northern Ireland (8.3) and England (8.3)

83. Public Health Scotland also regularly publishes indicators of harm. Primarily, these relate to naloxone administration, drug-related attendances at emergency departments, drug related hospital admissions, and suspected drug deaths (using Police Scotland's published quarterly information).

The most recent publication reported that, between March and May 2025, there were 312 suspected drug deaths, 15% higher than the previous quarter (272), 7% higher than the same period in 2024 (291), but 4% lower compared to the same period in 2023 (325).

84. According to recent ONS reporting, in 2023 Scotland had the highest rate of alcohol-specific deaths (22.6 per 100,000) of the UK countries, followed by Northern Ireland (18.5), Wales (17.7) and England (15.0).

85. A broader look at alcohol harms is produced by Public Health Scotland in its Alcohol Consumption and Harms Dashboard, which addresses variables including inpatient

hospital stays, consumption, crime and homelessness.

Provisions of the Bill

86. The Right to Addiction Recovery (Scotland) Bill seeks to make provisions about the rights of people addicted to drugs and/or alcohol to receive treatment. It is divided into 11 sections.

Right to recovery

87. The Bill seeks to give people diagnosed as having a drug or alcohol addiction, by a relevant professional, a right to receive a treatment determination and be provided with treatment.

88. Section 1 of the Bill provides that the patient is to be offered the treatment deemed appropriate by a relevant health professional. The Bill lists a non-exhaustive list of treatments, but states that:

> "treatment" includes any service or combination of services that may be provided to individuals for or in connection with the prevention, diagnosis or treatment of illness.

89. "A relevant health professional" is defined in section 9 of the Bill as a medical practitioner, nurse independent prescriber or a pharmacist independent prescriber.

The Policy Memorandum notes:

> It is envisaged that, where a person has been diagnosed they will normally have a treatment prescribed by the individual that diagnoses them. The Member considers that this will usually be a General Practitioner or Nurse Practitioner who would be authorised to prescribe any of the treatments in the list set out in the Bill.

90. Section 2 of the Bill lays out the procedure for determining treatment. It states that the health professional must explain the treatment options available, provide information to the patient, and involve them in the decision making process. It also makes provision for the patient to request a specific treatment and for the appropriateness of this treatment to be considered by the health professional.

The Policy Memorandum elaborates on this further:

> The Member would intend that this approach should then begin a holistic process based around a clear plan for the person seeking to recover from alcohol and/or drug addiction.

Section 2 also provides that, if the health professional deems no treatment is appropriate or that the treatment requested by the patient is not appropriate, they must provide the patient with a written statement. This section also gives patients the right to consult another health professional for a treatment determination.

The Policy Memorandum accompanying the Bill recognises that there are numerous existing processes for receiving treatment that are not initiated by a formal diagnosis by a health professional, such as processes involving self-referral. It is stated that the Bill will not affect those who already access treatment through

these existing routes not involving a health professional, the specific purpose of the Bill being to give people a right to treatment after receiving a diagnosis of drug and/or alcohol addiction.

91. Section 3 focuses on the provision of treatment and outlines that treatment should be made available as soon as is reasonably practicable, and no later than three weeks after the determination is made.

The Policy Memorandum elaborates further:

> The Member considers that the key to addressing the level of alcohol and drugs deaths in Scotland lies in ensuring that patients do not have to wait for treatment which may potentially save their lives. For that reason, the Bill explicitly places in statute the requirement for treatment to commence no later than three weeks after the treatment determination being made.

Section 3 also provides that the treatment may not be refused unless another relevant health professional considers that it is not in the best interests of the patient. This section also provides a non-exhaustive list of reasons that may not be used to refuse treatment.

Duties of Scottish Ministers

92. The Bill would also place various duties upon Scottish Ministers.

93. Section 4 places a duty on Ministers to secure delivery of the rights established by the Bill.

94. Section 5 places a duty on Ministers to report annually on progress towards meeting the requirements of the Bill. This would include information broken down by health board on:

- Number of patients that had received a treatment determination
- Type of treatment
- Number of patients receiving treatment, by treatment
- Number of people who are not receiving treatment despite a treatment determination being made
- Average waiting times by treatment
- Longest waiting time by treatment
- Number of patients that had received a written statement
- Number of patients who have sought a second opinion

This section also provides that, in preparing the annual report, Scottish Ministers must consult with individuals with lived experience of drug or alcohol addiction, people representing the interests of patients and health boards (and the Common

Services Agency NHS National Services Scotland), local authorities and integration joint boards.

95. Section 6 of the Bill requires the Scottish Ministers to prepare a code of practice setting out how the duty to fulfil the right to treatment must be carried out by health boards and others such as integration joint boards.

Final provisions

96. Sections 7 to 11 of the Bill cover ancillary provisions, regulation making powers, interpretation, commencement and short title.

Health, Social Care and Sport Committee consideration

97. The Health, Social Care and Sport Committee launched a call for evidence on the Bill which ran from 1 November 2024 to 20 December 2024. Respondents were invited to answer eight questions about the Bill (see Annexe B for further details).

A total of 129 responses were received which can be viewed on the Scottish Parliament website. 41% of responses (50) were from organisations, including health boards, third sector organisations, ADPs and Royal Colleges.

The key themes raised in the written evidence focused around:

- Scope and extent of the Bill
- Person centred approach
- Clinical decision making
- Harm reduction and absence based treatment
- Access to services
- Unintended consequences
- Implementation and enforcement
- Standards and regulation of services
- Drafting suggestions
- Financial implications

98. On 7 January 2025, the Committee received a letter from the Cabinet Secretary for Health and Social Care including a memorandum setting out the Scottish Government's position on the Bill.

The memorandum indicated that the Scottish Government supports the intended purpose of the Bill as introduced, but encouraged the Committee to consider how the proposals in the Bill would fit with the existing delivery framework for drug and alcohol services and what effect any changes arising from the Bill might have on broader drug and alcohol support services.

99. The Committee took formal oral evidence on the Bill at five meetings in March and May 2025 (more detail available in Annexe A).

The programme of oral evidence was as follows:

- 18 March 2025 – Legal and Human Rights, Professional Organisations
- 25 March 2025 – Health Boards, IJBs and ADPs
- 13 May 2025 - Third Sector organisations

- 20 May 2025 – Cabinet Secretary for Health and Social Care, Scottish Government
- 27 May 2025 – Member in charge of the Bill, Douglas Ross MSP

The following witnesses gave oral evidence:

- Legal and human rights context
  - Scottish Human Rights Commission
  - Law Society of Scotland
  - Public Health Scotland
- Professional Organisations
  - Social Work Scotland
  - Royal College of Psychiatrists in Scotland
  - Royal College of General Practitioners in Scotland
- NHS, Local Authorities and IJBs
  - NHS Lothian (Public Health and Health Policy)
  - NHS Fife (Department of Public Health)
  - Aberdeenshire HSCP
  - COSLA
- Alcohol and Drug Partnerships
  - East Ayrshire ADP
  - Dundee ADP
  - Glasgow City ADP
- Third Sector Organisations
  - Scottish Drugs Forum
  - Scottish Families Affected by Alcohol and Drugs
  - Scottish Recovery Consortium
  - Salvation Army
  - Favor UK
  - With You
  - Turning Point Scotland

100. Transcripts of the above meetings are available via the Official Report (18 March 2025; 25 March 2025; 13 May 2025; 20 May 2025; 27 May 2025.)

101. On 18 February 2025, members of the Committee undertook informal engagement with people with lived experience of recovery from alcohol and/or drug addiction.

An anonymised note of this informal engagement has been published on the Scottish Parliament website.

102. The Committee wishes to thank everyone who contributed evidence to its Stage 1 consideration of the general principles of the Bill.

Issues raised in the Call for Views

103. Analysis of the call for written evidence highlights a discrepancy between responses from individuals when compared to those from organisations.

Of the total 129 responses, the majority of respondents indicated they strongly agreed or agreed with the purpose and extent of the Bill.

However, of these responses, only 15 came from organisations - with the majority of organisations stating they strongly disagreed or disagreed with the purpose and extent of the Bill.

104. As highlighted in the SPICe briefing on the Bill, the themes raised in written submissions by individual respondents varied from those raised by organisations -

- Most individuals in favour of the Bill highlighted residential rehabilitation, harm reduction, lived experience, mental health, and timescales in their submissions - whereas those individuals who disagreed with the Bill had more of a focus on population health.

- Most organisations in favour of the Bill tended to focus on treatment options, recovery, lived experience, timescales and harm reduction - whereas those organisations who disagreed with the Bill tended to focus more on human rights, mental health, impact on professionals, MAT standards, and trauma informed- approaches.

Consideration by other committees

105. The Finance and Public Administration (FPA) Committee issued a call for views on the estimated financial implications of the Bill as set out in its accompanying Financial Memorandum. This was open for submissions between 1 November 2024 and 20 December 2024 and received 9 responses.

The Finance and Public Administration Committee also took evidence from Douglas Ross as the Member in charge of the Bill at its meeting on 11 March 2025. Douglas Ross then sent a follow-up letter to the Committee on 29 April 2025.

On 15 May 2025, the Finance and Public Administration Committee Convener wrote to this Committee setting out the outcome of its scrutiny of the Financial Memorandum.

In the letter, the FPA Committee highlighted those submissions it had received which raised concerns regarding potential underestimates of costs associated with the Bill's implementation, particularly due to a lack of available data. This lack of data was acknowledged in the Financial Memorandum accompanying the Bill:

> ...mapping existing costs and funding arrangements for alcohol and drug treatment is challenging, this is in part due to the number of different policy initiatives and associated funding streams. It is also challenging to track the number of people diagnosed each year with an addiction to drugs and/or alcohol through to the types of treatment they do, or do not, go on to receive.

The FPA Committee's letter then outlines the Committee's engagement with Douglas Ross through oral evidence as well as follow-up written submissions:

> In light of the submissions received, the Committee took oral evidence from the Member in charge on 11 March 2025. During this session, the Member acknowledged challenges relating to the availability of data, particularly around unmet need, and the difficulty of producing accurate costs, however, he emphasised that "annual reporting to the Parliament will significantly improve that data because the Government will be duty bound to include it in a statement to the Parliament and will be held accountable for that".
>
> The potential for increases in costs due to unknown unmet need and the potential for a higher number of people coming forward as a result of increased awareness of treatment availability were also discussed during this session, alongside issues including -
>
> - capital investment and the use of private providers;
> - existing funding challenges faced by local authorities and the potential of the Bill to add further pressure on Councils' budgets;
> - equitable delivery of the provisions in the Bill, including in rural areas;
> - the impact of increased employer National Insurance Contributions on the budget and local authority costs more generally; and
> - the possible impact of provisions in the Bill on communities in deprived areas.

106. The Delegated Powers and Law Reform (DPLR) Committee considered the Bill at its meetings on 24 September 2024 and 29 October 2024.

It published a report on 1 November 2024 in which it set out a series of recommendations in relation to the provisions and powers to make subordinate legislation conferred on Scottish Ministers by the Bill.

107. In particular, the DPLR Committee recommended that section 8(1), which allows certain regulation-making powers to be used to make incidental, supplementary, consequential, transitional, transitory or saving provision, and to make different provision for different purposes, should not apply to the powers in section 1(6) or 3(3).

Interaction with the existing legal framework

108. As a rationale for creating a statutory right to treatment under the Bill, the Policy Memorandum states:

> There is currently no specific statutory right to treatment for addiction. There is a general duty to provide a health service within section 1 of the National Health Service (Scotland) Act 1978. That section places a general duty on the Scottish Ministers to continue to promote a free, comprehensive and integrated health service to secure: a) improvement in the physical and mental health of the people of Scotland and b) the prevention, diagnosis and treatment of illness. Although that Act provides a general overarching basis for provision of health services, it does not provide any specific rights to treatment.[i]

109. In most of the oral evidence, the Committee heard broad support for the intended purpose of the Bill - with a number of witnesses agreeing that there are issues with the current provision of drug and alcohol services in relation to choice, access and quality.

However, Members also heard concerns that the Bill as drafted would not, in itself, address the current issues facing services and may complicate an area which is already underpinned by a number of existing policies and strategies.

Eleanor Deeming from the Scottish Human Rights Commission told the Committee:

> [...] there is a wider point about the interconnected nature of all human rights. The Scottish Government is still committed to introducing the human rights bill, and work is going on to incorporate the wider international treaties. Bringing in certain rights now would be taking a more piecemeal approach, which would risk confusing the legal framework.

110. The Committee heard extensive support in oral evidence for the Charter of Rights for People Affected by Substance Use.

In oral evidence to the Committee, Flora Ogilvie from NHS Lothian argued:

> […] it is really important that everyone's rights are enshrined in existing human rights. There is a potential risk that a bill that singles out a particular group of service users would stigmatise them by not recognising that their right to treatment is already enshrined elsewhere. The recent publication "National Collaborative Charter of Rights For People Affected by Substance Use" sets out that people should be empowered to access their existing rights rather than needing a whole new and additional piece of legislation.

111. Kelda Gaffney from Glasgow City ADP was similarly supportive of the Charter and contrasted the language it uses with the language used in the Bill:

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i National Health Service (Scotland) Act 1978

> The language that is used in the charter of rights is far more collaborative than the language in the bill, which, if we are looking to work with other agencies and with people themselves, is not very collaborative in nature and is very medicalised. The charter of rights takes away that language, puts rights where they should be—with the people who receive the services—and places duties on the people who provide those services and on the whole system of care.

112. Jan Mayor from Turning Point Scotland also argued that the legal underpinning provided by the Bill would be better applied to the Charter, expressing concern that the rights provided by the Bill were limited to the point at which someone actively sought treatment:

> The bit that I am worried about is that we also work with people who have not even got near treatment services. We are advocating for them to get into those services, but they are a long way from them. As the bill focuses only on treatment, it does not give those people rights at that earlier stage—which the charter of rights does.

113. However, expressing a contrary view, Annemarie Ward from Faces and Voices of Recovery UK was dismissive of the role of the Charter and any suggestion that it offered a better alternative to the current Bill:

> A charter is not enforceable. It is a poster on a wall, but it is not a right. It is a suggestion, and it is one that offers no route to challenge, no legal redress and no accountability when treatment is denied. We know that because our clients have been waving those charters in meetings for years. Hell, we even created one—the UK recovery declaration of rights—but we are still being told, "You're not really ready for detox," or "You're not really ready for rehab."

114. Hilary Steele from the Law Society of Scotland told the Committee:

> The difficulty in the way that the bill is drafted is perhaps that it does not particularly align with the medico-legal position on how treatment is provided. For example, in the McCulloch case, which was decided by the UK Supreme Court, the court stated clearly that it is for a medical professional to decide what is a reasonable treatment option for a patient who is accessing treatment. Under the bill as drafted, it would be for medical professionals to explain a series of treatment options, some of which they may not consider to be reasonable for the patient.

115. Giving evidence to the Committee alongside Douglas Ross, Alison Fraser from Scottish Parliament Legal Services addressed Hilary Steele's comments about the McCulloch case:

> The Law Society of Scotland has said that the bill takes a different medico-legal position, but I would say that it makes different medical provision, because it provides for a non-exhaustive list of treatments in the particular area of alcohol and drug addiction. The member's policy is that all of those treatments should be explained to the patient, whereas in the Supreme Court judgment…there was a question of clinical negligence in failing to discuss an option that the consultant did not think was appropriate.

116. The Committee notes concerns about the way the Bill might interact with the existing legal framework governing the rights of people suffering harm from alcohol or drug use. Some have argued that the Charter of Rights for People Affected by Substance Use is more collaborative and less medicalised in its scope and use of language. However, others have pointed out that the rights set out in the Charter are not legally enforceable whereas the rights created by the current Bill would be. Should the Bill be approved at Stage 1, the Committee calls on Douglas Ross to consider further ways of ensuring that the Bill would operate in a manner that is consistent rather than in conflict with existing policy and legal framework.

Prevention and early intervention

117. Many witnesses argued that, in their view, there was too little focus in the Bill on prevention and tackling the root causes of harmful substance use. Graeme Callander from WithYou told the Committee:

> The bill as it is currently drafted does not explicitly mention early intervention and prevention—it just does not. It speaks about the narrow definition of "treatment". We support the intent of the right to treatment, but the bill does not explicitly say how early intervention work is going to be done. It does not guide the system or tell us that.
>
> If the bill is to go forward, that aspect needs—as others have said—to be explicitly mentioned. The bill provides a narrow definition of what we understand to be "treatment". At that point, for many people, it is almost too late, is it not? They are at a point at which things are so bad that they need a medical intervention. We would much prefer that they see people much earlier than that. Unfortunately, the bill as it is currently drafted does not really capture that.

118. Annemarie Ward from Faces and Voices of Recovery UK argued that:

> The claims that there is no prevention in the bill completely misunderstand what the bill is and what it is designed to do. This is a health rights bill; it is not a national strategy. It is not replacing prevention, and it does not reject it. It simply focuses on the part of the system that has been consistently broken, which is access to treatment when somebody is ready to get help.

119. The Committee recognises the fundamental importance of prevention and early intervention in tackling harmful drug and alcohol use. It notes widespread concerns that there is a risk that passage of the Bill could result in investment in this area being deprioritised. It therefore calls on Douglas Ross, should the Bill be approved at Stage 1, to consider how the Bill might be amended in order to address these concerns.

Setting a precedent for other areas of treatment

120. As previously highlighted in the legal position section of this report, existing legislation generally does not specify a right to a particular service or treatment.

At the Committee's meeting on 20 May 2025, the Cabinet Secretary for Health and Social Care said:

> I believe if this Bill were to be enacted it would be the first time that legislation would provide a right to a treatment which isn't incorporated in any other aspect of health and social care, which is in itself a potential challenge.

121. Asked about these concerns, Douglas Ross argued that the unique approach he was taking with the Bill was justified by the unique circumstances in which Scotland finds itself in terms of drug and alcohol-related harms and deaths:

> I think that what the cabinet secretary was alluding to last week in response to Dr Gulhane's questions is that what is being proposed is new because we have never specified a particular treatment in legislation. Of course, we do not specify a particular treatment. Section 1(5) lists a range of treatments, including "any other treatment the relevant health professional deems appropriate." Indeed, not providing treatment is an option.
>
> As I said in my opening statement, it is for the individual, when they are not recommended for any treatment, to seek a second medical opinion, and that second opinion will look at the individual's circumstances. Therefore, yes, I understand that we are proposing something that is different and new, but, as other witnesses have said, we need something different and new, because the current approach is still leading to far too many people losing their lives due to drug and alcohol misuse each year.

122. The Committee has heard strong evidence about the precedent and expectation that could be created for the treatment of other conditions by providing a right to treatment in legislation, as the Bill proposes to do. The Committee is concerned that this will need to be carefully considered in determining whether and in what form the Bill progresses to become law.

A whole-family approach

123. Witnesses spoke of the importance of family-centred practice in the field of substance use services. This is an area where a number of witnesses considered that the Bill could be strengthened, with Kelda Gaffney from Glasgow City Alcohol and Drug Partnership arguing in oral evidence to the Committee:

> We need to embed the whole-family approach and family inclusive practice to ensure that we work alongside our families in communities […] The issue is about recognising people's needs as they present, as we have said previously. It is also about recognising that what families might want for their son or daughter might be different from what the person themselves wants. That is what needs to be recognised. With whole-family wellbeing and whole-family support, it is absolutely recognised that there can be tensions in the system, but it is a case of including families, as well as speaking to the people affected and carers.

124. Justina Murray from Scottish Families Affected by Drugs and Alcohol was critical of the Bill's failure to address the needs of family members and carers supporting individuals with alcohol or drug problems:

> I think that that is the bit of the bill that has caused the most anger, frustration and disappointment for families. When the bill was in its very first form a few years ago, a colleague and I met Douglas Ross, who was leading on the bill at that point, and pointed that out to him. He was very understanding, and our interpretation of that meeting was that corrections would be made, because he very much recognised that there was an omission. You can imagine the reaction when we saw that families are not even mentioned once in the bill as introduced.

125. During informal engagement, family members of individuals suffering harm from drug or alcohol use emphasised the crucial role they play in supporting those individuals. In particular, they highlighted the importance of family members accompanying individuals during their recovery journey, particularly in setting out the truth of the situation facing that individual when the individual could not be relied upon to tell the truth due to their dependence on drugs or alcohol. These participants called for the role of family members to be explicitly reflected on the face of the Bill, expressing fear that failing to do so would give a signal to medical practitioners to ignore them. Asked about the possibility of amending the Bill to give family members "named person" status that would entitle them to accompany individuals to appointments, contributors pointed out that the individual might grant "named person" status to a family member "on a good day" only to withdraw it "on a bad day".

126. Responding to this criticism, Douglas Ross acknowledged the crucial role of families in supporting individuals suffering harm from alcohol and drug use. He outlined his rationale for not making reference to families on the face of the Bill but added that he would be willing to look at the matter again should the Bill progress beyond Stage 1:

> If I can do something by way of amendment, including amendments from organisations, to strengthen that role and make that clear in the bill, I would be content to look at that. It is a hugely important part of the recovery process that there is support not just for the individual who is going through rehabilitation and trying to get their life back on track, but for their family. I did not include them in the bill simply because I did not want it to seem as though there is a gap at the moment. They are very much part of the process and would be part of the process under the bill—that is crucial.

127. The Committee notes the disappointment of families and carers of individuals experiencing harm from drug or alcohol use that the Bill makes no reference to the crucial role they play in supporting an individual through their treatment and recovery journey.

128. It therefore welcomes Douglas Ross' preparedness to re-examine this issue should the Bill progress to Stage 2 to ensure the role of families and carers is appropriately recognised and they are suitably involved in the processes set out in the Bill.

A trauma-informed approach

129. Many contributors to the Committee's scrutiny raised concerns that the Bill's primary focus on a medical model of treatment overlooks crucial psychosocial factors that contribute to problematic relationships with alcohol and drugs, such as trauma histories and poor mental health. Witnesses argued that drug and alcohol problems often represent the surface-level symptom of deeper mental health challenges, including trauma, and therefore require a broader, more holistic and trauma-informed approach to support.

130. These contributors argued that these types of support often extend beyond medical intervention to encompass housing assistance, mental health support, addressing experience of poverty and deprivation, domestic violence services, and other essential psychosocial services. Certain witnesses argued that the Bill must be more flexible in addressing these complex needs, suggesting that the Bill as introduced adopts a narrow definition of treatment which focuses solely on medical intervention.

For example, Highland ADP stated:

> It is important for those intending to use a service to have a choice. This list is extensive but is a medicalised model of support. It does not recognise the psychosocial support that many people require on their recovery and treatment journey. This can include needs around mental health and wellbeing, dealing with trauma, unstable and unsafe housing, vulnerability to exploitation, and financial crisis. It is important to note that the third and independent sector have a valuable role to play in service provision. To achieve a positive change in terms of stabilisation and recovery a holistic, person-centred response across all these areas will be required.

131. Conversely, some contributors were of the view that the Bill as introduced was already suitably trauma-informed and person-centred in its approach. Pamela Dudek from the Dundee Alcohol and Drug Partnership told the Committee:

> The bill is very strong on the principles of inclusion, understanding the person and taking a person-centred approach. The wording throughout the bill pays attention to the principle of taking a trauma-informed approach, which is really important.

132. However, Liam Wells from East Ayrshire Alcohol and Drug Partnership took a contrary view, arguing:

> The bill is not strong enough on a range of adverse childhood experiences, and it does not fully recognise the historical nature and complexity of the trauma that people experience.

Liam Wells added:

> Trauma is historical and complex in nature and is not just the domain of the health professional. The challenge for us is that the complexity of trauma requires a multi-agency response, not one solely or primarily from the health professional.

133. The Trauma-informed practice Toolkit, developed by the Rivers Centre (NHS Lothian's specialist service for people affected by psychological trauma) and published by the Scottish Government, outlines five key principles of trauma informed services to prevent further harm or re-traumatisation for those who have experienced psychological trauma or adversity. These include safety, trustworthiness, choice, collaboration, and empowerment.

134. The Evaluation of the Scottish Government Residential Rehabilitation Programme: Baseline Report emphasised that poor mental health is a key barrier preventing effective treatment and support for individuals with drug and alcohol problems. Addressing the contents of this report, the Policy Memorandum accompanying the Bill notes:

> This report, in addition to highlighting the refusal of treatment of some individuals, also reflects experiences where referrals for certain treatments do not suit the individual's circumstances and therefore make take-up of treatment for the individual very challenging [...] This issue informed the provisions in the Bill, specifically those which ensure the individual's preferences for treatment are taken into account in the decisions made by the health professional responsible for assessing what would be most appropriate for them.

135. Responding to the concerns raised by contributors about the Bill's lack of focus on engendering a trauma-informed approach, Douglas Ross responded:

> I suppose that that goes back to the narrow focus of a member's bill. I can look at only one element of the drug and alcohol issues that people face. However, the bill does not step on the toes of any other issues. It does not supersede anything else that has gone before it or will go after it; it looks specifically at the treatment element. Anything around trauma-informed diagnosis or support would continue and would in no way be affected by what is in the bill that is in front of us. It is an extremely important element of the overall package to help people to overcome their addiction issues.

136. The Committee does not share Douglas Ross' assessment that the narrow scope of the Bill prevents him from ensuring that its provisions embed a trauma-informed approach to the processes it sets out. Should the Bill progress to Stage 2, it calls on Mr Ross to consider further how trauma-informed practices can be properly reflected in the wording of the Bill.

A multi-disciplinary approach

137. Members also heard concerns from witnesses that the Bill's emphasis on healthcare professionals determining treatment pathways does not align with the multidisciplinary approach that currently occurs in practice.

138. For example, in oral evidence to the Committee, Eddie Follan from COSLA stated:

> We support the intention behind the bill to increase people's access to treatment. However, we are concerned that the focus on having a single health professional determining treatment overlooks the role of whole-system working, including the work of multidisciplinary teams. I have looked at the evidence given so far, and a number of witnesses have said that that might be quite restrictive.

Members also heard similar concerns from NHS Fife, who stated:

> [The Bill] makes an assumption about diagnosis as a medical task or activity. That goes against current practice, because the diagnosis is often reached in a multidisciplinary or multi-agency way.

139. Written submissions from several ADPs also raised concerns that the Bill prioritises the opinions and treatment recommendations of individual health professionals. They argued this risks overlooking the widely adopted collaborative multi-disciplinary model, which integrates skills and expertise from health, social care, and third sector services to provide comprehensive support for individuals in recovery.

140. Pamela Dudek from Dundee Drug and Alcohol Partnership was similarly concerned that the Bill takes an overly medicalised approach that, in her view, fails to reflect the role of the wider multi-disciplinary team:

> As it stands, the bill feels very focused on health professionals. On one level, that is understandable, but health professionals are only one part of the holistic system. If you think about it from the perspective of a person who comes forward looking for help and is not 100 per cent sure what that help needs to look like for them, you will see that the more points of access to the system, the better. In most systems, there are third sector access points that are really quite good at being open out of hours and at engaging people in a non-threatening way. There are good examples of that.

141. During the Committee's informal engagement session on 18 February 2025, individuals with lived experience of drug and alcohol problems raised concerns that the medical model underpinning the Bill could hinder health professionals in making effective treatment recommendations, particularly if GPs lack expertise regarding these matters.

142. Asked how he would respond to concerns that the Bill failed to sufficiently recognise the need for a multi-disciplinary approach to supporting individuals suffering harm from alcohol or drug use, Douglas Ross responded:

> I am sorry to labour the point, but it bears repeating: the bill would not stop any of that multidisciplinary working, and it would not prevent any of the good working between the third sector and a number of different organisations. It would add treatment options in the narrow area of drug and alcohol addiction, but it would not prevent, stop or in any way diminish the work done by others; I hope that it would work in collaboration with it. It would simply add tools to the toolkit, so that people could seek the support and help that they were looking for.

143. The Committee recognises the crucial importance of a multi-disciplinary approach to supporting individuals experiencing harm from drug or alcohol use. While accepting that the Bill is intended to cover a particular stage of an individual's treatment and recovery journey, it nonetheless shares concerns that the focus on a medical practitioner making the determination of treatment risks over-medicalising that stage of the process. It therefore calls on Douglas Ross, should the Bill progress to Stage 2, to give further consideration to how the wider multi-disciplinary team might be appropriately involved in the procedure for determining treatment set out in the Bill.

Resource implications

Impact on priorities

144. Members heard concerns from witnesses that the Bill does not sufficiently account for Scotland's changing drug trends, particularly the rise in poly-drug use (a term for the use of more than one drug or type of drug at the same time or one after another) and the ongoing harms associated with alcohol consumption. Witnesses stressed the need for flexible and rapid intervention, noting that individuals consuming newer, more potent opioids may be more likely to seek access to emergency services, and the Bill's emphasis on diagnosis may fail to address the needs of this population.

145. Additionally, some witnesses called for greater clarity on the process for adding new treatments to the Bill's approved list, raising concerns that the Financial Memorandum does not adequately account for the costs associated with the potential addition of new treatments. Some witnesses also highlighted the evolving nature of substance use patterns, with the emergence of new highly potent synthetic drugs and increased use of prescribed pain medications, and argued that this reinforces the critical role of harm reduction in mitigating risks to life on the basis there will not necessarily be a medical treatment available for every new drug.

146. Dr Peter Rice from the Royal College of Psychiatrists Scotland raised concerns that the Bill risked diverting attention from existing processes of referral for treatment that are not initiated by a formal diagnosis:

> The bill is right to acknowledge the importance of such work, but I have to say that although the bill says that it will not affect it, I think that, in practice, it will—in particular, if it sets up a list of expectations with regard to governance around a particular activity. There is a real risk of that drawing attention away from other activity, such as is described in the bill.

147. Dr Rice went on to highlight the impact legislation can have in determining priorities as well as the potential impact on staff:

> As I was saying earlier, legislation and targets shape behaviour and set the direction of priorities, which means that other things are deprioritised. In the evaluation of the national mission, we saw comments about how it has affected prioritisation. That is relevant to workforces because this is a person business, and the hours of person time that must be devoted to a particular activity are what really matters.
>
> The workforce issues are potentially substantial. That needs to be considered when people think about the bill.

148. Gillian Robertson from Aberdeenshire Health and Social Care Partnership was concerned that the Bill's implementation could require a further redesign of services when services had only recently been redesigned to conform with the MAT standards:

> We do not want to lose any of that if we redesign our services again under a different model, which would also cause more burnout for staff. We have recruitment issues in our rural areas, and having nursing staff prescribing would mean that they would have to do another qualification—because nurses have to be at a certain grade before they can do that—which would create additional pressure and costs. There are lots of implications that probably need to be discussed more.

149. Eddie Follan raised concerns about the impact the Bill might have on provision of services in the context of significantly restrained budgets:

> I cannot stress enough how much pressure our system is under. We are having discussions about that every day at a national level, and I am also sure that there will be similar pressure locally. For instance, our health and social care partnerships are carrying a deficit of about £500 million at the moment. The situation is that serious.
>
> I talked earlier about having to collaborate, pool our resources and use what we have well, because there is no easy answer to the workforce pressures that we face. It is difficult to see how the bill fits with that, but that will be for others to judge.

150. Pamela Dudek from Dundee Alcohol and Drug Partnership raised concerns that the Bill would re-orientate priorities in a way that would have a detrimental impact on relationships:

> The challenge for the workforce will be the pressure that that approach brings. Given the pressures as they are at the moment, my worry is that what should be a relational-based interaction, with a lot of thought, empathy and working through, becomes more transactional as a result of the pressure of numbers.

151. Tracey McFall from the Scottish Recovery Consortium was concerned that the Bill would have the unintended consequence of diverting yet more resources towards treatment and away from services designed to keep people in sustained recovery:

> We need to be careful about more resources going into the treatment end. That has happened in relation to the MAT standards: a huge amount of resource and money has gone into treatment and less money has gone into all the broader recovery-orientated systems of care, which are the elements that we know keep people well. That is another important unintended consequence.

152. Responding to these concerns, Douglas Ross acknowledged that the Bill was deliberately focused on treatment but argued that, in his view, this would not divert focus from other aspects of support:

> Again, I would say that the wider psychosocial aspects would in no way be impinged on if the bill were to go through. A number of treatment options are specified in the bill, because we are taking a narrow focus on just this element of the drug and alcohol addiction journey that people go on. As Annemarie Ward said in her evidence, if there is criticism that the bill is too narrow in scope, perhaps that just means that the bill aims to do one small thing in the best possible way. That is quite a good way to look at it.
>
> I understand those concerns, but I hope that I can reassure you...that the bill would in no way diminish the other aspects of drug and alcohol rehabilitation for those who seek help and support but would simply add to them.

153. The Committee notes widespread concerns that implementation of the Bill could result in priorities within drug and alcohol services being refocused towards delivering a relatively narrow suite of treatment options and other aspects of drug and alcohol support being de-prioritised.

154. Should the Bill progress to Stage 2, the Committee calls on Douglas Ross to consider the inclusion of additional safeguards within the Bill to ensure this is not the practical effect of its implementation.

Impact on workforce

155. The Financial Memorandum accompanying the Bill identifies additional costs associated with the Bill related to staff training and staff time. Drawing on the example of the Human Tissue (Authorisation) (Scotland) Bill, which similarly required training to be developed and rolled out on a new NHS procedure, the Financial Memorandum concludes:

> Adjusted for inflation, the cost of a similar programme of training would be £200,000. It is anticipated that this would be a one-off cost and then the training would be incorporated into existing training for new health professionals.

156. In relation to staff time, the Financial Memorandum acknowledges there will be additional costs associated with the procedure for determining treatment. However, it goes on to conclude:

> … the implementation of the Bill will lead to more completed treatments. This in turn will mean fewer repeat appointments being needed for patients who are seeking a new treatment, having had an unsuccessful patient journey. It is assumed that this reduction in appointments to determine a treatment will offset the staff time required to provide a written statement of reasons and to provide second opinions.

157. The Committee heard from witnesses that the Bill's requirement for a formal medical diagnosis, the proposed treatment determination process, and the obligation for healthcare professionals to provide written statements when declining a requested treatment, would likely add to the already significant pressures on

clinicians.

158. Witnesses also highlighted ongoing challenges in staff recruitment and retention, as well as widespread burnout in the healthcare sector, warning that the increased workload resulting from the Bill could further exacerbate these issues

In written evidence to the Committee, COSLA stated:

> [...] the workforce is under immense pressure and there are serious capacity challenges. While the National Mission has rightly increased the level of ambition to address substance use and harm, this has come with a plethora of targets and increased scrutiny on local areas

159. The Royal College of Psychiatrists in Scotland also emphasised that the 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.

160. Dr Sue Galea-Singer from NHS Fife had similar concerns about the impact the Bill's implementation might have on those working in drug and alcohol services:

> The bill could have a negative effect on the current flow of work. That started with the national mission and the MAT standards. There is a lot of good will, there are a lot of good measures and we are moving forward, but introducing another legal requirement, although it is not totally in conflict with that work, would have unintended consequences on the burnout levels of our workforce.

161. During the Committee's informal evidence session with individuals with lived experience of drug and alcohol issues, participants emphasised that typically short GP appointments would be inappropriate for assessing someone seeking treatment for drug and alcohol problems. Concerns were raised about GPs' capacity to be able to offer the longer appointments required.

162. Gillian Robertson from Aberdeenshire Health and Social Care Partnership emphasised the significant implications the Bill could have for staffing and recruitment and the potential for this to impact negatively on the provision of other related services:

> If everyone in our service were to be seen by a clinical or health member of staff, that would have huge implications for our staffing balance, and we would need to consider whether we would have to pay off and lose some of our other multidisciplinary roles, so that we could recruit in that way. We would also have to consider timescales, and we would need the ability to cover quite a large geographical area. Having all of that in one discipline would be challenging.

163. The Committee also heard concerns from witnesses that effective implementation of the Bill would require additional specialist training for a range of healthcare staff, who would be responsible for diagnosing individuals with drug and alcohol problems.

164. These witnesses emphasised the need to equip professionals with sufficient knowledge of all available treatment options to ensure the most appropriate treatment determinations. Some witnesses also argued that additional training and CPD for healthcare professionals would be essential to foster cultural change within the health sector.

The Royal College of Nursing also echoed these concerns in written evidence, stating:

> As highlighted by Scottish Health Action on Alcohol Problems (SHAAP) and the Royal College of General Practitioners, the Bill would shift diagnosis from specialist services to GPs, some other medical practitioners, nurse prescribers and pharmacist prescribers who would then be responsible for discussing and agreeing treatment options and referral. This would be a significant shift in workload, knowledge and responsibility.

165. Evidence from people with lived experience also highlighted concerns that GPs, nurses, and other medical staff may lack the awareness or knowledge of the full range of treatment options available to patients seeking treatment, particularly community based options. They emphasised the need for medical professionals to hear from those with lived experience during their training and to incorporate this into their practice.

166. The Committee notes the estimate of costs of training associated with the Bill as set out in the Financial Memorandum. It has heard evidence that substantial additional training to that budgeted for in the Financial Memorandum would be required to enable the sort of cultural change that would be necessary for the Bill to be effectively implemented.

167. The Committee further notes the Financial Memorandum's conclusion that any additional costs in staff time will be offset by a reduction in repeat appointments from individuals who, in the absence of the Bill, would have experienced an unsuccessful journey towards treatment.

168. The Committee recognises the scepticism of many stakeholders that this offset in staff time will be realised in practice. For example, contributors have cited the need for longer appointments to allow proper assessment of individuals seeking to exercise their rights under the Bill. The Committee further notes concerns that staffing requirements associated with the Bill may have a knock-on impact on recruitment for other multi-disciplinary roles.

169. The Committee has heard substantial evidence of the significant strain those working in drug and alcohol services are currently under and concludes that the Bill's potential impact on the workforce must be carefully assessed in that context.

Cost and resource

170. As highlighted previously in this report, the Financial Memorandum (FM) which accompanies the Bill estimates the cost of increased provision of treatment for drug and alcohol addiction, promoting awareness and understanding, reporting to the Parliament, producing a code of practice and staff training that would be necessitated by the Bill's implementation.

The Financial Memorandum identifies several areas where the implementation of the Bill would require significant additional financial costs and resources. However, it also highlights areas where the Bill is expected to result in financial savings in the long term.

171. Section 3 of the Bill stipulates that a treatment may not be refused on the basis of cost. The Policy Memorandum argues:

> […] all available treatments in the health and care system need to be reviewed and prioritised based on a cost-benefit ratio, including considering the opportunity cost of diverting limited resources away from existing evidence-based interventions to support our most vulnerable populations.

172. When considering the potential increase in demand for residential treatment services that could result from implementation of the Bill, the Financial Memorandum advises:

> In relation to residential rehabilitation, the Scottish Government has committed to continuing to provide funding in its annual budget including in 2025-26 towards increasing the number of publicly funded residential rehabilitation beds. This increase will, it is hoped, establish 650 publicly funded beds in residential rehabilitation by March 2026. It is assumed these beds will be operational on a year-round basis and be provided for across the NHS and the third sector. It is assumed that each of these 650 beds will, over the course of a year, support two to three patients (assuming an average programme of 23 weeks). It is also assumed that the Scottish Government will further increase residential rehabilitation bed numbers in future years beyond 650 in order to achieve the stated desired outcome that 11% of treatment episodes occur in residential accommodation. On that basis, assuming Government planned work is delivered, there would be capacity for hundreds more residential rehabilitation placements in the period following this Bill's implementation.

173. The Financial Memorandum notes:

> In 2021, Dame Carol Black carried out an independent review of drugs in England for the UK Department of Health. Phase 2 of that report focused on prevention, treatment and recovery. The report called for "significant investment in this area", but argued that: "…the payoff is handsome: currently each £1 spent on treatment will save £4 from reduced demands on health, prison, law enforcement and emergency services.

174. Some contributors to the Committee's scrutiny of the Bill expressed concern about the substantial financial costs and additional resources that they thought would be required for the Bill's implementation. Several ADPs expressed doubts about the estimated costs outlined in the Financial Memorandum, suggesting that these may

be significantly underestimated. Some witnesses also noted that any projected financial savings from the Bill's implementation would likely be redirected towards fulfilling the new legal treatment requirements established by the Bill.

175. Additionally, witnesses highlighted that the Bill's implementation would incur substantial expenses in critical areas, including expanding infrastructure and IT investments to support health boards to record and report patient treatment numbers as mandated by the Bill.

These witnesses were doubtful that these potential costs had been fully accounted for in the Financial Memorandum, with Dundee ADP stating:

> We note that the Financial Memorandum anticipates savings to public sector spend in the long-term. However, we believe that on introducing this bill, there is the potential that resource and capacity will be diverted to meet the provisions of a legal requirement rather than need. Focusing on the specific complex needs of each individual requires a range of responses and available options, including prevention interventions, and fully implementing all the MAT standards. There is also a need to have the flexibility to act fast when there is a change of prevalence and in the type of substances being used.

176. Members also heard some witnesses express concerns that the Bill would impose considerable additional financial costs, as many services would need to be redesigned to comply with its requirements, despite having recently undergone similar restructuring to align with MAT standards.

177. While many witnesses supported the initiative to expand access to detoxification and residential rehabilitation services, several expressed concerns that the Bill could result in a significant, unsustainable increase in demand for these services. They noted that such pressure might strain already limited resources and inadvertently lead to the de-prioritisation of other critical services, such as psychosocial support, provision of clean injecting equipment, BBV testing, and substitute prescribing.

178. The Committee notes assumptions from the Financial Memorandum accompanying the Bill that the number of residential rehabilitation beds in Scotland will increase significantly over the coming years in line with recent Scottish Government commitments and that the marginal cost implications of the Bill's implementation should be relatively limited and manageable in that context.

179. At the same time, many stakeholders are concerned that the costs of implementation set out in the Financial Memorandum are a significant underestimate.

180. In assessing the case for or against the Bill, the Committee concludes that further work is required to account for a range of potential associated costs, including redesigning services as well as infrastructure and IT costs associated with the reporting provisions of the Bill.

181. The Committee further notes concerns that the Bill may result in resources being diverted from addressing the needs of individuals and towards achieving legal compliance with the Bill.

Risk of litigation

182. Hilary Steele from the Law Society of Scotland highlighted the potential for significant litigation as a possible unintended consequence of the Bill:

> If, for example, a person who, it was determined, needed residential treatment but was unable to access it because the health board did not have such facilities available, and then suffered injury or took an overdose and passed away as a result of being unable to access a place, their family would, I believe, be able to raise a clinical negligence action. There would have been a breach of the duty of care, because the bill would give a right to treatment, and there would be causation, in that the delay in accessing treatment caused the person harm. The health board could be held accountable. However, is that what the bill wants to happen, given that there is already financial difficulty in providing the resource? There could be the unintended consequence of significant litigation.

183. In his written response to the Committee's call for views, Mr Stephen Wishart highlighted that the Bill's requirement for written justifications and opinions when making a decision on treatment would remove the necessity to use current routes for legal challenge, stating:

> [...] the Bill’s requirement for written justifications and second opinions takes away from the routes available to people just now (negligence and collective action) and allow immediate access to appeals and/or Judicial review - which when used in areas such as homelessness are a cheaper and more immediate option - usually settled out of court by the court mandating a declarator for decision makers to make a new decision - this cannot in any way delay what already exists, which is very little. It also legally enshrines existing policies such as The MAT Standards, in law.

Mr Wishart elaborated on the legal and judicial review implications later in his submission, stating:

> The Bill's current structure focuses heavily on when judicial review can be initiated, implying that patients may have grounds for legal action if treatment is delayed beyond the three-week window or if the written decision refuses treatment or states they cannot access an option - which is then deemed as breaching their rights. This would at least ensure immediate access to patients rights, that is currently not available in this form - all other current options are more costly.

184. Responding to the concerns raised by the Law Society of Scotland, Douglas Ross argued that the same risk of litigation already exists under the current law:

> It is a potential consequence at the moment. If someone has been told that they are the right fit and their circumstances mean that residential rehab is the right approach for them but they are on a waiting list for months or years, do not get into residential rehab and then overdose— as in the example that I gave—or die through further complications, their family is, at the moment, entitled to take a civil action against a health board or other authority.

185. Asked if he had made provision within the Bill’s Financial Memorandum to address

the risk of litigation, Douglas Ross responded:

> I hope that, by putting the issue in law and raising it in that way, we avoid, in the future, getting to the point where people are denied the treatment, as they currently are. A consequence of the bill would be the reduction of that risk, because people would get the treatment within a far more constrained period of time than is currently the case. That goes back to the capital increase that is mentioned in the letter to the Finance and Public Administration Committee. The Government is already doing a lot of work, and there would be the uplift in the budget. Currently, it is a risk, but I hope that the risk will be reduced if there is more availability.

186. The Committee notes concerns that the Bill may have the unintended consequence of a significant rise in litigation. It remains to be persuaded by Douglas Ross' counter-argument that an increase in availability of treatment resulting from the Bill will counteract this risk. The Committee takes the view that legislation does not necessarily lead directly to an increase in availability of treatment. However, this Bill will create a legal right to access treatment which, if unmet for whatever reason, could be subject to legal action on grounds of clinical negligence. The Committee is sympathetic to concerns that such actions could place additional strain on already constrained resources for drug and alcohol services.

Enforcement

187. The Policy Memorandum outlines options available to individuals to enforce their rights as follows:

> At an individual level, should a person consider that they have been refused the opportunity to exercise their rights under the Bill, they could seek to enforce that right through existing NHS complaints procedures. If still unsuccessful, a person may have grounds to raise a petition for judicial review in the Court of Session.

188. A number of third sector organisations giving oral evidence to the Committee highlighted what they perceived to be key challenges related to enforcement of the rights created by the Bill.

Giving oral evidence to the Committee, representatives of the Scottish Drugs Forum, Scottish Recovery Consortium, and Scottish Families Affected by Alcohol and Drugs highlighted what they perceived to be immediate issues around treatment, quality of services and the stigma people accessing these services face.

They argued that legislation was not the right vehicle for addressing these issues, concluding that the core issues associated with accessing treatment services related to culture, capacity and resourcing rather than being legal in nature.

They went on to emphasise the importance of fully implementing the standards and recommendations already in place, and of embedding lived and living experience in service design.

189. Tracey McFall from the Scottish Recovery Consortium observed:

> ... the fact that it is in law that people have rights does not mean that people will be able to access those rights. We know as much in relation to housing legislation and, indeed, a range of bills right now.

190. Hilary Steele from the Law Society of Scotland raised concerns that, in the context of current resourcing, it was difficult to see how a right to residential treatment could be legally enforced:

> I am struggling to see how that right to treatment could be enforced without the facilities or the funding being present to allow for that care and treatment.

191. Building on that point, Dr Chris Williams from the Royal College of General Practitioners Scotland suggested the approach taken in the Bill risked raising unrealistic expectations amongst patients:

> I can see why some organisations would favour some aspects, such as the residential aspects, having some form of guarantee behind them. However, I worry that, if we promise too much in relation to those treatment options, which can be quite expensive at times, and they are not carefully matched to the other longer-term approaches and behaviour change elements, we might set up unnecessary clashes with patients and their families, who will have raised expectations that cannot then be met. Things may unravel for some of those people, so I can see difficulties in trying to provide a guarantee on a narrow spectrum of interventions.

192. In oral evidence, Eleanor Deeming from the Scottish Human Rights Commission identified that "one of the areas where the Bill could be strengthened is the accountability gap". She suggested that the Bill's current reliance on judicial review as a means of challenging decisions was unrealistic and risked perpetuating existing access-to-justice barriers. She concluded:

> Steps should be taken—there could be an opportunity to do so through the bill—to bring access to justice closer and make it simpler and easier.
>
> More broadly, the proposed human rights bill would plug some of the accountability gap, but the bill presents an opportunity to consider what complaints or challenge mechanisms should be in place that do not lead an individual down the route of the NHS complaints process or having to raise a legal action, which is not realistic for a lot of people.

193. Tracey McFall from the Scottish Recovery Consortium was of a similar view that expecting people to seek redress through legal channels if their rights under the Bill were not upheld was unrealistic and would be counterproductive:

> In our work on the bill, it was clear from the people we spoke to that the last thing that they want to do when they are vulnerable and their lives are chaotic is go and see a lawyer to get legal redress regarding access to treatment. That does not happen in reality, because it is just not where people are at. The people we have spoken to will disengage, which creates more harm.

194. As highlighted previously in this report, section 4 of the Bill seeks to place a duty on the Scottish Government to secure delivery of the rights established by the Bill.

In its submission to the Committee, the Scottish Government noted:

> Local commissioning is in place to support provision of services appropriate to local need. Whilst Ministers would have the power to place functions and duties on other bodies, it might be helpful for the Committee to explore how this is intended to operate in practice and what the scope and effect of any Regulations might be.

195. Asked about the potential for individuals to bring legal challenges as a means of realising their rights under the Bill, Douglas Ross acknowledged that the costs of bringing a legal challenge could be potentially significant. However, he went on to argue :

> I also hope that, ultimately, by enshrining the rights in law and by shining a light on the issue in your committee and in Parliament, we will send a very strong signal that the rights should be delivered and that, when medical professionals believe that someone deserves and is entitled to a certain form of treatment, they should get that. I hope that that would negate much of the need to take anything into the legal sphere, because people would understand that the right for people to get the help and support that they need and want had been enshrined in law by the Scottish Parliament.

196. The Committee acknowledges Douglas Ross' view that the act of creating certain statutory rights in legislation will, in itself, send a signal that those rights should be upheld and the need for individuals to realise those rights through legal challenge would therefore, in many cases, be negated. However, the Committee has also heard multiple concerns that creating such rights in law fails to address the underlying obstacles to access to treatment, namely culture and a lack of capacity and resource. The Committee has also heard concerns that the available routes for individuals to enforce their rights would be prohibitively onerous and expensive. Should the Bill progress to Stage 2, the Committee calls on Douglas Ross to explore developing alternative routes from those currently envisaged that would make access to justice for individuals simpler and less costly.

Language and definitions

"Intoxication" and "detoxification"

197. During his oral evidence to the Committee, Douglas Ross indicated that the definition of a drug as an "intoxicant" was taken from section 11 of the Road Traffic Act 1988. He said that this definition was intended to make a distinction between substances that would render an individual intoxicated or out of control as opposed to other substances such as caffeine or nicotine that would not.

198. The Royal College of Physicians of Edinburgh suggested that there should be a discussion around replacing the word "detoxification" with "controlled withdrawal". Some fellows of the College raised concerns about some of the language used in the Bill saying that it "may validate unhealthy beliefs associated with addictions that the agency for resolving their problems lies entirely with others".

"Stabilisation"

199. Lee Ball from the Salvation Army raised some specific concerns about the way "stabilisation" is defined in the Bill:

> ... “stabilisation” is one of those terms that could potentially be really loaded. It is about literally that: stabilising the person. In the glossary at the back of the bill, however, “stabilisation” is defined as stabilising with a view to reduce consumption. That has an explicit motive within it.
>
> However, it should be up to the person to say, collaboratively, “This is what stabilisation means to me.” For some people, the approach that gives them the best quality of life is to optimal dose and leave them there for a period of time to be able to stabilise all the peripheral issues that go along with addiction. We cannot say that stabilisation has a motive, which is to reduce.

"Misuse"

200. In its written submission, the Salvation Army proposed removing the term "misuse" and replacing it with either "use" or "harmful use". It also suggested using the term "persons experiencing addiction to drugs or alcohol" instead of "persons addicted to drugs and alcohol".

These suggestions were supported by the Church of Scotland, who stated:

> The Bill uses the term “misuse of alcohol or other substances” in section 2 (b) and (c). While we recognise that this choice of term might relate to previous legislation (e.g. Misuse of Drugs Act 1971), it should be understood that the word ‘misuse’ can for many people carry a sense of judgement or morality. If we want to address the issue in a person-centred way that places due importance on health considerations, it would be better if the language that we use could talk about ‘substance use’ or ‘drug and alcohol recovery'.

"Patient"

201. In its written submission, Turning Point Scotland stated:

> We fundamentally object to the use of 'patient' to refer to people accessing treatment – we are all people, even when we need treatment and support. Reducing people to a medical condition is stigmatising, and also limits the scope of the work we need to do.

"Right to recovery" versus "Right to treatment"

202. Some respondents, including Turning Point Scotland, considered that the Bill provided for a right to treatment rather than a right to recovery and that the language used in the legislation should be amended accordingly.

203. The Committee notes a range of concerns about the language and definitions used in the Bill and calls on Douglas Ross, should the Bill progress to Stage 2, to give careful consideration to how these concerns might be addressed through an alternative use of terminology.

Requiring a diagnosis of addiction

204. Under the terms of the Bill, an individual seeking a treatment determination would firstly have to have been formally diagnosed by a health professional as having an addiction to drugs or alcohol.

Stigma / Barriers to treatment

205. Social Work Scotland commented on the use of the word "addiction" in the Bill, saying that the term “addiction”, is problematic and contributes to stigma:

> We feel that the language used in the Bill is stigmatising and confused, with a lack of clarity around what constitutes “addiction” and what constitutes “dependency”.

206. A number of witnesses considered that requiring a diagnosis for addiction could act as a barrier to seeking treatment. Dr Tara Shivaji from Public Health Scotland argued:

> The other side of that is the impact of having a diagnosis and carrying a particular label that could continue for the rest of that person’s life, and that has wider consequences. Particularly in the case of women and those with young families, describing and identifying yourself as someone with dependence or someone with addiction can be challenging, and it can be a barrier to accessing services […] We know that stigma and the stigma of seeking help are still important barriers, particularly for some subgroups within our population. You mentioned people in rural communities, but there are particular issues for women and ethnic minorities.

207. Kirsten Horsburgh from the Scottish Drugs Forum argued that the requirement to receive a diagnosis of addiction would create unhelpful additional barriers to access to treatment:

> Such a requirement will allow for a system in which there is gatekeeping, given that someone will need a diagnosis before they are able to access any specific treatment.
>
> The whole process creates something adversarial rather than collaborative. We do not want this to be a battle, do we?

208. Justina Murray from Scottish Families Affected by Alcohol and Drugs supported this view, adding:

> I think that the bill misappropriates the language around rights and a focus on the individual, because it only cements the power imbalance that is already there.

Right to anonymity

209. On a related point, Graeme Callander from WithYou highlighted the importance of confidentiality and the potential risk to individuals from a diagnosis of addiction appearing on their medical records:

> A lot of the people who we support are in work and might be worried about disclosing things that are tied to what is going on in their personal lives. Our clients raised concerns about that. As the bill progresses, if it does progress, that is one aspect that needs to be carefully considered. People have the right to remain anonymous.

Harm versus addiction

210. Dr Peter Rice from the Royal College of Psychiatrists in Scotland highlighted that many people suffering significant harm from alcohol would not necessarily be assessed as being addicted or dependent and might therefore be unable to exercise a right to treatment under the terms of the Bill as introduced:

> My own work has been on alcohol harm, and we know that many people who come to considerable harm or die from alcohol will not have been dependent on it. For instance, many people who have alcohol-related liver disease—a diagnostic event—are able to quit drinking and do not experience any great cravings. They might not experience much in the way of withdrawal, yet they come to harm. Some of that group will not recover from their liver disease and may well die from it. In our written response, we mention that it is not just dependence that leads to harm, and that is particularly true for alcohol. A lot of harm is non-dependent.

Definition of addiction

211. Dr Tara Shivaji from Public Health Scotland suggested that further nuance was required in relation to the use of the terms "addiction" and "dependence" in the Bill and suggested the classification of substance use set out in the fifth edition of the "Diagnostic and Statistical Manual of Mental Disorders" (DSM-5) could be informative in this respect:

> Our recommendation would be that it is important to consider the impact that the use of a substance has on an individual's life. Rather than the presence of symptoms, the presence of negative consequences in someone's life is an important factor to consider. Those are included in the DSM-5 classification of substance use.

212. Dr Rice from the Royal College of Psychiatrists in Scotland agreed with this view, concluding:

> My own view is that "substance use disorder" is the best term. Without getting too much into the niceties, DSM-5 is probably going to drop the term "dependence" altogether and talk about substance use disorders that are of mild, moderate or high severity. That is my suggestion.

213. Dr Shivaji argued it would be important to ensure the Bill was future-proofed against the changing nature of substance use in Scotland:

> To remain future proofed, there is a need to consider a definition that would enable support to be provided to people for whom regular or daily use and the classical features of dependence are not the prominent features of that use, but they are still experiencing harm. That might be the case with cocaine use, for example.

Requiring a diagnosis

214. Flora Ogilvie from NHS Lothian was concerned that the Bill's approach risked closing off access to alternative forms of support for those who had not been given a formal diagnosis:

> Wrapping up diagnosis with treatment potentially risks limiting access to other forms of support for people who might not have a formal diagnosis or who might not have a diagnosis that is treatable through, for example, opioid substitution.

215. Gillian Robertson from Aberdeenshire Health and Social Care Partnership raised similar concerns and argued that the requirement to receive a diagnosis could discourage many patients from coming forward to seek treatment:

> Putting another label on them is often not helpful. It does not help people to come into services; it probably makes them shy away from them.

216. As part of her oral evidence to the Committee, having raised concerns about the Bill's focus on diagnosis, Dr Sue Galea-Singer from NHS Fife was asked what alternative approach she would like to see. She responded:

> Diagnosis is just a tool, and I would prefer to see some reference to a collaborative care plan that is determined not necessarily by a diagnosis but by the needs of the individual and, indeed, their family. After all, we cannot forget the family, who are often quite distressed. That aspect needs to be included, too.

Ensuring sustained recovery

217. Dr Galea-Singer went on to argue that the Bill as introduced failed to recognise the reality that many individuals seeking support and treatment for substance use were likely to require that support and treatment over a prolonged period of time and would also be liable to multiple setbacks on their journey to recovery:

> The issue with the bill is that it almost assumes that, when somebody goes in for treatment, the problem goes away. It does not; we are talking about a chronic relapsing condition like diabetes, and the individual will need to continue to work on their addiction problems, whether or not they have been in rehab.

218. Kelda Gaffney from Glasgow Alcohol and Drug Partnership echoed this view, citing evidence from individuals who had recently participated in their abstinence-based residential programme:

> Twenty-five per cent of those people had achieved sustained abstinence at the end of 18 months. There is no judgment in that, but it raises a difficult issue. Because of all the trauma that we have talked about, recovery is not linear. People will go from harm reduction to abstinence and back to treatment, and we should have systems that are set up to respond to that.

219. Responding to these concerns in oral evidence, Douglas Ross acknowledged that individuals experiencing harm from drug or alcohol use who had not been diagnosed as having an addiction would not be able to exercise the rights conferred

by the Bill. However, he argued that those individuals would retain their existing rights:

> The bill would not take away any of the other rights that exist or that could exist in the future. The bill seeks to complement what we already have.

220. Douglas Ross went on to indicate that he would be willing to consider further the use of the term "diagnosis" in the Bill were it to progress beyond Stage 1:

> I know that the use of the term "diagnosis" has come up quite a lot, and I would be keen to look at that, depending on what your committee decides about whether elements of the language could be exclusionary. I think that the cabinet secretary even said that it would never be my intention, as the member in charge of the bill, for it to be exclusionary. So, if that is an unintended consequence, I will look to address that at stages 2 and 3.
>
> At the moment, the bill is drafted as it is because any treatment starts with a diagnosis— that is why it was put in that way. However, given the evidence that I have heard, I am certainly willing to consider the point.

221. The Committee notes Douglas Ross' acknowledgement that individuals experiencing harm from drug or alcohol use who had not received a diagnosis of addiction would not be able to exercise the rights to access treatment conferred by the Bill. The Committee further notes concerns that focusing the Bill in this way risks ignoring the harm from use of alcohol or drugs experienced by many individuals who are not technically addicted to or dependent on the substance causing them harm. The Committee has also heard substantial evidence that the Bill's focus on "addiction" and "diagnosis" risks creating stigma and discouraging many individuals from putting themselves forward for treatment.

222. The Committee shares the view that individuals receiving a diagnosis of addiction under the terms of the Bill should retain an absolute right to anonymity.

223. The Committee also highlights suggestions that a more appropriate alternative term to "addiction" would be "substance use disorder", as defined by the "Diagnostic and Statistical Manual of Mental Disorders" (DSM-5).

224. The Committee further welcomes Douglas Ross' willingness, should the Bill progress to Stage 2, to reconsider use of the term "diagnosis" in the Bill to ensure its use is not inadvertently exclusionary.

Advocacy

225. The Policy Memorandum accompanying the Bill advises that those seeking treatment would have the option to bring someone with them, for support and to act as an advocate when discussing treatment options. It states:

> Section 6 requires Scottish Ministers to prepare a code of practice alongside the regulations setting out further how the duty to fulfil the right to treatment will be carried out by health boards and others such as joint integration boards [...] It is anticipated that the code of practice should give health professionals guidance to assist the health professional in proactively encouraging the person diagnosed with an addiction to drugs and/or alcohol to bring along a person with lived or living experience to the discussion of treatment options, and setting. Patients are currently able to bring someone along to appointments, but the Member considers that being proactively informed of their right to do so and provided with the means to easily access an advocate would increase uptake of this form of support.

226. Concerns were raised in both written and oral evidence that any reference to advocacy in the Bill lacked clarity and detail. Kelda Gaffney from Glasgow City ADP argued:

> We need to be absolutely explicit on advocacy. Without explicit reference to advocacy, it would be very difficult. I am a strong supporter, as is everybody on the panel, of advocacy for people. Independent advocacy is really important.

227. Pamela Dudek from Dundee ADP also underlined the importance of advocacy to the Committee, stating:

> It is important to have advocacy on offer to help people to navigate the system and to give us feedback on where it did not feel as it should have felt. If the advocate is struggling to navigate or is getting an unhelpful response, it is useful to have that feedback. Mostly, it is about being able to facilitate and manage that conversation and assert appropriately with the individual where possible. Our most vulnerable would benefit the most, but I agree that most people would probably benefit from having some level of advocacy in navigating the system

228. The Bill seeks to ensure that individuals seeking treatment for drug and alcohol problems are able to actively participate in consultations with a relevant healthcare professional to determine the most appropriate course of treatment. However, the Committee heard several witnesses across the evidence sessions raise concerns around this approach.

Several ADPs argued that the Bill could inadvertently exacerbate existing power imbalances between health professionals and patients. They raised concerns that the Bill's treatment determination process could foster adversarial dynamics between medical professionals and patients, potentially undermining the positive, collaborative, therapeutic relationships central to person-centred and trauma-informed practice. They emphasised that individuals seeking treatment are often in an extremely vulnerable state, making them unlikely to challenge any decision reached by healthcare professionals. Witnesses expressed a view that the lack of

reference to advocacy and the role of families in the Bill further exacerbated these concerns.

229. Lee Ball from the Salvation Army emphasised the importance of advocacy in enabling individuals to realise the rights attributed to them by the Bill:

> If there is a right to contest and a right to a second opinion, who will support the person in that? How bills are written is above and beyond my pay grade and my level of understanding, but I have direct experience of people struggling to advocate for themselves, sometimes. What support will there be for them to do that? It is one thing to give a person a right; it is another to give them the ability to exercise that right. We need to think about that.

230. Asked what consideration he had given to the role of independent advocacy in drafting the Bill, Douglas Ross responded:

> We are dealing with some of the most vulnerable people in our society, and individual advocacy plays an important role in people getting the rights that they deserve, which I hope the bill will enshrine.

231. The Committee notes Douglas Ross' acknowledgement of the importance of independent advocacy in supporting individuals through their treatment and recovery journey. It further notes Mr Ross' intention that the role of advocacy be addressed by the code of practice to be prepared by Scottish Ministers once the Bill has become law. Nonetheless, it regrets that the importance of independent advocacy is not really reflected in the wording of the Bill itself which makes no direct reference to advocacy. Should the Bill progress to Stage 2, the Committee calls on Douglas Ross to reflect further on how the role of independent advocacy can be properly integrated into the processes set out on the face of Bill. The Committee considers that this will be particularly crucial to addressing the existing power imbalances that it fears will otherwise persist.

Requirement for in-person appointments

232. As set out in the Policy Memorandum, section 2(1) of the Bill "requires a treatment determination to be made in person". The Policy Memorandum continues:

> This is a deliberate policy choice, reflecting the fact that a relevant health professional can make a fuller assessment of the patient at an in-person consultation, and the patient is naturally more involved in the process if it is face to face. However, it is possible that this may be more challenging among smaller island communities, as well as in remote parts of the mainland. It is the Member's view that the code of practice should assess what additional steps, if any, need to be taken to ensure that consultations are able to take place in person in island and in more remote communities without the patient's treatment journey being delayed.

233. Members heard concerns that the requirement for individuals to attend an in-person appointment with a healthcare professional to initiate treatment could create significant barriers, particularly for vulnerable populations, such as those experiencing homelessness. The Salvation Army argued in written evidence:

> The necessity to meet in person, whilst likely intended to improve the quality of healthcare, may unintentionally reduce access to treatment. We work with 10,000+ people per year experiencing homelessness and we regularly see people who are not able to make appointments for numerous reasons, such as being unable to afford transport, cognitive issues (cognitive decline is common within this cohort), health issues etc – what happens if the person should miss the appointment? The Salvation Army believes it is possible to safely provide treatment in some circumstances without a face-to-face consultation. Tele-health is making this more achievable and may offer advantages, particularly for those who find travel, waiting rooms and inflexible appointments difficult.

234. Members heard similar views from NHS Fife who argued that the requirement for individuals to meet with a healthcare professional in person:

> [...] goes against the current direction of innovation, because we are trying to be a bit more digital in our approaches. For example, a young person is less likely to come in for an appointment unless you have already spoken with them using a digital method to break the ice. That provision of the bill goes not in the direction of the innovation on which Scotland is leading but against it.

235. Asked about his rationale for requiring in-person appointments, Douglas Ross explained:

> I put in that requirement to begin with because I wanted to give as much support as possible to an individual seeking help, and I felt that that face-to-face interaction would be important.

236. However, Mr Ross went on to indicate he would be willing to consider the matter further should the Bill progress beyond Stage 1:

> … I am keen and would be happy to look at an amendment at stage 2 to widen the scope of that provision … It would be absolutely an unintended consequence of my trying to give an individual as much support as possible through having that in-person meeting if people from the islands or the more remote and rural areas were then excluded.

237. In light of the evidence it has received that it could act as an unnecessary obstacle to individuals exercising their rights under the Bill, the Committee welcomes Douglas Ross' willingness to re-consider the requirement for in person appointments should the Bill progress to Stage 2.

Abstinence versus harm reduction

238. Section 1(5) of the Bill provides a list of types of treatment that may be determined as appropriate for the individual diagnosed as having a drug or alcohol addiction under the terms of the Bill. These are:

- residential rehabilitation,
- community-based rehabilitation,
- residential detoxification,
- community based detoxification,
- stabilisation services,
- substitute prescribing services, and
- any other treatment that the health professional deems appropriate.

239. While there was general support for the broader intentions of the Bill, the Committee heard concerns about its strong emphasis on abstinence-based approaches to recovery and omission of any reference to 'harm reduction'.

Contributors highlighted the importance of harm reduction strategies in early recovery stages and warned against encouraging individuals into residential rehabilitation prematurely, which could increase relapse risks and raise unrealistic expectations. Witnesses noted that recovery is often a cyclical process, where relapse is common due to the complexities of the issues faced by individuals with alcohol and substance use problems, including experience of past trauma.

240. Gillian Robertson from Aberdeenshire Health and Social Care Partnership described the list of potential treatments in the Bill as "really quite restrictive", adding:

> Even the last one — "any other treatment"— is about the health professional's understanding, whereas a much wider offer is out there to address multiple issues. It is not just about substance misuse; often, it is about the trauma that goes before that and the person's current living and family situation. There needs to be a multiple approach, and that may not be so evident in the bill.

241. Many contributors to the Committee's scrutiny were concerned that the approach set out in the Bill was overly medicalised and failed to address the underlying causes of harmful substance use. Dr Galea-Singer from NHS Fife told the Committee:

> I do not think that there is a good balance in the bill. It talks about treatment but, although that sentiment is important, it is all about the edge of the cliff, and I think that we need to look prior to that. Moreover, I do not think that the bill addresses the social determinants of health that contribute significantly to continuing drug use in families and communities. Indeed, I have already mentioned the issue of poverty; the fact is that there are 15 times more deaths in more poverty-stricken areas.

242. Dr Galea-Singer was concerned that an excessive focus on detox as the default treatment, coupled with a legal requirement to provide access to that treatment, could set many patients up for failure:

> Often, you know that a detox is not what is needed straight away, because you have to get the patient ready for what happens post detox. Detox is easy. You have 10 days in a hospital, are weaned off your addiction and are given medication. The issue is what happens once you are discharged. Unless you prepare the patient well for how they maintain themselves in that recovered position post discharge from hospital, you will not be successful. Often, they end up going to the off-licence straight after the detox.

243. Some witnesses cautioned that the Bill's abstinence-focused approach could inadvertently reinforce stigma against those requiring multiple recovery attempts. For example, in its written submission, Turning Point Scotland stated:

> We believe that a person's history is important to the decision-making process. For instance, going through multiple alcohol detoxes carries the risk of 'kindling', a phenomenon in which each subsequent detox results in heightened withdrawal symptoms and increased health risks, ultimately making it more difficult for a person to successfully detox. It is also important to recognise that recovery is not a linear journey and will look different for everyone; what didn't work for someone in the past may still be the right option for them now.

244. Members also heard some witnesses argue that, while the Bill does not explicitly exclude harm reduction strategies, the lack of a direct reference to them would be likely to effectively limit their availability in practice. Some witnesses argued that what is explicitly written in the Bill would shape individuals' understanding of their treatment options, potentially leading to the assumption that harm reduction is not a viable path.

Orkney ADP also argued that harm reduction should be included as a treatment choice for patients who were not yet ready to embrace substitute prescribing or detox.

245. Several witnesses raised concerns that the Bill's emphasis on abstinence-based approaches could lead to the de-prioritisation of critical harm reduction services, such as psychosocial support, provision of clean injecting equipment, Blood Borne Virus (BBV) testing, and substitute prescribing. They challenged the perspective that the Bill must adopt either harm reduction or abstinence-based approaches exclusively, arguing that recovery should flexibly integrate both based on the particular needs of individuals.

In its written submission, The Salvation Army stated:

> A choice has been made as to what options to list specifically and what options to group under any other treatment. That decision currently prioritises some treatments over other, by emphasis. The Salvation Army is supportive of a harm reduction approach to addiction support [...] The Salvation Army is concerned that the term “harm reduction” is absent and that the stipulated types of support are very much focused on pure abstinence-based support. The Salvation Army fears that the omission of a specific mention to “harm reduction” may lead to many people being shepherded down an abstinence route, when harm reduction is a more appropriate form of support for them. Omitting “Harm Reduction” polarises the debate and signals prioritisation. It may also add to stigmatisation of opiate substitute treatment for example[...] Some believe that only treatment that leads to abstinence is worthwhile. This is a moral judgement, not an evidence-based one.

246. The Royal College of General Practitioners (RCGP) argued that the Bill's focus on abstinence-based rehabilitation services was at the expense of harm reduction treatments, while Social Work Scotland concluded that the "scope of treatment is too focused on abstinence-based options".

247. Jan Mayor from Turning Point Scotland was similarly concerned that the Bill's focus on abstinence could result in access to harm reduction services being restricted:

> There is a line in the bill that refers to “any other” approaches, but my fear is that, unless we spell out the harm reduction approaches, we will put more emphasis on the abstinence-based approaches and people will not have a route into them through harm reduction services such as drug checking and needle exchange.

248. Contrary to this view, Annemarie Ward from Faces and Voices of Recovery UK argued that the effect of the Bill would not be to close off treatment options but instead to empower individuals to get access to whatever treatment they were looking for:

> If somebody wants a methadone script or a needle exchange, they can get it. If they want a detox bed or a rehab placement, they should be able to get that, too. The bill is not about taking options away; it is about ensuring that all the options are on the table and that people—not systems or organisations—get to choose what their recovery looks like.

249. Douglas Ross acknowledged concerns about a perceived focus on abstinence-based treatment options but told the Committee:

> Although I can understand why some people think that the bill is heavily reliant on an abstinence-based approach, it is not exclusively so. Any other form of treatment could be added at any point—section 1(6) allows Scottish Government ministers to add to that list. I hope that that will reassure you that, although that may be a perception, it is certainly not the intent, and, in the detail of the bill, more options are available, and there may be further options in the future.

250. The Committee notes concerns that the Bill places a particular emphasis on

abstinence-based types of treatment over harm reduction. It further notes Douglas Ross' acknowledgement that there is a perception that the Bill is "heavily reliant on an abstinence-based approach". The Committee has heard extensive evidence that abstinence-based treatment pathways will not suit every individual at every stage of their treatment and recovery journey, and that, in those circumstances, many individuals will benefit more from harm reduction interventions.

251. In this context, the Committee questions the value of including a list of treatment options on the face of the Bill when such a list can never be exhaustive.

Timescales for accessing treatment

252. As set out in the Explanatory Notes accompanying the Bill, subsection (1) of section 3 of the Bill "requires the treatment to be made available to the patient as soon as reasonably practicable and provides a backstop of three weeks from the date of the treatment determination."

253. Annemarie Ward from Faces and Voices of Recovery UK set out the rationale for the three-week timescale set out in the Bill:

> Right now, someone can wait three months, six months or indefinitely for treatment, and no one is being held accountable. That is not a system that is functioning. The bill does not say that treatment must take three weeks; it says that you cannot be left in limbo beyond that with no action, no plan and no urgency. If it can be done sooner, which it absolutely should be in many cases, that is great, but if treatment is delayed beyond three weeks, people will have a route to challenge that.

254. The Committee heard concerns from witnesses regarding the proposed three-week timescale, which many suggested was too short for critical preparatory work to take place before abstinence-focused recovery treatments can begin.

Some advised that key steps like assessments, psychosocial interventions, and stabilisation require sufficient time to ensure meaningful and effective treatment engagement. Some witnesses highlighted that different types of treatment operate on varying timelines, and existing long waiting lists, particularly for residential services, could make meeting the proposed 3-week deadline challenging.

In its written submission, WithYou commented on this further, stating:

> Different types of treatment operate on different timescales and could make meeting the timeframe of 3 weeks after the treatment determination is made challenging. It is also not always a suitable timeframe for some types of treatment. For example, the process of accessing residential rehabilitation may require more than 3 weeks, as this will often include a preparation stage which could require at least 6 weeks of psychosocial interventions and practical organisation.

255. Members also heard from witnesses that greater clarity on what constitutes acceptable engagement within the 3-week timescales was required.

Some raised concerns that strained, under-resourced services might consider placement on a waiting list as progress to meet this deadline, rather than reflecting actual engagement. Additionally, several witnesses highlighted that the proposed 3-week timescale conflicts with existing MAT standards, which stipulate that initial support should be offered within 24 hours. They emphasised that certain treatment can and should begin immediately and raised concerns that the new timescale might introduce confusion, delaying access to services that would have been offered sooner under MAT standards.

256. Justina Murray from Scottish Families Affected by Alcohol and Drugs highlighted concerns she had heard from family members and family support workers that, by

offering individuals a narrow list of options subject to a very tight timeframe, the Bill would reduce the quality and choice of services available:

> They felt that the bill was narrowing everything down and that NHS boards would be under a legal duty to provide something, so they might just provide anything to tick the box of having met the bill's requirements rather than provide a quality option.

257. Many respondents to the Committee's call for evidence also questioned if the three week timescale for starting treatment was suitable for certain treatments. In particular, residential rehabilitation was mentioned as not always being suitable in such a short time frame. Scottish Health Action on Alcohol Problems (SHAAP) noted that people entering residential rehabilitation may be expected not to have been consuming substances for a period of time before entry. Falkirk ADP argued:

> Enforcing a right to treatment within a three-week time frame seems impractical and unrealistic, especially for resource-intensive services like residential rehabilitation.

Similarly, West Lothian Health and Social Care Partnership stated in their response:

> The legislation may create unrealistic expectations that any individual can access interventions such as residential rehabilitation and detoxification within 3 weeks, as opposed to a longer timescale. The time spent assessing an individual for rehabilitation and carrying out preparatory work can be very valuable. There is no clear evidence that faster access to rehabilitation results in higher completion rates, reduces the risk of relapse or the risk of drug related death.

258. Lyndsey Turfus from Social Work Scotland suggested the three week timescale set out in the Bill failed to take account of the additional time that might be needed to stabilise an individual before they would be ready to enter rehabilitation:

> We also need to understand that it is not as straightforward as going into recovery. There is that period in between, when we need to stabilise somebody, which I do not feel is reflected.

259. Lyndsey Turfus also raised concerns about the impact the three week timescale would have on overstretched staff:

> On timescales, I do not think that there is anything in the bill that we do not already have. Our concern is that the bill will put additional pressures on staff who are already stretched.

260. In its written submission to the Committee, the Scottish Drugs Forum also raised concerns regarding the potential unintended consequences of setting timescales in the legislation:

> There is a significant risk that the Bill would allow 'gaming' of the system where a promise of 'treatment commencement within three weeks' is likely to result in the unintended consequence of hugely significant delays in receiving a diagnosis and/or a treatment determination similar to ones seen in other parts of the NHS – with neurodiversity and child and adolescent mental health services being current examples.

261. The written submission from the Royal College of Physicians of Edinburgh indicated that its fellows had concluded that the timescales set out in the Bill were:

> "currently wholly unrealistic with assessment stages alone taking significantly more than three weeks and with long waiting times for inpatient treatment".

The submission went on to raise concerns that the timescales in the Bill might lead to practitioners downgrading their treatment advice to all patients to match available resource.

262. In response to these concerns, Douglas Ross provided clarification that any requirement for preparatory work would be factored into the health practitioner's thinking before they got to the point of referring an individual to a specific type of treatment, which would be the point at which the three week timescale would commence:

> The medical professional will know what work has to be done by the patient, the third sector and others to get somebody ready. However, if, having gone through the process of meeting with the individual, remotely or in person, the medical professional is saying that the individual is ready for residential rehab, that person should get that treatment within three weeks. That is why it is part of the medical assessment.

263. Responding to concerns that currently long waiting lists for treatment would render the timescales set out in the Bill unachievable in practice, Douglas Ross highlighted the uplift in resource he was proposing to achieve through enactment of the Bill:

> Once the budget uplift is enshrined in law, the Government will accept it going forward … The bill would send a very strong signal and indication that this is an area that we should be focusing on. Although it is not a small amount of money, it is not an unachievable budget uplift for an area that every party leader, politician and representative in the Parliament agrees needs to be tackled. We are talking about spending an extra £38 million in Scotland to deal with an issue that is uniquely bad in Scotland.

264. The Committee has heard multiple concerns about the proposed three week timescale for individuals to commence treatment under the terms of the Bill. These included concerns that the timescale and the statutory nature of the Bill's provisions might result in quality and choice of treatments being restricted; would be unrealistic for certain types of treatment and could increase the risk of relapse, particularly in the case of residential rehabilitation; would place further strain on an overstretched workforce; and could result in the unintended consequence of individuals having to wait much longer for an initial treatment assessment.

265. Should the Bill progress to Stage 2, the Committee calls on Douglas Ross to give further consideration to these concerns and whether a rigid three-week timescale is appropriate in all circumstances or whether a more flexible approach that distinguishes between different types of treatment might be preferable.

Recommendation on the general principles of the Bill

266. The Health, Social Care and Sport Committee draws its conclusions and recommendations on the Bill to the attention of the Parliament.

267. The Committee recognises the strength of evidence it has seen and heard throughout its Stage 1 scrutiny of this Bill of a high level of dissatisfaction with current availability of and access to support services for those experiencing harm from drug or alcohol misuse.

268. The Committee notes that Douglas Ross has himself acknowledged the need for the Bill, should it progress to Stage 2, to be significantly amended to address those concerns raised during Stage 1.

269. Some Members of the Committee have concluded that, were it to progress beyond Stage 1, the Bill would require such significant amendment that there would be a need for substantial additional evidence to be taken at Stage 2.

270. Having concluded its scrutiny of the Bill at Stage 1, the Committee is unable to recommend that the general principles of the Bill be agreed to[ii].

[ii] This recommendation was agreed to by division - For 6 (Jackie Dunbar, Emma Harper, Patrick Harvie, Clare Haughey, David Torrance, Elena Whitham), Against 1 (Brian Whittle), Abstentions 2 (Carol Mochan, Paul Sweeney).

Annexe A: Extracts from Committee minutes

This annexe sets out relevant extracts from the minutes of the Health, Social Care and Sport Committee throughout the inquiry. Each main heading links to a web-page that gives access to:

- the agenda and public papers for the meeting
- the Official Report of the meeting (public business only), and
- minutes of the meeting.

28th Meeting, 2024 (Session 6), Tuesday 29 October 2024

Right to Addiction Recovery (Scotland) Bill (in private): The Committee considered its approach to the scrutiny of the Bill at Stage 1, and agreed to issue a call for written views on the Bill.

35th Meeting, 2024 (Session 6), Tuesday 10 December 2024

Right to Addiction Recovery (Scotland) Bill (in private): The Committee considered its approach to informal engagement as part of its scrutiny of the Bill at Stage 1

2nd Meeting, 2025 (Session 6), Tuesday 21 January 2025

Right to Addiction Recovery (Scotland) Bill (In Private): The Committee considered its approach to scrutiny of the Bill at Stage 1. The Committee agreed its plan for informal engagement on the Bill

4th Meeting, 2025 (Session 6), Tuesday 4 February 2025

Right to Addiction Recovery (Scotland) Bill (In Private): The Committee agreed a revised programme of oral evidence and witnesses to be invited and to delegate to the Convener responsibility for any further changes to the programme that may be required due to other work programme commitments.

9th Meeting, 2025 (Session 6), Tuesday 18 March 2025

Right to Addiction Recovery (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Eleanor Deeming, Legal Officer, Scottish Human Rights Commission;

Hilary Steele, Solicitor, Law Society of Scotland;

Dr Tara Shivaji, Consultant in Public Health Medicine, Public Health Scotland;

and then from—

Lyndsey Turfus, Chair of Substance Use Subgroup, Social Work Scotland;

Dr Peter Rice, Former Chair, Royal College of Psychiatrists in Scotland;

Dr Chris Williams, Vice Chair, Royal College of General Practitioners Scotland.

10th Meeting, 2025 (Session 6), Tuesday 25 March 2025

Right to Addiction Recovery (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Eddie Follan, Chief Officer, Health and Social Care, COSLA;

Dr Sue Galea-Singer, Clinical Lead, Addiction Services, NHS Fife;

Flora Ogilvie, Public Health Consultant, NHS Lothian;

Gillian Robertson, Service Manager, Aberdeenshire Health and Social Care Partnership;

and then from—

Pamela Dudek, Independent Chair, Dundee Alcohol and Drug Partnership;

Liam Wells, Lead Officer, East Ayrshire Alcohol and Drug Partnership;

Kelda Gaffney, Chair and Interim Assistant Chief Officer of Adult Services, Glasgow City Alcohol and Drug Partnership.

14th Meeting, 2025 (Session 6), Tuesday 13 May 2025

Right to Addiction Recovery (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Kirsten Horsburgh, CEO, Scottish Drugs Forum;

Tracey McFall, Chief Executive, Scottish Recovery Consortium;

Justina Murray, CEO, Scottish Families Affected by Alcohol & Drugs;

and then from—

Lee Ball, Director of Addictions, Salvation Army;

Graeme Callander, Policy and Public Affairs Lead, WithYou;

Jan Mayor, Practice and Innovation Lead Alcohol and other Drugs, Turning Point Scotland;

Annemarie Ward, CEO, Faces & Voices of Recovery UK.

15th Meeting, 2025 (Session 6), Tuesday 20 May 2025

Right to Addiction Recovery (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Neil Gray, Cabinet Secretary for Health and Social Care;

Morven Davidson, Lawyer;

and Laura Zeballos, Deputy Director, Drugs Policy Division, Scottish Government.

16th Meeting, 2025, (Session 6) Tuesday 27 May 2025

Right to Addiction Recovery (Scotland) Bill: The Committee took evidence from—

Douglas Ross, Member in charge of the Bill;

Neil Stewart, Senior Clerk, Non-Government Bills Unit,

and Alison Fraser, Solicitor, Legal Services, Scottish Parliament.

22nd Meeting, 2025 (Session 6), 9 September 2025

Right to Addiction Recovery (Scotland) Bill (In Private): The Committee considered a draft Stage 1 report. Various changes were agreed to, and the Committee agreed to consider a revised draft at its next meeting.

23rd meeting, 2025 (Session 6), 16 September 2025

Right to Addiction Recovery (Scotland) Bill (In Private): The Committee considered a revised draft Stage 1 report. Various changes were agreed to including two by division.

Record of divisions in private

The Convener asked the Committee whether it wished to make no recommendation on the general principles of the Bill. This option was disagreed to by division: For 3 (Carol Mochan, Paul Sweeney, Brian Whittle), Against 6 (Jackie Dunbar, Emma Harper, Patrick Harvie, Clare Haughey, David Torrance, Elena Whitham), Abstentions 0.

The Convener then asked the Committee whether it wished to conclude that it was unable to recommend that the general principles of the Bill be agreed to. This option was agreed to by division: For 6 (Jackie Dunbar, Emma Harper, Patrick Harvie, Clare Haughey, David Torrance, Elena Whitham), Against 1 (Brian Whittle), Abstentions 2 (Carol Mochan, Paul Sweeney).

Annexe B: Evidence and information gathered

This annexe provides links to:

- oral evidence taken (links to the Official Report of relevant meetings), together with associated written submissions and follow-up correspondence;
- other written submissions;
- other correspondence;
- notes of engagement; and
- SPICe briefings and blogs.

Oral evidence (and associated submissions and correspondence)

- Legal and human rights context

- Scottish Human Rights Commission

- Law Society of Scotland (written follow-up correspondence from 18 March meeting)

-Public Health Scotland

- Professional Organisations

- Social Work Scotland

- Royal College of Psychiatrists in Scotland

- Royal College of General Practitioners in Scotland

- NHS, Local Authorities and IJBs

- NHS Lothian (Public Health and Health Policy)

- NHS Fife (Department of Public Health)

- Aberdeenshire HSCP

- COSLA

- Alcohol and Drug Partnerships

- East Ayrshire ADP

- Dundee ADP

- Glasgow City ADP

- Third Sector Organisations

- Scottish Drugs Forum

- Scottish Families Affected by Alcohol and Drugs

- Scottish Recovery Consortium

- Salvation Army

- Favor UK

- With You

- Turning Point Scotland

Other correspondence

HSCS Committee

- Letter from the Cabinet Secretary for Health and Social Care to the HSCS Convener concerning the Right to Addiction Recovery (Scotland) Bill, 7 January 2025
- Letter from Douglas Ross MSP to the HSCS Convener concerning the Equality Impact Assessment for the Right to Addiction Recovery (Scotland) Bill, 25 September 2024

DPLR Committee

- Letter from Douglas Ross MSP to the DPLRC Convener, 16 October 2024
- Letter from the DPLRC Convener to Douglas Ross MSP, 24 September 2024

FPA Committee

- Letter from the FPA Convener to the Convener of the Health, Social Care and Sport Committee, 15 May 2025
- Letter from Douglas Ross MSP, Member in Charge of the Bill to the FPA Convener, 29 April 2025
- Letter from the Cabinet Secretary for Health and Social Care to FPA Convener, 7 January 2025

Notes of fact-finding visits and engagement activity

On 18 February 2025, the Committee undertook informal engagement with people with lived experience of recovery from alcohol and/or drug addiction as part of its scrutiny at Stage 1 of the Right to Addiction Recovery (Scotland) Bill.

- Notes on informal engagement session from 18 February 2025.

SPICe briefings and blogs

- Right to Addiction Recovery (Scotland) Bill Briefing (SPICe)