

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 01 May 2025 11:38  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** FW: For clearance: Draft sub on approach to R2R evidence session and flagging of key risks re Bill

Hi [Redacted-Section 38(1)(b)],

[Redacted-Section 30(c)] have asked for a final pass of this before it goes to CS – incase I am dropped off copy list in her response.

AB

[Redacted-Section 38(1)(b)]

[Redacted-out of scope information]

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**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 01 May 2025 15:25  
**To:** DL for Drugs Policy Division <DLforDrugsPolicyDivision@gov.scot>  
**Subject:** R2R Bill - Oral Evidence Session - HSCSC - 20th May

Hi everyone,

You will be aware we have the upcoming oral evidence session for the R2R bill on 20 May.

We are currently preparing the briefing and will be circulating for contributions on Tuesday, with a very tight turnaround for COP Thursday 8 May. We wanted to give you a heads-up (especially with the Monday bank holiday) so everyone's ready for all hands on deck when we come chasing for review/input.

I would be grateful if you could drop me a quick line to let me know if anything (such as leave or a NWD) will stand in the way of meeting the deadline.

Many thanks,

[Redacted-Section 38(1)(b)]

[Redacted-Section 38(1)(b)]

Policy Officer | Participation and Human Rights Integration Team | Drugs Policy Division

Scottish Government  
3 E St Andrews House  
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Edinburgh  
EH1 3DG



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**From:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Sent:** 01 May 2025 17:34  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;



I will get a revised version to you by end of today

Many thanks

**[Redacted-Section 38(1)(b)]**

**From:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>

**Sent:** 01 May 2025 18:26

**To:** **[Redacted-Section 38(1)(b)]@gov.scot**>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>

**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]gov.scot**>; **[Redacted-Section 30(c)]@gov.scot**>; **[Redacted-Section 30(c)]@gov.scot**>; **[Redacted-Section 30(c)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>

**Subject:** RE: For clearance: Draft sub on approach to R2R evidence session and flagging of key risks re Bill

Hi **[Redacted-Section 38(1)(b)]**,

Thanks for sight of this. I have added comments in the doc. **[Redacted-Section 30(b)(ii)]**

- **[Redacted-Section 30(b)(ii)]**
- **[Redacted-Section 30(b)(ii)]**

It may however be that this is standard format/template for Bill advice?

I have suggested also a standalone para on timeline and implications – I took from discussions over the last weeks that **[Redacted-Section 30(b)(ii)]**

Happy to pick up further and aware **[Redacted-Section 30(c)]** will also have views.

Thanks

Laura

Laura Zeballos

Deputy Director – Drugs Policy  
Population Health Directorate  
0**[Redacted-Section 38(1)(b)]**

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

**From:** [Redacted-Section 38(1)(b)]

**Sent:** 02 May 2025 11:57

**To:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>

**Subject:** R2R evidence sessions

FPAC official transcript 11 March: Meeting of the Parliament: FPA/11/03/2025 |  
Scottish Parliament Website

HSCS official transcript 18 March: Meeting of the Parliament: HSCS/18/03/2025 |  
Scottish Parliament Website

HSCS official transcript 25 March: Meeting of the Parliament: HSCS/25/03/2025 |  
Scottish Parliament Website

Summaries are attached.

If you need anything else just give me a shout

**[Redacted-Section 38(1)(b)] | Drugs Policy | Health & Social Care Directorate |  
Scottish Government**

Email: [Redacted-Section 38(1)(b)]@gov.scot

**Pronouns she/her**



## Summary of themes emerging

Some provisions in the Bill are already part of treatment landscape; i.e. MAT1, same day treatment, and MAT 2, making an informed choice. As well as repetition, some provisions potentially cut across current standards and guidance, i.e. treatment target within 3 weeks vis a vis same day in MAT, and supreme court judgements on health professionals explaining all possible treatments vs the treatments suitable for an individual. However, there was some discussion on hopes that the Bill could align with MAT, or that it could further incorporate aHR framework to improve Bill.

Questioning related also to if the Bill would have the proposed effect of reducing deaths and harm. The Bill was proposed as supporting compliance to article 2 of ECHR.

Lack of resource and capacity to deliver the provisions in the Bill were highlighted, and the risks of this to patients, staff and services; i.e. on staff/services morale; on losing public trust and the potential impact of the Bill on altering patients expectations (giving potential unrealistic expectations, and the ethics of this). Potential stigma was raised as an outcome if monies were to be diverted to meeting legislation. Further risks were discussed, e.g. the impact of a focus on narrow legislative compliance and away from a whole system approach/wraparound care and the impact on low threshold services, and what the impact would be on those services, and those people who did not want to seek a diagnosis.

Open questions on accountability remained. In relation to lack of resource/capacity to deliver, queries were raised around how a right could be enforced if no capacity for a preferred treatment was available, and the potential impact of increased litigation on already strained budgets (as well as a need to account for increased legal aid costs).

Panellists considered that the challenge mechanisms were not currently realistic, and should be improved. It was posited that if this were to happen, the Bill could be viewed as making justice more widely accessible to a marginalised group.

The terminology of 'addiction' and its definition was discussed, i.e. the impact on people's lives of substance use should be a key consideration, as opposed to only a set of symptoms. The focus should be on minimising harm, as this can be experienced outside of a clear-cut diagnosis (i.e. alcohol harm). Any terminology should also take account of Scotland's changing landscape of substances used. Clarity on terminology was needed to understand what was in scope.

The breadth of treatment options was considered somewhat narrow (and not linked to MDT working), not linked in enough with harm reduction and should perhaps include mental health support – further detail and clarity is needed, also on HP's 2<sup>nd</sup> opinions, to ensure all HPs have same level of expertise when considering the 'treatment determination'.

A potential oversimplification of 'treatment' was flagged, which should be viewed as ongoing support rather than one off 'treatment' or intervention, and with specific mechanisms of support being suitable for specific people at specific times – there was an acknowledgement that support had to be tailored to an individuals circumstances

at a specific point in time – some concerns as to how clear this was in the Bill and expectations it set up.

Requirement of diagnosis was considered as potentially raising the threshold for access and directing people away from support, but also was considered as potentially positive in providing clear eligibility and an articulation of support available.

Lastly, SHRC specifically discussed, at a number of points, the Bills ability to support compliance to Article 2 of ECHR, the Right to Life, although this was caveated as potentially a piecemeal intervention, and that the same (supporting compliance) could be said of many interventions in healthcare.

### Extended Summary

#### Some provisions in the Bill are already part of how services work

- MAT already calls for informed choice around treatment, which is not reflected in Bill.
- Sector already working towards seeing people more quickly; i.e. treatment around timescales (i.e. MAT 1)

#### How integrated are Bill provisions with the current service landscape?

- **Potential confusion in relation to MAT Standards:** between 3-week treatment stipulation and MAT 1 (same day). The sector increasingly understands people need to be seen quickly, need to continue to ensure clarity in good care/timings. Need to be clear that 3-week treatment doesn't take precedent and become new minimum obligation.
- **Different from CoR, but HR framework could be included in Bill to improve it.**
- Could the Charter of Patient Rights provide a measurable standard and encourage a collaborative approach for agencies to meet deadlines?
- **Bill runs counter to supreme court judgements/current practice** which state that patients do not need to know about all treatment, only the ones the clinician considers relevant, whereas the Bill stipulates all treatment options must be explained – even if they are not suitable - goes against the current medico-legal position (can also overwhelm patient)

#### Would a right to treatment have the intended effect?

- **Risk of losing public trust/demoralising staff due to deliverability challenge:** If we have a right to treatment in law, but the system cannot provide it due to a lack of resource, then public trust will be lost and workforce demoralised. Is it ethical to promise something that does not exist? Services already at capacity currently, don't have enough resource to deliver.
- **It would aid likely aid compliance to art 2** but would need a wider consideration of funding and services needed – for example a human rights budgeting assessment.
- **Risk of stigma if monies from one area of healthcare diverted towards meeting legislation.** I.e. move from drugs to alcohol as noted in Audit Scotland report

- **Not clear how 3 week timescale could be met** all across Scotland, for all different services and all different people requiring support – difficult to see how this could be achieved.

#### Impact on support

- **Risk whole system focus is lost:** if focus is on legislative compliance, within a pressured environment, risk that this becomes sole focus outside of whole system and other things become deprioritised - (i.e. adequate housing, employment), away from third sector, low threshold support.
- **How will the important work of low threshold services be impacted?** If there is a move towards needing a diagnosis, how will that impact low threshold services who engage people informally?
- **Potential risk of inadvertent gatekeeping for help by requiring a diagnosis.** Low threshold help without a diagnosis should exist – should not need to be first port of call for help.

#### How does accountability work (if provisions are not met), and what are unintended consequences?

- **Questions on accountability** - if the patient does not get the preferred treatment within specified time period set out for example, who is accountable? Is it the HP, HB?
- **Unintended additional pressures:** how can rights be enforced if there is no capacity within system? Could bring criminal negligence but if there is significant litigation this brings unintended consequences – further straining healthcare provision, and increased funding requirements for legal aid for clinical negligence cases.
- **Bill has no challenge mechanisms** – this should be strengthened. Expecting people to access judicial review is not realistic.
- **The Bill could be a mechanism to make access to justice easier for people,** if it considered mechanisms beyond judicial review and NHS complaints.

#### Definition of 'addiction'/'dependency' for purposes diagnosis

- Further detail needed – consider impact on lives (i.e. harm experienced), not just presence of symptoms which can be defined as addiction. Significant harm is routinely experienced outside of a diagnosis (i.e. alcohol)
- Also need to future proof – use of substances is changing in Scotland, classic features of dependence not always present but harm still caused – Bill needs to accommodate this.
- Terminology – would substance use disorder be better?
- Clarity needed, otherwise Bill could include gambling, nicotine etc

#### What is included in treatment and how treatment is defined

- Should treatment options include mental health support to be better aligned with human rights standards/policy on drugs?
- Further detail added on treatment options – more recognition that people need wider treatment options than detailed in Bill; specific treatments in Bill not linked with harm reduction and not clear why. 'Any other treatment' may need further detail.

- **Clarity on 2<sup>nd</sup> opinions in treatment determination:** care needs to be taken with 2<sup>nd</sup> opinions – that they have same expertise and understanding.  
Question of who gives 2<sup>nd</sup> opinions

#### Oversimplification of 'recovery' and treatment

- **Treatments are ongoing pathways** to recovery, not one-off interventions. Should consider this – process not single event.
- **Treatment pathways are tailored to individual** – what works for one might not work for others, danger that families and people think what works for others works for them.
- **People's individualised needs are potentially glossed over in bill** - RR should not be gatekept, but this is not a simple treatment + people need understanding of the significant difficulty and challenge of such a method.
- **MDTs approach is important and sees whole picture**, which is beneficial – its not a single HP, single issue, which then allows 'recovery'.
- **Medicalised focus** – the Bill is narrow and doesn't take account of all other actors in the field

#### Risk of making services less accessible/increase stigma by requiring diagnosis

- **Could requiring diagnosis create a barrier to access?** Could some people not get treatment if they don't have the diagnosis?
- If priority for treatment is given to those (willing to) get a diagnosis, could this redirect focus, i.e. away from those unable or unwilling to attach to a diagnosis?
- Diagnosis is a label carried for life, may create barriers
- Could requiring diagnosis be positive in clearly providing communication – on articulating eligibility for support/what is available.

#### SHRC suggestion that Bill could be a way to work towards compliance in relation human rights obligations, in lieu of the Human Rights Bill

- The Bill as a mechanism to support state compliance to human rights, specifically article 2, the Right to Life.
- However, it should have a broader alignment with human rights framework, such as access to justice and accountability; a human rights budget assessment, to have broadest alignment possible.
- A single, piecemeal approach is possible (i.e. the Bill to be a way of incorporating some human rights), given HR Bill is delayed.
- Accepted that article 2 could apply across a broad area of healthcare, but comments reflect focus on this specific issue only.

### Pros (as described by committee guests)

- Intentions of Bill are supported.
- Purported compliance to Article 2 ECHR (right to life)
- Bill highlights importance of participation of patients, which supports quality improvement
- Written reason for treatment determination could help ensure there is no unintended discrimination
- Could increase ordinary people's access to justice (if other forms of remedy are integrated in Bill)
- Requiring diagnosis could be positive in that it articulates eligibility for support/what is available.

### Cons (as described by committee guests)

- Increased stigma/some people may not come forward
- Not clear how 3 week time limit could currently be met - inability to deliver provisions; services demoralised and public lose trust
- Focus shifts to narrow provision compliance and broader or wraparound care is deprioritised
- Monies moved from other healthcare budgets
- Increased litigation and thus further pressure on health budgets
- Unanticipated budget for legal aid
- Services do not have capacity/resource to deliver Bill
- Difficulty to model increased need and cost of Bill in advance
- Medicalised focus
- Need for diagnosis increases barriers to support?
- Individual needs and complexity glossed over (i.e. people might need different treatments, or at different times)
- Arguably puts forward a simplistic view of treatment – i.e. a one time event as opposed to long term, multiple 'treatments'.
- Definition of 'addiction' needs work.
- Cuts across existing medico legal context; current standards and good practice – creates confusion and problems.
- No challenge mechanisms.

### Reference to existing work

- Charter of Rights and Knowledge and Skills Framework (forthcoming) provide a better framework for training within the workforce, and a better way to tackle drug and alcohol challenges
- The CoR was presented as a fuller means to recognise rights
- WEDG referenced

Questions asked by committee members

Sandesh Gullane

- Is the Bill needed? Is the current situation acceptable and could the Bill improve outcomes?
- What are the current measurable outcomes in Scotland in relation to change? What would we like to see?
- What are the measurable outcomes of the Thistle Centre? Could these be used to measure the outcomes in the Bill?
- Could establishing a right for an individual for treatment improve outcomes?
- How would the Bill intersect with existing human rights?
- Would the Bill work alongside MAT Standards...the 3 week timeline is a maximum and would not prevent same day prescribing under MAT ?
- What about the lack of standard definition of addiction to drugs?
- Is there a need for a health professional to diagnose and make treatment determination?
- What do you think about the requirements of the Bill for health professionals to explain all treatments and explain why they are/not suitable?

Elena Whitham

- Could be a vehicle for realising those rights - could this Bill bring incorporation or would a Human Rights Bill still be needed.
- How does the Bill intersect with the Charter of Rights: could they work together; could the CoR strengthen this Bill and fill a gap in being able to realise rights?
- What about the concern expressed in the written evidence responses about the perceived emphasis on abstinence in the Bill?
- On the LLE emphasis and the need for wrap around support...does the Bill adequately promote that?

Emma Harper

- Does the Bill effectively integrate harm reduction in the range of treatment options offered?
- Would the Bill mean that the MAT standards will still work, or would they need to be 'ripped up'?
- Will the Bill build on the Charter of Patients' Rights?
- What are the challenges in rural areas...of lack of anonymity and if people may not want a diagnosis?
- How do we futureproof the Bill, for example how harmful vaping is, and it not becoming more prevalent among young people?

Claire Haughey

- In reference to the previously mentioned Montgomery and McCulloch cases, could the Bill run counter to the judgements in these cases?
- Could the Bill include other addictive substances like caffeine or tobacco?

Brian Whittle

- Does the Bill makes clear in its current form, which bodies would be held accountable for upholding the rights put forward in the Bill?
- Are the health professionals views on best treatment are currently privileged above a patients views.
- As a patient has the right to seek a second opinion - given medicine isn't an exact science – would this be sufficient to protect health professionals?
- How could the rights be enforced?
- How could the NHS could be held to account, if one a particular night, there are no beds available – how could the NHS be held accountable for this.
- Does the reference in the Bill to intoxication help to specify what the Bill relates to (further to comments in previous panel about potential for Bill to inadvertently include nicotine or addictive behaviours)?
- What is the role of the third sector?

Gillian McKay

- A right to treatment is not a normal approach, are there any drawbacks to having the right in law and is there a danger that the focus on compliance would distract from the range of treatments we would like to see?
- Would a focus on compliance with the Bill would lead to underfunding of other services like mental health support for people affected?
- Is it appropriate to put a timescale on accessing treatment?
- Is there a risk of pushing people into inappropriate treatment in order to meet legislative requirements?
- Does the three week deadline risk sidelining other treatment and support needs people may have (eg. mental health) to meet the statutory obligations?

Joe Fitzpatrick

- Would moving the approach away from the mainstream health approach (by singling out with specific legislation)increase stigma?

Caroline Mochan

- What training would be required for health professionals to deliver the requirements of the Bill?

Paul Sweeney

- Is there any modelling available on what the increased need is likely to be and the costs if meeting this?

## **Summary of issues emerging**

Current approach, brought in through National Mission, MAT Standards, Charter of Rights, together with other clinical good practice, is achieving (and working towards) some of what the Bill is setting out: targets for treatment within timescales are part of drug and alcohol services, and shared decision making is already part of good practice.

Current system is working in multidisciplinary teams, pooling resource and shared understanding, providing a range of support and looping in a range of expertise, and providing low threshold intervention.

It is unclear how this approach, and provisions of the Bill would work together; specifically the approach of legislating, and the narrow approach for providing treatment (through a diagnosis by HP), and the narrow range of interventions (treatment) which is different from the whole systems, person centred approach Scotland is working towards. A risk of confusion between standards and legislation; i.e. MAT 1 and the 3 week treatment provision, or other existing guidance; i.e. alcohol treatment was also highlighted.

Requiring a diagnosis of addiction, or presenting in person raises the threshold, may alienate some that have not acknowledged a problem, or push others away from services for fear of 'outing' or stigma. A diagnosis of addiction was considered as not always the clear-cut best way to access the best support in the same way that, for example, a cancer diagnosis would be. The assumption of 'treatments' as discreet, narrow and one off was also not seen as reflective of lived experience.

More focus 'upstream' on prevention and social determinants of health (such as poverty and inequality) was considered preferable to the Bill. The panel also mentioned the importance of family support, community support, psychosocial support, advocacy and meeting broader support needs (housing, education, employment) as pivotal.

Concern was voiced over the overall pressures that could be faced as a result of the Bill. Relevant services are already understaffed and feeling burned out. The impact of service redesign after recent redesign through MAT would likely cause disruption and increased burnout. Costs were also considered to be calculated in a flawed way (from Health Boards rather than the broader system that delivers drug and alcohol services), and increasing costs/cuts would be expected to be a result of increasing numbers of clinicians and provision of the 3 week treatment under legislation. The panel noted that it is normal for costs to be considered at population level when delivering healthcare, and that it was important to understand what the Bill would provide in addition to current provision.

Panel members voiced their support of the intentions of the Bill, but that they were unsure if the Bill added anything positive to the current landscape, but risked unintended consequences.



## Extended Summary

Some provisions in the Bill are already part of DA services – treatment within timescales and shared decision-making.

How would the Bill work with existing systems – not clear on the face of the Bill, potential for unintended consequences or even entire restructure to meet the requirements of the Bill

- **Problems potentially created by the lever of legislation** – by legislating, *placing in law*, for narrow treatment interventions to be provided, within 3 weeks, which must not include consideration of key clinical factors, decisions are moved from being made in relation to best needs for individual within a MDT, towards being made on the basis of fulfilling a legal obligation (servicing the legislation). Driver for decision-making altered – from medical expertise with an understanding of what is available, and what is needed, to the obligation to simply fulfil a narrow legal stipulation (issue: this may be oppositional to our whole systems, person centred ambitions in being narrow and inflexible, and may have further impacts – financial, workforce, quality of care).
- **Bill provisions are not integrated within, nor complimentary to current system (issue: changing would be significant work; potential consequence of cost to budgets, pushing interventions to HPs and narrowing, and inefficient working).**
  - **Impact of increasing private prescription;** for example, private providers not aware of wider discussions happening in multidisciplinary teams, nor have a full understanding of patient history/needs, therefore a potential risk to Additional risk to budgets if public sector needs to treat private treatment determinations.
  - **Decision-making/treatment provision sits broader than described in Bill.** Diagnosis often happens in MDT/agency way, but the bill presupposes/creates it as discreetly medical issue. Currently the MDT approach aims to address (treat) the broadest range of needs of individuals – whatever individual deems as most important/is most urgent
  - **People require** ongoing support, not one intervention – not considered in Bill.
  - **Treatment determinations (interventions) offered are narrow,** and based specifically on a HP's view, but treatment, i.e. interventions, are much broader in reality (risk is that if only a narrow set of needs are attended to, which won't give individual best opportunity for recovery)
  - **Treatment determinations (interventions) are currently made on patient needs, pool of resources and expertise together, to provide** the best treatment possible. If HPs are making these without the bigger picture, they don't have insight into multiple patient needs, nor wider resource available – if everyone works together resources are pooled.
  - Focus is away from primary prevention/social determinants of health, which is Scotland's approach.

- **Confusion between MAT 1 and 3 week treatment for services.** Moreover, peoples shouldn't need to wait 3 weeks, should get treatment when needed also because peoples motivation changes
- **3 week period doesn't reflect guidance in all areas** (i.e. in relation to alcohol treatment)

Risk of making services less accessible by requiring diagnosis. The need for diagnosis may raise the threshold for intervention and could create a barrier for some to access support.

- **Lowest threshold** service access is the best - the less formal and the more frequent the interactions with potential support the better. Opportunities for 'brief interventions' should be common, rather than requiring a diagnosis from HP to access support. Third sector vital
- **Harm can be experienced outside of diagnostic criteria** – interventions and support shouldn't be dependent on it, should happen at earliest opportunity.
- **Diagnosis** not wanted by all, for some seen as stigmatising or risky (on health record, discrediting in rural communities, for women with children)
- Focusing on diagnosis too much takes away focus from individuals needs
- Most important is a collaborative care plan that addresses a range of need.
- System should support individual with what they need, rather than a move towards a narrow medicalised diagnostic model in the case of addiction, which has many socially determined causes
- **In person requirement** as not suitably flexible (i.e. young people, rural, whatever individual needs or prefers, flexibility for service as well because people can present chaotically) – but bottom line bill is rigid when flexible and holistic is better.

Risk of services becoming less flexible in addressing complex needs:

- Those that present with immediate, high end complex needs, i.e. in A&E, polysubstance use, wont be reached by the bill. 4 substances on average implicated in deaths, requires broad range of interventions

Concern over additional pressures from statutory requirements on an already pressured system

Strain on workforce/burnout/resource/financial implication:

- ...from absolute legal measure – system facing resource limitations (not enough social workers, psychiatrists, precarity of 6 month funding).
- ...from redesigning services again (+ redesigning monitoring + evaluation), especially after recent redesign through MAT
- ...from disruption to current effort to pool resources.
- ...from disrupting current NM/MAT/Scotland approach
- Significant cost to an area if everyone must see clinician (+impact on overall staffing budget + potential cut to other posts) + delivering in 3 weeks for those covering broad geographical area.
- NM has already added significant pressure. Is it right to add more (especially if benefits are not clear)

- On its own cost shouldn't be a key consideration, but at population level must be considered
- FM weighted towards health boards, rather than cost to other sectors involved
- Savings are unclear
- Potential for reallocation of funds from other services which could create stigma.

### Pros

Intentions of the Bill are supported and lauded, but Bill not seen to add any substantive benefit, and carry significant problems

### Amendments

- Language of CoR should be used in Bill
- More reference to MAT
- Expand the application of Bill beyond applying to Health Professionals
- Bill should properly bring in harm reduction

Questions posed by Panel

**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

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

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

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

Question themes

- Emma Harper - What difference would the Bill make to people?
- Emma Harper – Could the Bill further stigmatise in its need for diagnosis? Are there risks in requiring a diagnosis, i.e. (people’s right to privacy in seeking treatment, especially in rural areas and for women?)
- Emma Harper – Does the Bill’s stipulation of treatment within 3 weeks conflict with MAT Standards?
- Emma Harper – Should everyone be aware of a trauma informed approach through training?
- Emma Harper: How do we manage cross border costs? Does the Bill address this?
- Emma Harper asked about the potential to widen the Bill beyond health professionals making reference to the many places/people that can use brief interventions
- Emma Harper mentioned the comments about harmful drinking levels that individuals do see as dependency and if the need for diagnosis could be stigmatising
- Emma Harper asked if the Bill would provide additional benefits
- Emma Harper asked about the three week deadline for starting treatment and asked how it would work if people drop in and out of contact
- Emma Harper referred to the Financial memo which suggests number of people who self report dependency is low, but there is a hidden population who do not self report, what would happen if they were no longer hidden, would this be a challenge to the resource/numbers laid out in the financial memo?

Carole Mochan asked if there was any idea about the additional spend on the Bill, would there be future savings? And would the Bill be useful to other parts of the system?

Carole Mochan asked where would additional funding best be targeted

- Claire Haughey – Do people (already) take part in the decision-making process?

- Claire Haughey – Do people already have a right to access a second opinion?
- Claire Haughey – What would the impact of increasing treatment determinations being made privately (which would then need to be delivered publicly?)
- Claire Haughey asked about the need for diagnosis and if this would impact open doors that are needed for access
- 
- Elena Whitham – What could the impact of needing to have a diagnosis of addiction be for people affected by substance use?
- Elena Whitham – ‘Addicted’ is a contested term, some like it or some don’t. What is the interaction with Equalities Act as its not a protected characteristic?
- Elena Whitham: How would the Bill impact those living rurally – i.e. the need for a treatment determination to be made in person?
- Elena Whitham – Some treatment forms require much longer lead in times, such as RR. Is more detail required in the Bill as to when clock starts and what is included?
- Elena Whitham asked if the Bill needs to strengthen reference to families (Whole Family Approach, Family Inclusive Practice)
- Elena Whitham asked if the Bill adequately addresses advocacy support and using a human rights based model of practice
- Elena Whitham asked about formalising advocacy, as it is in MAT 8, and how this gives weight to what the advocate says
- 
- David Torrence – Does the health professional who diagnoses then continue to carry out the treatment?
- David Torrence – How does the Bill interact with multidisciplinary team working?
- Gillian McKay - To what extent does the Bill address changing patterns of substance use – polysubstance use and alcohol usage?
- Gillian McKay - Is there the correct balance in the Bill of prevention, harm reduction and treatment in the Bill, and if there is not – what do you think needs to change in the Bill to address that correctly?
- Gillian McKay asked about the concerns raised in evidence about a perceived focus on abstinence in the Bill and limiting access to harm reduction. Could the bill be amended to change this?
- Gillian McKay asked how Bill would interact with other recent changes like MAT Standards
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- Sandesh Gulhane: How can we make things better when award winning services are being cut?
- Sandesh Gulhane – (On what people ‘need’ for treatment) – instead of a diagnosis of addiction, what should people have?
- Sandesh Gulhane – Would legal requirement for treatment not be a good thing? re timescales for getting treatment?
- Sandesh Gulhane – You spoke how treatment often begins in 24 hours, how there that there are wide treatment options and rehab and intervention services being there to pick up every patient – then why area deaths as bad as they are?

- Sandesh Gulhane – You spoke of the other determinants of health. Do you think its reasonable for a members Bill to cover all these huge areas?
- Sandesh Gulhane asked about the current Glasgow budget, and if that has changed – mentioned £100m cuts in past three years and predicted £118m cuts in next three years
- Sandesh Gulhane asked if legislating the rights of the individual through the Bill would not bolster ability to maintain budget
- 
- Brian Whittle – The whole system isn't working, and the Bill highlights this – we can't not proceed with the Bill just because there are current difficulties? (i.e. staff pressure, budget pressure?)
- Brian Whittle –Treatment within 3 weeks is not happening across Scotlnd, this Bill would set out the right to treatment in 3 weeks.
- Brian Whittle – What impact would the Bill have on staff working on sector?
- Brian Whittle – Does the Bill reflect trauma informed practice sufficiently/what would make the Bill more trauma-informed?
- Brian Whittle as about the role of the third sector as a facilitator of access to treatment.
- Brian Whittle asked about the staff pressures and commented that the Financial memo suggested the Bill would lead to less need for repeated treatments which would reduce workforce pressure
-

[Redacted-Section 36(1)]  
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[Redacted-Section 36(1)] [Redacted-Section 36(1)]

[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]

---

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 02 May 2025 17:57  
**To:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: For clearance: Draft sub on approach to R2R evidence session and flagging of key risks re Bill

Hi Laura

Link again for ease:  OFF SEN - Draft Submission - R2R update on evidence sessions, risks and approach - April 2025a.docx

I have taken into account comments throughout.

[Redacted-Section 30(b)(ii)]

I've added the table for the timeline as requested.

[Redacted-Section 30(b)(ii)]

Many thanks

[Redacted-Section 38(1)(b)]

[Redacted-out of scope information]

- [Redacted-out of scope information]
- [Redacted-out of scope information]

[Redacted-out of scope information]

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**From:** [Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 06 May 2025 16:43

**To:** [Redacted-Section 38(1)(b)]@gov.scot>

**Subject:**

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-Section 38(1)(b)] she/her | **Participation and Human Rights Integration Team | Drugs Policy Division | 07[Redacted-Section 38(1)(b)]**  
Scottish Government | 3 E St Andrews House | Regent Road | Edinburgh | EH1 3DG

---

**From:** [Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 07 May 2025 09:46

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; R2R Shadow Bill Team

<R2RShadowBillTeam@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: For input: Cabinet Secretary for HSC Briefing to Right to Recovery Bill evidence session - Deadline Thursday 8 May

Hi [Redacted-Section 38(1)(b)],

Thanks so much for your e-mail. Give me a second, I will add you now – sorry about that!

AB

[Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)]

**Sent:** 07 May 2025 09:39

**To:** R2R Shadow Bill Team ; [Redacted-Section 38(1)(b)]

**Cc:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]

**Subject:** RE: For input: Cabinet Secretary for HSC Briefing to Right to Recovery Bill evidence session - Deadline Thursday 8 May

Hi [Redacted-Section 38(1)(b)]

I'm unable to access or request access to the document linked below. Are you able to add me manually, please?

I'll add some lines on the Mental Health and Wellbeing Workforce Action Plan and the soon to be published Mental Health Nursing Review.

Many thanks,

**[Redacted-Section 38(1)(b)]**

**[Redacted-Section 38(1)(b)]**

**Team Leader | Mental Health Workforce | Mental Health and Wellbeing  
Directorate | Scottish Government**

**From:** **[Redacted-Section 38(1)(b)]@gov.scot** > **On Behalf Of** R2R Shadow Bill Team

**Sent:** 07 May 2025 09:13

**To:** **[Redacted-Section 38(1)(b)]@gov.scot** >

**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot** >; **[Redacted-Section 38(1)(b)]@gov.scot** >;

**[Redacted-Section 38(1)(b)]@gov.scot** >; **[Redacted-Section 38(1)(b)]@gov.scot** >; **[Redacted-Section 38(1)(b)]@gov.scot** >

**Subject:** FW: For input: Cabinet Secretary for HSC Briefing to Right to Recovery Bill evidence session - Deadline Thursday 8 May

Morning **[Redacted-Section 38(1)(b)]**,

As discussed on Teams, below is the commission for the R2R oral evidence briefing.

Thank you for preparing the MH workforce lines and grateful if you could add them in by COP tomorrow.

Many thanks,

**[Redacted-Section 38(1)(b)]**

**[Redacted-Section 38(1)(b)]**

Policy Officer | Participation and Human Rights Integration Team | Drugs Policy Division

Scottish Government  
3 E St Andrews House  
Regent Road  
Edinburgh  
EH1 3DG



**From:** **[Redacted-Section 38(1)(b)]@gov.scot** > **On Behalf Of** R2R Shadow Bill Team

**Sent:** 06 May 2025 17:13

**To:** R2R Shadow Bill Team <R2RShadowBillTeam@gov.scot>



**[Redacted-Section 38(1)(b)]** are available on Teams to discuss further if required.

Our timelines for this are unfortunately tight, and we are looking for returns by COP Thursday 8 May. The briefing is still in draft format, but due to time and capacity pressures, we request that you input at this stage, to ensure that we can finalise the paper in adequate time for CS. If you think someone who should be on this copy list has not been included, please let us know, and please get in touch with any questions – we will be working on this document live over the next few days, and welcome any other input or consideration.

Many thanks

Right to Recovery Shadow Bill Team

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**From:** **[Redacted-Section 38(1)(b)]@gov.scot** > **On Behalf Of** Cabinet Secretary for Health & Social Care 2024  
**Sent:** 07 May 2025 12:02  
**To:** **[Redacted-Section 38(1)(b)]@gov.scot**; Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>  
**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot**; **[Redacted-Section 38(1)(b)]@gov.scot**; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Subject:** RE: CS premeet for evidence session with HSCS committee on 20th May on Right to Addiction Recovery Bill (R2R)

No that's fine, but if Cab Sec asks for it earlier, will let you know.

**[Redacted-Section 38(1)(b)]**

Deputy Private Secretary to the Cabinet Secretary for Health and Social Care – Neil Gray MSP

Scottish Government | St Andrew's House, Regent Road, Edinburgh EH1 3DG |

Mob: 07**[Redacted-Section 38(1)(b)]** | Email: CabSecHSC@gov.scot

All e-mails and attachments sent by a Ministerial Private Office to any other official on behalf of a Minister relating to a decision, request or comment made by a Minister, or a note of a Ministerial meeting, must be filed appropriately by the recipient. Private Offices do not keep official records of such e-mails or attachments.

Scottish Ministers, Special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See [www.lobbying.scot](http://www.lobbying.scot)

**From:** **[Redacted-Section 38(1)(b)]**

**Sent:** 07 May 2025 11:19

**To:** Cabinet Secretary for Health & Social Care 2024

**Cc:** **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]** ; Deputy Director - Drugs Policy

**Subject:** RE: CS premeet for evidence session with HSCS committee on 20th May on Right to Addiction Recovery Bill (R2R)

Thanks **[Redacted-Section 38(1)(b)]** – just to note, we agreed to send you the briefing for committee session on COP 14<sup>th</sup> May – will this now need to change? It will be difficult for us to send a final briefing before this date.

AB

**[Redacted-Section 38(1)(b)]**

**From:** **[Redacted-Section 38(1)(b)]@gov.scot** > **On Behalf Of** Cabinet Secretary for Health & Social Care 2024

**Sent:** 07 May 2025 11:17

**To:** **[Redacted-Section 38(1)(b)]@gov.scot**; Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot**; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]@gov.scot**>

**Subject:** RE: CS premeet for evidence session with HSCS committee on 20th May on Right to Addiction Recovery Bill (R2R)

Hi **[Redacted-Section 38(1)(b)]**

No unfortunately not – we will have to move this meeting to 14 May as we have a number of things to update in the diary, so the team will send an update asap.

**[Redacted-Section 38(1)(b)]**

Deputy Private Secretary to the Cabinet Secretary for Health and Social Care – Neil Gray MSP

Scottish Government | St Andrew's House, Regent Road, Edinburgh EH1 3DG |

Mob: 07**[Redacted-Section 38(1)(b)]** | Email: CabSecHSC@gov.scot

All e-mails and attachments sent by a Ministerial Private Office to any other official on behalf of a Minister relating to a decision, request or comment made by a Minister, or a note of a Ministerial meeting, must be filed appropriately by the recipient. Private Offices do not keep official records of such e-mails or attachments.

Scottish Ministers, Special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See [www.lobbying.scot](http://www.lobbying.scot)

**From:** **[Redacted-Section 38(1)(b)]@gov.scot** >

**Sent:** 07 May 2025 11:05

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot**; **[Redacted-Section 38(1)(b)]@gov.scot**

**Subject:** CS premeet for evidence session with HSCS committee on 20th May on Right to Addiction Recovery Bill (R2R)

Hi [Redacted-Section 38(1)(b)],

Our Deputy Director has asked if the pre-meet scheduled for 16<sup>th</sup> May @ 13:45 with Mr Gray on his evidence session on the R2R Bill could be moved to between 9-12?

Best wishes,

**Dr [Redacted-Section 38(1)(b)] she/her | Participation and Human Rights Integration Team | Drugs Policy Division | 07[Redacted-Section 38(1)(b)]**  
Scottish Government | 3 E St Andrews House | Regent Road | Edinburgh | EH1 3DG

---

**From:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Sent:** 07 May 2025 12:25  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Cab Sec HSC meeting with Professor Alan Miller

For awareness re post 26/CS engagement

**From:** [Redacted-Section 38(1)(b)]  
**Sent:** 07 May 2025 10:45  
**To:** Cabinet Secretary for Health & Social Care 2024  
**Cc:** Deputy Director - Drugs Policy ; [Redacted-Section 38(1)(b)]; [Redacted-Section 38(1)(b)]  
**Subject:** RE: Cab Sec HSC meeting with Professor Alan Miller

Hi [Redacted-Section 38(1)(b)],

That's great, thanks. I'm happy to confirm I've had a quick response from Prof Miller and he is able to accommodate the 18<sup>th</sup> June 12:00 – 12:30 online.  
Kind regards,

[Redacted-Section 38(1)(b)]

[Redacted-Section 38(1)(b)] | Culture Change Team | Drugs Policy Division |  
Scottish Government | Atlantic Quay | Glasgow | G2 8LU | **Email:** [Redacted-Section 38(1)(b)]@gov.scot

**From:** [Redacted-Section 38(1)(b)]@gov.scot> **On Behalf Of** Cabinet Secretary for Health & Social Care 2024  
**Sent:** 07 May 2025 10:23  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>  
**Subject:** RE: Cab Sec HSC meeting with Professor Alan Miller

Hi [Redacted-Section 38(1)(b)],

Cab Sec is keen to do this and added I think it would also be useful to get his view on the future of the national mission as per the roundtable discussions, please. We would be able to accommodate the 18<sup>th</sup> June 12:00 – 12:30 online if this would be possible for Professor Alan, grateful if you could please confirm with us asap?

Many Thanks

**[Redacted-Section 38(1)(b)]**

Assistant Private Secretary to Neil Gray, Cabinet Secretary for Health and Social Care  
Ministerial Private Office  
St Andrews House  
Edinburgh

**From:** **[Redacted-Section 38(1)(b)]@gov.scot**>

**Sent:** 06 May 2025 10:30

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;

**[Redacted-Section 38(1)(b)]@gov.scot**; **[Redacted-Section 38(1)(b)]@gov.scot**>

**Subject:** Cab Sec HSC meeting with Professor Alan Miller

Dear Private Office,

Professor Miller, who chairs the National Collaborative (as part of the drugs Mission) has asked to meet with Cabinet Secretary to discuss the Charter of Rights for People Affected by Substance Use, the Right to Recovery Bill and the Human Rights Bill. As part of his arrangement as Chair, he is supposed to meet with the Drugs and Alcohol Minister on a quarterly basis to provide regular updates but obviously this hasn't been happening.

I would be very grateful if you could share with the Cabinet Secretary for his views, and if appropriate, suggest some potential meeting times.

Many thanks,

**[Redacted-Section 38(1)(b)]**

**[Redacted-Section 38(1)(b)]** | Culture Change Team | Drugs Policy Division | Scottish Government | Atlantic Quay | Glasgow | G2 8LU | **Email:** **[Redacted-Section 38(1)(b)]@gov.scot**

---

**From:** **[Redacted-Section 38(1)(b)]** On Behalf Of R2R Shadow Bill Team

**Sent:** 08 May 2025 07:17

**To:** **[Redacted-Section 38(1)(b)]@gov.scot**>; R2R Shadow Bill Team

<R2RShadowBillTeam@gov.scot>

**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>

**Subject:** RE: For input: Cabinet Secretary for HSC Briefing to Right to Recovery Bill evidence session - Deadline Thursday 8 May

Hi **[Redacted-Section 38(1)(b)]**

Yes, it is overall view as it is likely that the Bill would have an impact on the broader HSC workforce

Many thanks

**[Redacted-Section 38(1)(b)]**

**From:** **[Redacted-Section 38(1)(b)]**

**Sent:** 07 May 2025 16:53

**To:** R2R Shadow Bill Team

**Cc:** **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]**

**Subject:** RE: For input: Cabinet Secretary for HSC Briefing to Right to Recovery Bill evidence session - Deadline Thursday 8 May

Hi **[Redacted-Section 38(1)(b)]**

I think I've been copied into this from an over HSC workforce point of view as the briefing already contains lines about the drug & alcohol specific workforce. Could you confirm that is the case? If so, I can provide high level lines for NHS workforce and I've included **[Redacted-Section 38(1)(b)]** for social care interests

Best

**[Redacted-Section 38(1)(b)]**

**[Redacted-Section 38(1)(b)]**

Data, Analytics and Insights | Health Workforce Strategy, Planning and Reform Unit | Directorate for Health Workforce

Room Ground Floor Rear | St. Andrews House | Edinburgh | EH1 3DG

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

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**From:** **[Redacted-Section 38(1)(b)]@gov.scot**>

**Sent:** 08 May 2025 12:22

**To:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;

**[Redacted-Section 38(1)(b)]@gov.scot**; **[Redacted-Section 38(1)(b)]**

**Cc:** **[Redacted-Section 38(1)(b)]**; **[Redacted-Section 38(1)(b)]@gov.scot**>

**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

Hi All. **[Redacted-Section 36(1)]**

AB

**[Redacted-Section 38(1)(b)]**

**From:** Deputy Director - Drugs Policy

**Sent:** 08 May 2025 12:17

**To:** **[Redacted-Section 38(1)(b)]; [Redacted-Section 38(1)(b)]** ; Deputy Director - Drugs Policy ; **[Redacted-Section 38(1)(b)]**

**Cc:** **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]**

**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

Thanks **[Redacted-Section 38(1)(b)]**. Appreciate the drive to get **[Redacted-Section 30(b)(ii)]** pack.

**[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(c)]**

**[Redacted-Section 38(1)(b)]** is back online tomorrow – **[Redacted-Section 30(c)]**

**[Redacted-Section 30(b)(ii)]**

Thanks

L

**From:** **[Redacted-Section 38(1)(b)]@gov.scot>**

**Sent:** 08 May 2025 11:10

**To:** **[Redacted-Section 38(1)(b)]@gov.scot>**; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]@gov.scot>**

**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot>**; **[Redacted-Section 38(1)(b)]@gov.scot>**

**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

**Importance:** High

Hi Laura

Can we please get a steer on next steps with this? The sub can't really wait, and if it is delayed any further it is going to have a knock on effect on being able to get the briefing ready in time. We are seriously being stretched in terms of resource, so delays are presenting problems in managing what little time we have.

If you could get back to me asap that would really be appreciated.

Many thanks

**[Redacted-Section 38(1)(b)]**

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 08 May 2025 08:48  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]<[Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

Hi [Redacted-Section 38(1)(b)]

The sub can't wait until Monday, that is what needs to go to CS asap, as it is about ensuring he is content with the approach for the evidence session (which is what the briefing is for)

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 08 May 2025 08:45  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

Thanks [Redacted-Section 38(1)(b)] if you could send me the briefing draft today sometime, I will have finished adding my thoughts to the sub tomorrow and then if you can put some time in the diary for us to meet late morning tomorrow, it will give us time to finalise any other drafting in the afternoon for Laura to review on Monday.

How does that sound?

Best

[Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 08 May 2025 08:06  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

Thanks [Redacted-Section 38(1)(b)], Laura

We need to get the sub on risks and position for the evidence session to CS asap as this will inform some of the answers in the briefing and the speaking note. Ideally I would like to get the sub up today, but legal have asked for a final review to ensure that nothing has been inadvertently changed during the review process, and I need to update the cross referencing.

I know you both have a lot going on, but if you could let me know when you are likely to have finished reviewing the sub then I can plan accordingly and work with legal to make sure they have capacity for a final review?

The plan would then be to review the briefing tomorrow based on the input from the commission, and share an initial draft by COP. **Laura** you have advised that you could review on Monday after 11:30 am, so **[Redacted-Section 38(1)(b)]**, if you are able to look it over before then that would be great?

The briefing will change, as CS may want to take a different view during the evidence session, and there will be changes as a result of the final stakeholder evidence session on 13<sup>th</sup> May (Tuesday).

I know the timings are really tight, but if you are both able to prioritise this as much as possible that would be great, as we are working with deadlines we don't have much control over. If this isn't possible can you let me know and we can figure something else out to ensure clearance?

Just also to highlight that **[Redacted-Section 38(1)(b)]** is on leave from the end of this week, so it will just be **[Redacted-Section 38(1)(b)]** and I wrangling this for the next few weeks.

Many thanks  
**[Redacted-Section 38(1)(b)]**

**From:** **[Redacted-Section 38(1)(b)]@gov.scot**>  
**Sent:** 08 May 2025 07:30  
**To:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; **[Redacted-Section 38(1)(b)]@gov.scot**>  
**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>  
**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

**[Redacted-Section 38(1)(b)]**, can you possibly send me the briefing pack a bit before you send it to Laura, (even if it's not in its final, Final form at that point.

Many thanks  
**[REDACTED-SECTION 38(1)(B)]**

**From:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Sent:** 07 May 2025 18:56  
**To:** **[Redacted-Section 38(1)(b)]@gov.scot**>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>  
**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

Thanks **[Redacted-Section 38(1)(b)]** – that is helpful.

I have meetings in on Monday through to 11.30 but if you can have the briefing to me for then I'll make it a priority to review in that gap.

For the 14<sup>th</sup>, it would be really helpful to be clear on what is different/new in the pack and therefore needs review.

Noting PO likely moving pre meet to 14<sup>th</sup>

I will look for time for us to prep in advance of CS – eg key issues to date, hot topics etc

Thanks

L

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 07 May 2025 11:07  
**To:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

Hi Laura,

I'll check in with PO and keep you updated.

We will have some very tight timelines next week and no real flexibility because as you know, we are following parliament.

Our timeline:

- We need you to have looked at the briefing by midday 12<sup>th</sup> May. This means we can spend the rest of the day actioning any changes you suggest.
- On 13<sup>th</sup> in morning, we have to listen and summarise an evidence session in parliament, and then add to and amend briefing accordingly.
- We expect between 14<sup>th</sup> and 15<sup>th</sup> to receive the committee's themes for CS, depending on which day we will add to drafted briefing or add as a supplement. We need to get a final review from you on 14<sup>th</sup> (there will not be much time for amends at this stage, hence why we are asking for a broader view from you Monday, when we will have time to action any changes you suggest), with Richard copied, before then sending to SpAds in advance of meeting our 14<sup>th</sup> deadline set by PO, with CS premeet on 16<sup>th</sup>.
- I can't provide an exact time on 14<sup>th</sup>, but as I said this should just be a much shorter, quick check – the bulk will be done on Monday. If the clerk sends through committee's question themes later, then we will be coming to you additionally, later, to sign off any supplementary briefing. We don't control timings for this.

Hope this is helpful,

[Redacted-Section 38(1)(b)]

Dr [Redacted-Section 38(1)(b)] she/her | Participation and Human Rights  
Integration Team | Drugs Policy Division | 07 [Redacted-Section 38(1)(b)]  
Scottish Government | 3 E St Andrews House | Regent Road | Edinburgh | EH1 3DG

**From:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>

**Sent:** 07 May 2025 10:23

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy  
<Deputydirectordrugspolicy@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>

**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

Hi [Redacted-Section 38(1)(b)],

Thanks for flagging – I will really struggle to make that time – could we check with  
PO if any possibility it could be moved – even the morning (9-12)?

Re briefing – thanks for flagging - when are you aiming to get that over/when for CS  
– and I'll hold time ([Redacted-Section 38(1)(b)] would you mind popping in a  
space?)f

Thanks

L

**From:** [Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** Wednesday, May 7, 2025 10:06 AM

**To:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>

**Subject:** Pre-meet with CS and clearance of HSCS committee briefing

Hi Laura,

Following up on my teams message yesterday morning. As I mentioned, CSPO have  
moved the pre-meet on the oral evidence session on 20th May on R2R to next Fri  
afternoon (16<sup>th</sup>). As you're official support I think it is important that you can be there,  
so I just wanted to flag this and confirm your attendance?

We will be sending you the briefing for CS evidence session on R2R at HSCSC on  
Monday 12<sup>th</sup> May. Flagging for you to set some time aside for this so we can get it to  
SpAds and up to PO in good time.

AB,

**Dr [Redacted-Section 38(1)(b)] she/her I Participation and Human Rights  
Integration Team I Drugs Policy Division I 07[Redacted-Section 38(1)(b)]  
Scottish Government I 3 E St Andrews House I Regent Road I Edinburgh I EH1 3DG**

---

**From: [Redacted-Section 38(1)(b)] On Behalf Of R2R Shadow Bill Team**

**Sent:** 08 May 2025 13:54

**To:** R2R Shadow Bill Team <R2RShadowBillTeam@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;  
[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;  
[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;  
[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; HWF  
Directorate Support Unit <HWFDirectorateSupportUnit@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;  
[Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-  
Section 30(c)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
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38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section  
38(1)(b)]@gov.scot>

**Subject:** RE: For input: Cabinet Secretary for HSC Briefing to Right to Recovery Bill evidence session - Deadline Thursday 8 May

All

With thanks to those who have contributed to the briefing, and a gentle reminder to those who not been able to, we would like all contributions by end of today to allow time to review.

If you don't think you will able to meet the deadline please get in touch.

Many thanks

**[Redacted-Section 38(1)(b)]**

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]

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**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 08 May 2025 15:53  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>; R2R Shadow Bill Team  
<R2RShadowBillTeam@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;  
[Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: For input: Cabinet Secretary for HSC Briefing to Right to Recovery Bill evidence session - Deadline Thursday 8 May

Thanks [Redacted-Section 38(1)(b)] we do have the question, but its easy to miss as short! What we don't have is the background info you've so helpfully provided, so we will add that now.

Thanks and happy weekend when it comes.

[Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)]  
**Sent:** 08 May 2025 15:26  
**To:** R2R Shadow Bill Team  
**Cc:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)];  
[Redacted-Section 38(1)(b)]  
**Subject:** RE: For input: Cabinet Secretary for HSC Briefing to Right to Recovery Bill evidence session - Deadline Thursday 8 May

Afternoon,

I have no comments on the drafted Q&A at annex E on the Drug & Alcohol Strategic Overview, but I [Redacted-Section 30(b)(i)] I'll leave you to consider where this might best sit but below is [Redacted-Section 30(b)(i)] as well as some suggested background.

[Redacted-Section 30(b)(ii)]  
[Redacted-Section 30(b)(ii)]  
*[Redacted-Section 30(b)(ii)]*

Background

[Redacted-Section 30(b)(ii)]  
[Redacted-Section 30(b)(ii)]  
[Redacted-Section 30(b)(ii)]  
[Redacted-Section 30(b)(ii)]

Thanks,

**[Redacted-Section 38(1)(b)]**

**[Redacted-Section 38(1)(b)]** | Parliament and Legislation Unit | Cabinet, Parliament and Governance Division | Directorate for Communications and Ministerial Support | Scottish Government | Mobile: 07**[Redacted-Section 38(1)(b)]** | Email: PLUBillProgramme@gov.scot

*I often work remotely. If you would like to speak to me, please contact me via Microsoft Teams.*

**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
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**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**

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**From:** **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]@gov.scot**>  
**Sent:** 08 May 2025 16:22  
**To:** **[Redacted-Section 38(1)(b)]@gov.scot**>  
**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>  
**Subject:** RE: **[Redacted-Section 38(1)(b)]** assigned you a task in "DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025"

Thanks very much **[Redacted-Section 38(1)(b)]**

Just spoken to **[Redacted-Section 30(c)]** and he's kindly offered to support us with briefing for social care for tomorrow – much appreciated!

AB

**[Redacted-Section 38(1)(b)]**

**From:** **[Redacted-Section 38(1)(b)]**  
**Sent:** 08 May 2025 14:01  
**To:** **[Redacted-Section 38(1)(b)]**  
**Cc:** **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]**  
**Subject:** RE: **[Redacted-Section 38(1)(b)]** assigned you a task in "DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025"

Hi Both,

Please see below, can you loop in with **[Redacted-Section 38(1)(b)]** (we have been missing each other!) to get a bit of background on the Bill and what is required from us? Keen to provide the most relevant and helpful lines but the deadline is close today, so a quick check in with **[Redacted-Section 38(1)(b)]** on background, intent and suggested implementation will be useful to shape our response before we can consider more fully.

**[Redacted-Section 38(1)(b)]** – a quick skim suggest this may be a link to GIRFE, if not already covered

Thanks

**[REDACTED-SECTION 38(1)(B)]**

**From:** **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]@gov.scot**>

**Sent:** 08 May 2025 11:47

**To:** **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]@gov.scot**>

**Subject:** **[Redacted-Section 38(1)(b)]** assigned you a task in "DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025"



**DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025.docx**



**[Redacted-Section 38(1)(b)]** assigned you a task  
**@**[Redacted-Section 38(1)(b)]** @**[Redacted-Section 38(1)(b)]****  
**@**[Redacted-Section 38(1)(b)]**** , could you please add any relevant additional lines to **[Redacted-Section 30(b)(ii)]** and how **[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(b)(ii)]**

Any relevant background **[Redacted-Section 30(b)(ii)]**

**8. There has been discussion so far on **[Redacted-Section 30(b)(ii)]****

[Go to comment](#)

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**From:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Sent:** 08 May 2025 19:08  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing

[Redacted-Section 38(1)(b)] – following up on this and teams – noting legal will give consideration tomorrow – my view is that the options paras (21-28) and sensitivities paras (35) would benefit from condensing. Noting concerns re timescales inc due to briefing for 20<sup>th</sup>, I'd welcome [Redacted-Section 38(1)(b)] views and input on sub tomorrow and content that this go on her and [Redacted-Section 30(c)] sign off rather than be held up by my NWD.

[Redacted-Section 30(b)(ii)]

Thanks

Laura

**From:** [Redacted-Section 38(1)(b)]  
**Sent:** 08 May 2025 12:29  
**To:** Deputy Director - Drugs Policy ; [Redacted-Section 38(1)(b)]; [Redacted-Section 38(1)(b)]  
**Cc:** [Redacted-Section 38(1)(b)]; [Redacted-Section 38(1)(b)]  
**Subject:** RE: Pre-meet with CS and clearance of HSCS committee briefing  
**Importance:** High

Thanks Laura

In my email on Friday with the updated version [Redacted-Section 30(b)(ii)]

Theoretically it might be possible to craft a more streamlined annex, but not with time/resource constraints that we have ([Redacted-Section 38(1)(b)] taking time back tomorrow as she worked holiday Monday, I have a workshop for the stigma design team most of tomorrow afternoon. The briefing is going to require significant work to bring it into shape and streamline it sufficiently).

The paragraph with the timings is currently para 28.

**[Redacted-Section 30(c)]**, and have availability to do this today. I also need to update the cross referencing which I can't do until people stop editing and changing the para numbering.

Thanks

**[Redacted-Section 38(1)(b)]**

**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
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**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**

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**From:** **[Redacted-Section 38(1)(b)]@gov.scot**>

**Sent:** 09 May 2025 07:44

**To:** **[Redacted-Section 38(1)(b)]@gov.scot**>; R2R Shadow Bill Team

<R2RShadowBillTeam@gov.scot>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>

**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>

**Subject:** RE: For input: Cabinet Secretary for HSC Briefing to Right to Recovery Bill evidence session - Deadline Thursday 8 May

Thanks **[Redacted-Section 38(1)(b)]**

**From:** **[Redacted-Section 38(1)(b)]**

**Sent:** 09 May 2025 07:10

**To:** R2R Shadow Bill Team ; **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]**

**Cc:** **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]**

**Subject:** RE: For input: Cabinet Secretary for HSC Briefing to Right to Recovery Bill evidence session - Deadline Thursday 8 May

Good morning colleagues,

With my apologies for the delay, please find attached a brief on the Mental Health Workforce, Action Plan, Nursing Review, Psychiatry Working Group, MH and Primary Care with some background MH workforce stats and MH Strategy lines that might be helpful.

Please do get in touch if you have any questions or would like further information.

Many thanks,

**[Redacted-Section 38(1)(b)]**

**[Redacted-Section 38(1)(b)]**

**Team Leader | Mental Health Workforce | Mental Health and Wellbeing  
Directorate | Scottish Government**

**[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]**

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**From: [Redacted-Section 38(1)(b)]@gov.scot>**

**Sent:** 09 May 2025 11:55

**To: [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;  
[Redacted-Section 38(1)(b)]@gov.scot>**

**Cc: [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>**

**Subject: RE: [Redacted-Section 38(1)(b)] assigned you a task in "DRAFT - Right to  
Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social  
Care's evidence session on 20th May - 25th April 2025"**

Thanks **[Redacted-Section 38(1)(b)]**

**From: [Redacted-Section 38(1)(b)]**

**Sent:** 09 May 2025 11:48

**To: [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]**

**Cc: [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section  
38(1)(b)]**

**Subject: FW: [Redacted-Section 38(1)(b)] assigned you a task in "DRAFT - Right to  
Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social  
Care's evidence session on 20th May - 25th April 2025"**

Hi All,

I have copied in **[Redacted-Section 38(1)(b)]**, Professional Advisor for Social Work for his comments on this – I have given a 30 second brief update on this and we spoke

about some of the challenges in implementation from a SW / SC perspective, although appreciate there will be more nuance than I have been able to offer!

Thanks

**[REDACTED-SECTION 38(1)(B)]**

**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
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**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**

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**From**[Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 09 May 2025 12:26

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: [Redacted-Section 38(1)(b)] shared "DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025" with you

Excellent, thanks **[Redacted-Section 38(1)(b)]**

**From:** [Redacted-Section 38(1)(b)]

**Sent:** 09 May 2025 12:26

**To:** [Redacted-Section 38(1)(b)]; [Redacted-Section 38(1)(b)]

**Subject:** FW: [Redacted-Section 38(1)(b)] shared "DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025" with you

Hi,

Forwarding to you in light of **[Redacted-Section 38(1)(b)]** out of office message.

**[Redacted-Section 38(1)(b)] | Improvement Collaborative Senior Policy Manager  
Getting It Right For Everyone - GIRFE**

Scottish Government|St Andrew's House|3WR|Regent Road|Edinburgh|EH1 3DG|Email:

**[Redacted-Section 38(1)(b)]@gov.scot | Visit: [www.gov.scot/girfe](http://www.gov.scot/girfe)**

**From:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 09 May 2025 11:15  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: [Redacted-Section 38(1)(b)] shared "DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025" with you

Good Morning, [Redacted-Section 38(1)(b)],

Thank you for sharing your briefing with me. I was not clear where you would want me to insert any lines on GIRFE, so I am sending you our contribution by email so that it is not lost and you can drop it in where you feel appropriate. I have kept this pretty short as your brief is huge.

Below the six bullet points is a case study example which you may wish to put into one of your annexes. It illustrates the success of the approach.

Please do come back to me if there is anything more I can do for you. I will be here all day! 😊

### **GIRFE Lines**

- Getting It Right For Everyone (GIRFE) is the practice model shaping how public services in Scotland are designed and delivered.
- Health Boards are required to set out how they will embed the GIRFE principles and Toolkit in NHS Annual Delivery Plans (2025 – 2026) for the organisation and delivery of their services.
- The GIRFE approach was created by people who use health and social care services along with the workers who support them. This helps health and social care services to work better together for each person, ensuring they get the right, individualised support.
- The model brings the person, their families, carers and all the people providing services together to create a joined-up care and support plan. This plan looks at all their needs across different services to make sure they get the best possible results.
- A Toolkit has been prepared for professionals to help them use this approach in their everyday work.
- The GIRFE approach has been tested and developed in local and specialist areas to understand how it can be used in different situations – this includes addiction services where the results were positive. Please see the case study .....

## **Case Study – People in alcohol and drug services**

### **Situation**

- Young male, Simon, sustained head injury in 2020 and fractured spine resulting in paraplegia.
- History of drug and alcohol dependency, self-harm with 15 admissions /attendances to hospital for self-harm / seizures recorded within a 12 month period. Discharged from hospital following treatment for ungradable pressure ulcers, bone infection and severe anemia.

### **Risk**

- On discharge – he had no tenancy, clothes, furniture, no access to funds, and no referrals were made to relevant community disciplines.
- Social isolation, lack of social and community networks.
- Risk was heightened in both his social care and health needs. Re-admission the following week- similar discharge.

### **Action using the GIRFE approach**

#### **Team around the person**

- The team involved Simon in conversations.
- ‘Team Around The Person’ meetings arranged to share information and develop a clear understanding of how to support Simon’s wellbeing.
- Collective decision making at meeting with Simon.

#### **My team**

- Set up weekly locality meeting co-chaired and facilitated by a clinical nurse manager and principal social worker. Meeting included social work, intermediate care team, Community nursing, Allied Health Professionals, hospice, housing services, enablement, care at home, Mental health Addictions team, General Practice input and Simon.
- Shared accountability and decision-making regarding risk and safeguarding.

#### **Co-ordinator**

- Appointed and responsible for ensuring a care plan was in place and involved within his plan of care.

#### **My plan**

- The plan was used to support the development of a collaborative approach for Simon, taking into consideration what matters to him.

#### **Community hub**

- Engaged Simon with the local community hub for information and advice. Provided with access to wider services and support.

#### **Outcome**

- Simon trusted that his choices would be respected as he was listened to, understood and involved in the decision-making process.

- A 'whole life' approach was applied when making decisions about his health and social care.
- Support was put in place to assist with personal care and daily living.
- Community nursing now attend twice daily for clinical and holistic assessment and support with wound and continence management.
- Social work team input collaborating with housing, providing financial assistance, assessment of risk and support to ensure safety and well being
- Simon is no longer confined to his home and can access local amenities independently. He is in contact with his family and enjoys interacting with them.
- He engages with health and social care professionals and his plan of care works around his schedule for his addiction programme.
- Simon commented: "I have got my life back and never felt so safe"

**[Redacted-Section 38(1)(b)] | Improvement Collaborative Senior Policy Manager  
Getting It Right For Everyone - GIRFE**

Scottish Government|St Andrew's House|3WR|Regent Road|Edinburgh|EH1 3DG|Email:  
**[Redacted-Section 38(1)(b)]@gov.scot | Visit: [www.gov.scot/girfe](http://www.gov.scot/girfe)**

**From:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 08 May 2025 15:43

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** [Redacted-Section 38(1)(b)] shared "DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025" with you



**[Redacted-Section 38(1)(b)] invited you to edit a file**

Hi Colleagues,

Copying you in to our briefing for HSCSC with CSHC - I have discussed our ask with [Redacted-Section 38(1)(b)] who has said you'll be able to support with lines for COP Fri 9th.

Thank you,

**[Redacted-Section 38(1)(b)]**



DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025



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**From:** [Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 09 May 2025 17:11

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; Jennie Gollan <Jennie.Gollan@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: Invitation to give evidence to Health, Social Care and Sport Committee - 20th May

Thanks [Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)] On Behalf Of Cabinet Secretary for Health & Social Care 2024

**Sent:** 09 May 2025 16:32

**To:** [Redacted-Section 38(1)(b)] ; Cabinet Secretary for Health & Social Care 2024

**Cc:** Deputy Director - Drugs Policy ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; Jennie Gollan ; [Redacted-Section 38(1)(b)]

**Subject:** RE: Invitation to give evidence to Health, Social Care and Sport Committee - 20th May

Hi [Redacted-Section 38(1)(b)]

Just to flag that Mr Gray is unable to attend Committee on 20 May – I have sent an email this afternoon to let them know and asked if they can provide an alternative date which we will prioritise in the diary. I'll keep you updated.

**[Redacted-Section 38(1)(b)]**

Deputy Private Secretary to the Cabinet Secretary for Health and Social Care – Neil Gray MSP

Scottish Government | St Andrew's House, Regent Road, Edinburgh EH1 3DG | Mob: 07[Redacted-Section 38(1)(b)] | Email: CabSecHSC@gov.scot

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**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**

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**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 12 May 2025 08:03  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Subject:** RE: Committee Briefing

Thanks [Redacted-Section 38(1)(b)], I have it and will have sent it to Laura by this afternoon.

Best

**[Redacted-Section 38(1)(b)]**

**From:** [Redacted-Section 38(1)(b)]  
**Sent:** 12 May 2025 08:02  
**To:** [Redacted-Section 38(1)(b)]  
**Cc:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; Deputy Director - Drugs Policy  
**Subject:** RE: Committee Briefing

Hi [Redacted-Section 38(1)(b)],

Could you confirm you've picked this up and will be sending to Laura this afternoon?  
Also could you please keep me copied in?

AB

**[Redacted-Section 38(1)(b)]**


**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 09 May 2025 17:22  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** Committee Briefing

Hi [Redacted-Section 38(1)(b)]

As we don't have the new date for the CS evidence session I am proceeding as if it is still happening on 20 May, in case another Minister is asked to attend in CS place.

Attached is the current draft of the briefing. There are a couple of things to note:

- The format was provided by PO and is CS preferred format.
- **[Redacted-Section 30(b)(ii)]**
- **[Redacted-Section 30(b)(ii)]**
- Some of the info has been put in by PLU and needs to be kept as it relates to Parliamentary process **[Redacted-Section 30(b)(ii)]** about that
- It is based on evidence sessions so far, the final stakeholder session is Tuesday 13 May, so there will be changes made as a result of that
- The questions are based on what committee members have asked so far and they are likely to remain on theme

 **DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025.docx**

Current dates:

- Monday 12 May am – **[Redacted-Section 38(1)(b)]** to review
- Monday 12 May pm – Laura to review
- Tuesday 13 May – **[Redacted-Section 30(c)]** and **[Redacted-Section 30(b)(ii)]** to review
- Tuesday 13 May pm and Wed 14 May am – **[Redacted-Section 38(1)(b)]** and **[Redacted-Section 38(1)(b)]** to update in response to review feedback and amend as required from evidence session on 13 May
- Wed 14 May pm – Laura, **[Redacted-Section 30(c)]** and **[Redacted-Section 30(b)(ii)]** to review highlighted portions as these are amendments yet to be signed off
- Wed 14 May COP – Briefing to PO

For sanity and stress levels, until we have confirmation that there is a new date can the timings/dates please be adhered to (unless the world ends).

Any questions please give me a shout.

Thanks

**[Redacted-Section 38(1)(b)]**

**[Redacted-Section 38(1)(b)] | Drugs Policy | Health & Social Care Directorate | Scottish Government**

Email **[Redacted-Section 38(1)(b)]@gov.scot**

Pronouns she/her



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**From:** **[Redacted-Section 38(1)(b)]@gov.scot**>

**Sent:** 12 May 2025 10:25

**To:** **[Redacted-Section 38(1)(b)]@gov.scot**>

**Cc:** **[Redacted-Section 38(1)(b)]@gov.scot**>

**Subject:** RE: Routine Submission: Right to Recovery Bill Committee Evidence Sessions and proposed approach

So sorry **[Redacted-Section 38(1)(b)]** – released now. It should only take a minute, and then can you let PO know that it's been slightly updated. Many thanks

**[REDACTED-SECTION 38(1)(B)]**

**From:** **[Redacted-Section 38(1)(b)]**

**Sent:** 12 May 2025 10:18

**To:** **[Redacted-Section 38(1)(b)]**

**Cc:** **[Redacted-Section 38(1)(b)]**

**Subject:** RE: Routine Submission: Right to Recovery Bill Committee Evidence Sessions and proposed approach

Hi **[Redacted-Section 38(1)(b)]**,

You have the document locked and so I can't edit it. Could you please release it so I can complete your request?

AB

**[Redacted-Section 38(1)(b)]**

**From:** **[Redacted-Section 38(1)(b)]@gov.scot**>

**Sent:** 12 May 2025 10:01

**To:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Routine Submission: Right to Recovery Bill Committee Evidence Sessions and proposed approach

Hi [Redacted-Section 38(1)(b)],

I'll have a look on the erdm link [Redacted-Section 38(1)(b)] has provided and see if I can find the changes you're referring to.

AB  
[Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 12 May 2025 09:34  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Routine Submission: Right to Recovery Bill Committee Evidence Sessions and proposed approach

I cannot now open the document. If you can, and are able to edit, can you please do so. The changes are minor and obvious – annex numbering and para numbers, but careless. Otherwise, I guess it will have gone to Cab Sec in it's current form.

Thanks

[REDACTED-SECTION 38(1)(B)]

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 12 May 2025 08:44  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Routine Submission: Right to Recovery Bill Committee Evidence Sessions and proposed approach

Hi [Redacted-Section 38(1)(b)],

There are no tracked changes in this document for me to view cross reference into erdm. If you go into the erdm file you will be able to make any changes directly.

AB

[Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 12 May 2025 08:06  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** FW: Routine Submission: Right to Recovery Bill Committee Evidence Sessions and proposed approach



Drug and Alcohol policy - Ministerial - Right to Recovery Bill - Submission on  
Committee Evidence and Approach - May 2025 details - Objective

**[Redacted-Section 38(1)(b)] | Drugs Policy | Health & Social Care Directorate |  
Scottish Government**

Email: **[Redacted-Section 38(1)(b)]@gov.scot**  
Pronouns she/her



**From:** [Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 12 May 2025 10:49

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Director of Population Health <Directorofpopulationhealth@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]>; [Redacted-Section 38(1)(b)]>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: Routine Submission: Right to Recovery Bill Committee Evidence Sessions and proposed approachf

Dear Cabinet Secretary/PO,

We noted minor formatting mistakes in the previous submission, which now have been corrected in the erdm version below and attached.

AB,

**Dr [Redacted-Section 38(1)(b)] she/her | Participation and Human Rights Integration Team | Drugs Policy Division | 07[Redacted-Section 38(1)(b)] Scottish Government | 3 E St Andrews House | Regent Road | Edinburgh | EH1 3DG**

[Redacted-out of scope information]

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[Redacted-out of scope information]

## OFFICIAL SENSITIVE

Drug Policy Division, Population Health

9 May 2025

**Cabinet Secretary for Health and Social Care**

### **Priority and Purpose**

1. **ROUTINE:** To provide an update on the progress of Stage 1 of the Right to Addiction Recovery (Scotland) Bill and to
  - i. seek agreement on your approach to the Scottish Government oral evidence session on 20th May with the Health, Social Care and Sport Committee, and;
  - ii. **[Redacted-Section 30(b)(i)]**,

### **Recommendation**

2. **[Redacted-Section 30(b)(i)]**
  - i. **[Redacted-Section 30(b)(i)]**
  - ii. **[Redacted-Section 30(b)(i)]**
  - iii. **[Redacted-Section 30(b)(i)]**
3. **[Redacted-Section 30(b)(i)]**.

### **Context and Issues**

4. Douglas Ross introduced the Right to Addiction Recovery Bill on 14th May 2024. The Health, Social Care and Sport Committee was assigned as lead committee in October 2024, and since then the Committee has progressed its work in assessing the Bill proposals.
5. The memorandum submitted to the lead committee setting out the government position on the Bill was neutral, but highlighted concerns; including how the proposed rights would be enforced; flawed methodology of the financial memorandum in identifying financial implications; and its dissonance with current evidence on best practice.
6. For you to assess the options presented, policy, legal and financial implications are summarised below and set out in more detail in Annex C and D. Summaries of HSCSC evidence sessions is at Annex B.

### **Policy considerations/concerns**

7. **[Redacted-Section 30(b)(ii)]** Evidence has so far been heard from services and professional organisations, such as COSLA, RCGP, RCP and ADPs. **[Redacted-Section 30(b)(i)]** was generally expressed in how much value the **[Redacted-Section 30(b)(i)]** of putting the Bill into law.
  - i. **The intended outcomes of the Bill [Redacted-Section 30(b)(i)] on Drugs.** The Bill **[Redacted-Section 30(b)(i)]** to ensure recovery. The MAT standards **[Redacted-Section 30(b)(i)]** commit to high quality, accessible treatment

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**[Redacted-Section 30(b)(i)]** residential rehabilitation our commitment to 1000 available beds is on track.

- ii. **The Bill may in fact exacerbate existing challenges faced by people who use drugs, such as exclusion and stigma.** By insisting that a person needs a medical diagnosis to confirm their “addiction” and focussing heavily on narrow definitions of recovery, the Bill removes agency from the individual and significantly limits their choices in terms of how and when they may embark on their recovery journey. This is in direct opposition to both the evidence base and the values of the Mission on Drugs which promotes a person centred, trauma informed approach, and risks driving people further from services and support. In addition the Bill confers greater legal protection for substance use treatment than for other health conditions which may provoke challenges both legal and political. The need to comply with statutory duties in the bill may result in the reprioritisation and diversion away from other services.

8. Additional policy analysis is at Annex C.

### Legal considerations

**[Redacted-Section 36(1)]**  
**[Redacted-Section 36(1)]**  
**[Redacted-Section 36(1)]**  
**[Redacted-Section 36(1)]**  
**[Redacted-Section 36(1)]**  
**[Redacted-Section 36(1)].**

### Financial considerations

13. Evidence on the financial consideration of the Bill have so far taken the form of a session with the member in charge, Douglas Ross (DR), with FPAC on 11<sup>th</sup> March, and the publication in February of the written responses to FPAC in response to their call. Respondents were a number of ADPs/HSCPs, COSLA, SHAAP, Alcohol Focus Scotland (AFS), Scottish Ambulance Service. A summary of this is at Annex F.
14. FPAC requested an updated financial memorandum from the member in charge. Douglas Ross sent this letter on 29<sup>th</sup> April, however his response did not provide new financial evidence or modelling. A report will be submitted to HSCSC, However, it is unlikely that this will be before your evidence session on 20 May.
15. FPAC written stakeholder responses noted a range of issues including concerns included that costs, savings, and implications had not been accurately described; that the margins of uncertainty of cost/timescales were not accurate; and that as the delivery bodies who would be most likely affected by the Bill, they could not meet the costs of the Bill. There was however high-level agreement on the value of investment into the drug and alcohol sector.
16. Key financial risks identified by officials are:

## OFFICIAL SENSITIVE

- i. There is no methodology using the currently available data which could accurately identify the potential costs of the Bill, which presents a risk in enacting legislation with no limitations on potential cost. This could effectively amount to a blank cheque, which is enshrined in law.
- ii. Health budgets are finite, and resources must be managed across all services. The imposition of statutory obligations to provide treatment in this area within a specific timescale would result in a diversion of finite resources from other sectors within health and social care because of the need to comply with the law, this prioritising the rights of one group over others.
- iii. The challenges in identifying the unmet need of a largely hidden population indicate that it is unlikely to be any effective or accurate way to estimate the additional investment required to meet the legislative requirements within the Bill.
- iv. Underestimation of capital investment required to meet the statutory obligations of the Bill, for example, the creation of new and/or bespoke facilities and overall additional bed capacity.
- v. Additional staffing and training costs are not fully considered.
- vi. Total cost of care for individuals are not known as treatment and support pathways are tailored to the individual and individuals often require ongoing and repeated treatment interventions.
- vii. Increase in the cost of treatment within the private sector should demand outstrip supply and cost is explicitly stated as not being a valid reason to make a determination on treatment.
- viii. Potential for additional legal costs for legal challenges to claim rights within the Bill.

17. Additional financial analysis is at Annex E.

### Options Considered and Advice

[Redacted-Section 30(b)(i)]

[Redacted-Section 30(b)(i)]

[Redacted-Section 30(b)(i)]

18. The deadline for the end of Stage 1 is 10 October 2025 and this does not allow a great deal of time for the Bill to complete Stages 2 and 3 before the anticipated dissolution in Spring 2026. It is possible for the Bill to complete stages 2 and 3 if the financial resolution is lodged shortly after completion of stage one, but it will be challenging to meet the timescales.

### fAssessment of options

[Redacted-Section 30(b)(i)]

[Redacted-Section 30(b)(i)]

[Redacted-Section 30(b)(i)]

**Contribution to the Government’s Four Priorities**

- 21. The intention of this Bill is to contribute to improving public services by ensuring that people affected by substances use are able to access a broad range of treatment and support services that best suit their needs.
- 22. There are evidenced links between poverty and the harms experienced by people affected by substance use, the ongoing work of the National Mission, including the focus on a Whole Family Approach will support the priority to end child poverty.

**Verity House Agreement Implications**

- 23. [Redacted-Section 30(c)] with the Bill.
- 24. The Bill focuses on the provision of specific alcohol and drugs services, which are generally commissioned from providers other than local authorities. However, individuals’ engagement with such services often prompts a consequent demand for supportive wrap-around care that is provided by local authority social services. Whilst the Bill does not specifically cite it, if passed, local authorities may come under pressure to consider and revise their current service provision.

**New Deal for Business Implications**

- 25. N/A

**Financial Considerations**

- 26. See paras 13 – 17 and Annex E.

**Sensitivities**

- [Redacted-Section 30(b)(i)]
- [Redacted-Section 30(b)(i)]
- [Redacted-Section 30(b)(i)]
- [Redacted-Section 30(b)(i)]
- [Redacted-Section 30(b)(i)]
- [Redacted-Section 30(b)(i)]

**Quality Assurance**

- 27. This submission has been reviewed by Laura Zeballos, Deputy Director Drugs Policy

**Conclusion and next steps**

- 28. Officials recommend [Redacted-Section 30(b)(i)].
- 29. Officials will provide a briefing and support for the committee evidence session, and will continue to provide updates on the lead committee evidence sessions and further advice will be provided should additional risks be identified or evidence provided which suggests previously identified risks are mitigated.

[REDACTED-SECTION 38(1)(B)]

**OFFICIAL SENSITIVE**

DRUG POLICY, POPULATION HEALTH

<b>Cabinet Secretaries and Ministers Copy List</b>	<b>For Action</b>	<b>For Information Portfolio interest</b>	<b>For Information Constituency interest</b>	<b>For Information General awareness</b>
Cabinet Secretary for Health and Social Care	X			
Minister for Public Health and Women's Health		X		
Minister for Social Care, Wellbeing and Alcohol Policy		X		

<b>Officials Copy List</b>
Richard Fogo, Director Population Health Laura Zeballos, Deputy Director Drugs Policy Jennie Gollan, Special Advisor [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)] [Redacted-Section 30(c)] [Redacted-Section 30(c)] [Redacted-Section 30(c)] [Redacted-Section 30(c)] [Redacted-Section 30(c)]

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**ANNEX A**

**Timeline and summary of Bill progress to date**

14 May 2024	Right to Addiction Recover (Scotland) Bill introduce by Douglas Ross MSP	
May 2024	Initial government response stated wished to hear views of stakeholders before taking a view on the Bill	
September 2024	Meeting with CS HSC, FM and Douglas Ross	
October 2024	Health, Social Care and Sport Committee assigned as lead committee for the Bill	
20 December 2024	Deadline for lead committee and Finance and Public Administration Committee written evidence (including submission of Government Memorandum)	
January 2025	Written response to the call for views published	Submission containing analysis of evidence sent 13 February 2025
25 February 2025	A briefing from the Scottish Parliament Information Centre was published	<a href="#">Right to Addiction Recovery (Scotland) Bill   Scottish Parliament.</a>
18 February 2025	Informal session held by HSCSC with individuals with lived and living experience of substance use	<a href="#">Notes from informal session on 18022025</a>
11 March 2025	FPAC oral evidence session with Douglas Ross MSP on financial memorandum.	Summary of session at annex F

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	FPAC requested further information from Douglas Ross	
18 March 2025	Oral evidence session with professional organisations	
25 March 2025	Oral evidence session with statutory services	

**HSCSC evidence session attendees**

Policy analysis of the evidence given and based on officials assessment of current landscape is given in Annex C. The following table shows how the views of the stakeholders who have given evidence so far broadly align with the key themes covered in the analysis.

<p>Scottish Human Rights Commission</p>	<p>Support intentions of the Bill</p> <p>Provisions of the bill support state compliance with human rights, particularly Article 2 ECHR (right to life) and international human rights obligations, such as Article 12 ICESCR (right to the highest attainable standard of health)</p> <p>Charter of Rights is a way to support people</p> <p>Accountability needs strengthened</p>
<p>Public Health Scotland</p>	<p>Support intentions of the Bill</p> <p>Would not add to what is already happening</p> <p>Narrow treatment options</p> <p>How will it align with MAT Standards – there are areas of tension</p> <p>Treatment is not a single intervention/recovery is not linear</p> <p>Resource is not available</p> <p>Focus on compliance over supporting people</p> <p>Risk to other services due to need to meet legislative requirements</p> <p>Workforce pressure</p>
<p>Law Society of Scotland</p>	<p>Narrow treatment options</p> <p>Resource is not available</p> <p>Need for diagnosis is exclusionary</p> <p>Risk to other services due to need to meet legislative requirements</p> <p>Duty in the bill to discuss treatment options with patient runs counter to decision of UKSC and current practice</p> <p>Accountability and enforcement not clear</p>
<p>Former Chair, Royal College of Psychiatrists in Scotland</p>	<p>Need for diagnosis is exclusionary</p> <p>People need support who may not fit criteria for diagnosis</p> <p>Narrow treatment options</p> <p>Treatment is not a single intervention/recovery is not linear</p>

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	<p>Risk to other services due to need to meet legislative requirements</p> <p>Workforce pressure</p>
Social Work Scotland	<p>Would not add to what is already happening</p> <p>Ignore current multi-disciplinary approach</p> <p>Medicalised</p> <p>Workforce pressures</p> <p>Current frameworks (Charter of Rights, MAT Standards) are broader</p> <p>Third sector are equal partners – this isn't recognised in the Bill</p>
Royal College of General Practitioners in Scotland	<p>Does not align with current practice</p> <p>Danger in unrealistic expectations</p> <p>Workforce pressures</p> <p>Current frameworks (Charter of Rights, MAT Standards) are broader</p>
COSLA	<p>Support intentions of Bill</p> <p>Narrow treatment options</p> <p>Medicalised approach</p> <p>Need for diagnosis is exclusionary</p> <p>How will it align with MAT Standards</p> <p>Risk to other services due to need to meet legislative requirements</p> <p>Ignore current multi-disciplinary approach</p> <p>Workforce pressure</p>
Addiction Services NHS Fife	<p>Would not add to what is already happening</p> <p>Need for diagnosis is exclusionary</p> <p>People need support who may not fit criteria for diagnosis</p> <p>Ignore current multi-disciplinary approach</p>
Public Health NHS Lothian	<p>Rights should be universal</p> <p>Need for diagnosis is exclusionary</p> <p>People need support who may not fit criteria for diagnosis</p> <p>Medicalised approach</p> <p>Should focus on early interventions</p>
Aberdeenshire Health and Social Care Partnership	<p>Ignores current multi-disciplinary approach</p> <p>Narrow treatment options</p> <p>Need for diagnosis is exclusionary</p>

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	<p>Should focus on early intervention</p> <p>Workforce pressure</p>
Dundee Alcohol and Drug Partnership	<p>Support intentions of Bill</p> <p>Does not align with current practice</p> <p>Narrow treatment options</p> <p>Would not add to what is already happening</p> <p>Current frameworks (Charter of Rights, MAT Standards) are broader</p> <p>People need support who may not fit criteria for diagnosis</p>
Glasgow Alcohol and Drug Partnership	<p>Support intention of Bill</p> <p>Treatment options narrow</p> <p>Need for diagnosis is exclusionary</p> <p>Treatment is not a single intervention/recovery is not linear</p> <p>How will it align with MAT Standards</p> <p>Risk to other services due to need to meet legislative requirements</p>
East Ayrshire Alcohol and Drug Partnership	<p>Support intentions of Bill</p> <p>Current frameworks (Charter of Rights, MAT Standards) are broader</p> <p>Workforce pressure</p> <p>How will it align with MAT Standards</p> <p>Treatment is not a single intervention/recovery is not linear</p>
Informal engagement with people with lived experience	<p>Potential to empower individuals and ensure they receive necessary care</p> <p>Support should also address immediate needs beyond substance use</p> <p>Harm reduction is essential and more effective for some than abstinence</p> <p>Family members are crucial to the recovery process</p> <p>Community and peer support are essential</p> <p>Third sector and lived experience organisations should be equal partners</p> <p>Investing in treatment and recovery will save money in the long term</p> <p>How does the Bill align with MAT Standards</p> <p>Bill is vague about the types of treatment included</p> <p>Diagnosis can be exclusionary and stigmatising</p> <p>Services do not have the capacity to deliver</p>

**Policy Analysis**

**[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 36(1)]**

**[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(b)(i)]**

**[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(b)(ii)]**

**Legal Analysis**

[Redacted-Section 36(1)]

[Redacted-Section 36(1)]

[Redacted-Section 36(1)]

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[Redacted-Section 36(1)]

## Financial Analysis

1. Paras ? below provides further analysis of the challenges of identifying unmet need and assessing the potential financial requirements of the Bill. The costs of the Bill are difficult to confidently project, which some written respondents also commented on. Part of this relates to the difficulty in understanding the number of additional people who would come forward for 'treatment' because of the Bill as well as the actual cost of wrap around care which would go beyond a single treatment intervention. This is stated in the Financial Memorandum of the Bill itself, at Paragraph 52:

*...it is exceptionally challenging to put a precise figure on the number of people in Scotland who currently are addicted to drugs and/or alcohol but who are as yet undiagnosed or seeking any form of treatment. It is therefore also not possible to anticipate the extent to which this cohort would seek diagnosis and referral for treatment on the basis of the implementation of this Bill, including as a result of being encouraged to do so through any associated public awareness campaigns.*

2. Due to this challenge, the financial memorandum has put forward a single, wholly alternative calculation which attempts to set out what the costs would be if treatment completion rates were to increase from 69% to either 89.3% (high estimate) or 85.4% (low estimate). This is based on stopping between 50% and 66% of early discharges. The assumption is that the Bill allows more people to get the right treatment, and this would result in less early discharge and more completed treatments. This percentage has then been applied to the total annual Drug and Alcohol budget (DAB) of £160 million; with a low additional cost estimate of £28.5 million and a high estimate of £38 million.
3. In the oral evidence session with the Finance and Public Administration Committee, Douglas Ross MSP acknowledged the challenges around estimating the costs of the Bill as a result of limited data and that the cost included in the FM is at the lower end of expectations. DR also and proposed that implementation of the Bill would lead to better data. He also stated that it would be down to SG to find savings to fund the Bill.
4. The methodology of the calculation is flawed, which was highlighted by some written respondents and also discussed during DR's oral evidence session. This was also indicated in paper CSCLcorres(24)81 supporting more people with treatment cuts across broader budgets than calculated;
  - i. the Drug and Alcohol budget covers more than treatment as defined in the bill;
  - ii. the bill wants more people to access treatment, not just more completed treatments;
  - iii. treatment would be 'prescribed' in a different way in the bill thus the costs would differ,
  - iv. the financial memorandum does not consider the whole spectrum of practical cost implications of the Bill, that would then have a significant impact on Scottish budgets.
5. In relation to demand, there are a number of different ways to calculate this: for example, a loose, caveated calculation of £400 million revenue costs results from an

## OFFICIAL SENSITIVE

illustrative scenario where all people in Scotland currently suffering from a drug and/or alcohol dependency and who had an interest in residential rehabilitation were provided a placement. While this specific case is not a likely scenario, it aims to illustrate that there is an extremely broad range of cost implications related to how access for their 'right to recovery' – highly variable in terms of 'treatment' type and costs, also in terms of duration and frequency. Indeed, stakeholders have stated in evidence sessions that often significant long-term support is required, rather than a singular 'treatment' or intervention, as implicitly purported in the Bill.

6. In relation to the unknown spectrum of cost implications of the Bill, the potential expanding capital costs required to deliver the statutory obligations in the Bill are a good example to highlight. The projected capital expenditure required to upscale service provision has not been adequately considered in the Bill, and is thus a key omission, which was also highlighted during FPAC evidence session. Scottish Government committed £18 million over five years toward new rehabilitation facilities, aiming to increase capacity by 50%, reaching 650 beds by 2026. However, under the illustrative scenario above, the number of beds, and corresponding capital investment, would be an order of magnitude higher. This could also result in short term market distortions, and further additional costs; for example there is currently more private than state residential rehab provision – the statutory obligation to meet treatment provision could result in increasing demand while public capacity is built, with the result in increase in market prices for RR provision. This was also highlighted as a potential unintended consequence by a stakeholder in their response to FPAC's evidence call.
7. Ensuring adequate capacity to meet statutory obligations would also exert additional financial pressures. Because of the absolute statutory nature of a right to treatment within 3 weeks over-capacity would need to be created and maintained. Financial investment would be needed to achieve the increase in the legally required provision in time for the bill coming into force; e.g. in staffing in staffing, training and pivoting to a new approach, highlighted also by experts attending HSCSC. A further concern cited by stakeholder respondents to FPAC's evidence call, and by experts speaking at HSCSC, was the worry that inability to meet statutory obligations (for example, because of resourcing issues) may result in increased litigation, which would also need to be budgeted for.
8. For (only) people affected by substance use, the Bill would remove the ability for health boards to give consideration to overall cost of treatments and capacity of the sector when deciding overall provision within its budget. The cost of allocating the substantial resources to meet this right – relative to the provision of other public services - would not form part of any considerations. In contrast to services with capped budgets or clearly defined eligibility criteria the proposed Bill creates an open-ended commitment based on individual need within one sector of the population only. The overall ability to strategically allocate resources based on evidence, need and system-wide priorities could be significantly restricted. This is reflected in section 3(2)(a) of the Bill, which states that treatment may not be refused on the basis of cost. The potential for the diversion of resources to fund the required capacity to deliver on the proposed Bill was a key concern highlighted by stakeholder respondents to FPAC's evidence call; the FPAC committee itself in its questioning to Douglas Ross; and highlighted in the HSCSC sessions.

## **Challenges in assessing the financial and economic costs and benefits of the proposed Right to Addiction Recovery Bill**

### **Demand-led nature of proposals and uncertainty**

9. Removing cost and capacity considerations from decision-making introduces significant uncertainty, amplifying financial risks due to unpredictable increases in demand.
10. The impact of establishing a legal right to treatment on service demand is highly uncertain. The demand-led nature of these proposals makes it challenging to provide a robust assessment of cost implications.
11. Restrictions on considering cost or capacity in determining treatment amplify potential financial risks and uncertainties. Unlike services with capped budgets or clearly defined eligibility criteria the proposed Bill creates an open-ended commitment based on individual need.
12. Estimating the scale of current latent demand (i.e. unmet need) is complex, relying on survey data and epidemiological modelling, both of which carry inherent margins of error. The extent to which the legal right would convert latent demand into active service demand is a significant unknown variable.
13. There is also substantial potential for induced demand, where the existence of the right itself encourages more individuals, previously hesitant or unaware of options, to seek treatment.
14. Taking residential rehabilitation as an example, Public Health Scotland (PHS) highlights that fewer than 2% of individuals with substance use issues would currently be able to access residential rehabilitation annually, based on the target of providing publicly funded placements to 1,000 individuals each year.
15. The true scale of demand is likely to be significantly higher. An illustrative estimate of potential demand could be around 30% of those with drug and/or alcohol dependencies—approximately 30,000 individuals. This figure can be constructed based on surveys, which indicate substantial interest:
16. 43% of respondents expressed interest in residential rehabilitation, with 14% actively considering applying or awaiting a placement (Fig8 survey).
17. 31% of referrers discussed residential rehab with individuals within the past three months (IFF survey).
18. 29% of respondents with lived experience indicated they would have liked access to residential rehabilitation in the previous 12 months (unpublished PHS Lived Experience study).
19. PHS estimated that 47,100 individuals in Scotland had opioid dependency in 2019/20, and the Scottish Health Survey estimated that 1% of adults (approximately 46,000 individuals) were potentially alcohol-dependent in 2023. Although acknowledging limitations (self-reporting bias, survey reach, group overlap, opioid-only scope), this provides an illustrative total of around 100,000 individuals potentially within the scope of the proposed legislation.

## OFFICIAL SENSITIVE

20. The average cost of a statutory-funded residential rehabilitation placement (ADP-funded) between April 2021 and September 2024 was £13,537 per placement.
21. For the purposes of illustration, there would therefore be a potential revenue cost of around £400 million in the extreme scenario where all individuals currently suffering from a drug and/or alcohol dependency and who had an interest in residential rehabilitation were provided a placement.
22. Alongside this revenue funding, substantial capital costs would be required to expand bed provision. The Scottish Government committed £18 million over five years toward new rehabilitation facilities, aiming to increase capacity by 50%, reaching 650 beds by 2026. However, under the illustrative scenario described above, the number of additional beds required, and corresponding capital investment, would be an order of magnitude higher.
23. The true extent to which demand for residential rehabilitation would translate into the service being recommended by referrers is highly uncertain. There is mixed evidence around the proportion of individuals for whom residential rehabilitation is considered appropriate. For instance, in the IFF referrers survey, four in 10 (43%) respondents agreed that residential rehabilitation is only a valid option for a small proportion of people, however about one in three (35%) disagreed. And for those who did think it was only valid for a small proportion of people, clinical appropriateness did not feature in the responses given.
24. Notably, with regards to the proposals, the high cost of residential rehabilitation and lack of funding (19%), and limited places available (17%) were among the reasons given by those who thought it was only a valid option for a small share of people.

### **Supply-side capacity and elasticity**

25. Capacity limitations and restricted short-term supply elasticity create practical and financial risks, particularly under proposed statutory timelines and potential step-changes in demand
26. Meeting increased demand necessitates adequate supply-side capacity, including a trained workforce, appropriate facilities (e.g. residential rehabilitation beds), and robust community support structures.
27. Estimating supply elasticity (the investment required to achieve a specific increase in service provision) is challenging. This involves considering recruitment lead times, training costs, infrastructure investments, and wage pressures in specialised fields. Resource constraints may limit the speed at which services can scale up, irrespective of the legal entitlement.
28. In the short term, there could be significant divergence between supply and demand, potentially causing market distortions. For instance, if marginal residential rehabilitation placements are provided by the private sector at significantly higher costs, a legal obligation on the government could incentivise providers to increase prices while sector capacity expands.
29. The proposed three-week statutory timeline in the Bill could magnify these issues. Although approximately 95% of treatments currently commence within this period, legislating this deadline would necessitate maintaining over-capacity to manage demand variability.

## OFFICIAL SENSITIVE

### **Variability in service pathways and costs**

30. Diverse individual treatment needs and varying service intensities make it challenging to accurately estimate average costs and aggregate financial impacts.
31. Treatment for drug and alcohol dependencies is not homogeneous. Individual needs vary significantly based on substance type, dependence severity, co-occurring health conditions, and social circumstances.
32. The unit cost per individual accessing their right to recovery will vary considerably depending on required support intensity and duration (e.g. residential rehabilitation, community interventions, medication-assisted treatments).
33. Modelling an average cost is therefore challenging, and aggregate costs are highly sensitive to assumptions.

### **Wider social and economic impacts and 'Spend-to-Save'**

34. Determining wider economic and social costs and benefits—or the social return on investment—is challenging due to substantial uncertainty around potential impacts on service provision, treatment types, and individual outcomes.
35. The extent to which potential savings referenced in the Bill's Financial Memorandum (e.g., "each £1 spent on treatment will save £4 from reduced demands on health, prison, law enforcement and emergency services") would translate into cashable financial savings, rather than broader social value such as improved quality of life, remains unclear. Officials are engaging with colleagues in the Department of Health and Social Care for further clarification.
36. Removing the ability to consider costs or capacity constraints could undermine cost-effective resource allocation. The government's ability to strategically allocate resources based on evidence and system-wide priorities would be significantly restricted, leaving decisions solely to individual clinical judgement. Additionally, the opportunity cost of allocating substantial resources to meet this right – relative to the provision of other public services - would not form part of any considerations.

### FPAC scrutiny of Financial Memorandum

- The Finance and Public Administration Committee invited written evidence on the financial implications of the Right to Addiction Recovery Bill, as set out in its accompanying Financial Memorandum (FM), on November 1st, 2024, closing 20 December.
- Responses were published in February 2025: the Committee received 9 submissions to its call for views
- The substantive questions of the FM of the Bill were:
  - If the Bill has any financial implications for you or your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.
  - Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?
  - If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?
  - Does the FM accurately reflect the margins of uncertainty associated with the Bill's estimated costs and with the timescales over which they would be expected to arise?
- The 9 respondents consisted of a majority Alcohol and Drug Partnerships and Health and Social Care Partnerships (5); national organisations (2), other health services (1) and COSLA:
  - [Glasgow City Council / Glasgow City HSCP, Steven Blair](#) (GCC/GHSCP)
  - [Scottish Health Action on Alcohol Problems, Helen McCabe](#) (SHAAP)
  - [Fife Health and Social Care Partnership, Vanessa Salmond](#) (FADP)
  - [East Ayrshire Alcohol and Drugs Partnership, Liam Wells](#) (EAADP)
  - [North Ayrshire Alcohol & Drug Partnership, Caroline Cameron](#) (NAADP)
  - [Alcohol Focus Scotland, Aidan Collins](#) (AFS)
  - [Scottish Ambulance Service, Julie King, Clinical Services Transformation Manager](#) (SAS)
  - [Aberdeen City Alcohol and Drug Partnership](#) (ACADP)
  - Convention of Scottish Local Authorities ([COSLA](#))

### Key points

- Respondents **[Redacted-Section 30(c)]**
- Those respondents who are prospective key delivery partners of the Bill stated explicitly **[Redacted-Section 30(c)]** in the FM. There was also **[Redacted-Section 30(c)]** the required **[Redacted-Section 30(c)]** to deliver on the proposed Bill.

## OFFICIAL SENSITIVE

- There were a number of unintended consequences raised, including increasing the cost of the Bill, such as increased RR bed cost, legal costs, as well as some potential savings if harms were reduced.
- All respondents that would have a key role in delivery of the Bill stated that they would not be able to meet the costs of the Bill, citing the Scottish Government as responsible for funding.
- Respondents overwhelmingly did not believe that the margins of uncertainty on cost/timescales were accurately reflected.

### **Summary of Finance and Public Administration Committee oral evidence session with member in charge**

Scrutiny of the FM focused on key points made by stakeholders in the Call for Views on the FM issued by FPAC in December 2024:

- Significant discussion on underestimation of the cost of implementation of the Bill/inaccurate and incomplete costings (that may impact fiscal sustainability)
- Discussion on methodology/quality of calculation of savings/improvement for people affected by substance use
- Providing equitable delivery of the Bill/delivery given finite budget
- 'Spend to Save' – discussion around prospective savings the Bill proposes to deliver
- How to provide/resource an available and trained workforce to deliver the Bill nationally
- What should consequences of not meeting legislation be?
- The depth/quality evidence base on savings and improved outcomes for people affected by substance use through the Bill
- There are some unanswered questions/inaccurate information in the FM and so further information should be provided (quantifying proposed savings, improving calculation of cost)
- Cost is generally considered in decision-making, why should this be different?

### **Themes of Mr Ross' responses**

- People affected by substance use are much more likely to be poor, and live in deprived communities – through its legislative base the Bill will give them the recovery support they need.
- People are suffering, they want help, they want to change – they can't get it because of cost and availability. People who go through recovery make great contributions to our society. More demand is good if we can get help for more people.
- Money associated with National Mission isn't guaranteed next year. Putting Bill in law we will guarantee the money going forward.
- Productive meetings with CS and FM – they support intentions. Have cross-party support.
- The figures provided are the best we have; other methods would also have been problematic.
- There will be public cost and unmet need whether this Bill passes or not – people still have need – the Bill will address some of this and the existing budget will also address this.

## OFFICIAL SENSITIVE

- The concerns much of the respondents have on funding are about wider funding challenges.
- SG's commitment to 650 RR beds will do much to solve the capacity issue and provide what is needed.
- It's difficult to calculate the cost, SG couldn't do it either in their Gov Memo.
- Over time there will be a tipping point, and investment will result in savings. Early intervention creates savings.
- NGBs are narrow, so we can't address everything we would like (i.e. broader social issues).
- What we are doing isn't working, so we need to do something different – number of drug deaths in Scotland are a scandal and unique in their severity.
- It is for SG to consider how money should be distributed/for SG to back the Bill and find the money/make savings within current budget.
- The Bill will not replace existing support, but provide additional. The Bill complements existing work.
- People are told Resi Rehab is right for them, but they are told they can't get it – the Bill would stop this happening.
- Our Bill puts the target to get treatment in 3 weeks in law, complementing existing SG policy.
- Bill provides improved accountability, improved data.
- Previous FM made commitment to increase Resi Rehab treatments from 5 – 11% - Bill seeks to get us up to levels experiences in other places.

**From:** [Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 12 May 2025 14:40


**To:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: Cross Party Group - Substance Use 15 May 2025

Hi [Redacted-Section 38(1)(b)],

Finance and evaluation type sensitive topics are covered in the briefing that is being pulled together for the R2R bill evidence session.

Main tricky issues that come up frequently are that we're not focussed enough on alcohol, that we don't give enough long-term funding and that we don't know the cost-effectiveness of the National Mission. These points are covered in the R2R bill briefing:

 DRAFT - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary for Health and Social Care's evidence session on 20th May - 25th April 2025.docx

**[REDACTED-SECTION 38(1)(B)]**

**[Redacted-Section 38(1)(b)] – Mission Strategy Team**

Drugs Policy Division, Scottish Government

Mob: 07[Redacted-Section 38(1)(b)]

Pronouns: she / her

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

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**From:** [Redacted-Section 38(1)(b)]@gov.scot> **On Behalf Of** Cabinet Secretary for Health & Social Care 2024

**Sent:** 12 May 2025 14:42

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; Jennie Gollan <Jennie.Gollan@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: Invitation to give evidence to Health, Social Care and Sport Committee  
- 20th May

Hi **[Redacted-Section 38(1)(b)]**

Just to keep you updated – we've gone back to the Committee to ask if we can attend this meeting on 20 May at 12:00, will let you know when they respond.

**[Redacted-Section 38(1)(b)]**

Deputy Private Secretary to the Cabinet Secretary for Health and Social Care – Neil Gray MSP  
Scottish Government | St Andrew's House, Regent Road, Edinburgh EH1 3DG |  
Mob: 07**[Redacted-Section 38(1)(b)]** | Email: CabSecHSC@gov.scot

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**From:** **[Redacted-Section 38(1)(b)]**

**Sent:** 09 May 2025 17:11

**To:** Cabinet Secretary for Health & Social Care 2024

**Cc:** Deputy Director - Drugs Policy ; **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]** ; **[Redacted-Section 38(1)(b)]** ; Jennie Gollan ; **[Redacted-Section 38(1)(b)]**

**Subject:** RE: Invitation to give evidence to Health, Social Care and Sport Committee  
- 20th May

Thanks **[Redacted-Section 38(1)(b)]**

**From:** **[Redacted-Section 38(1)(b)]@gov.scot** > **On Behalf Of** Cabinet Secretary for Health & Social Care 2024

**Sent:** 09 May 2025 16:32

**To:** **[Redacted-Section 38(1)(b)]@gov.scot**>; Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; **[Redacted-Section 38(1)(b)]@gov.scot**>; Jennie Gollan <Jennie.Gollan@gov.scot>; **[Redacted-Section 38(1)(b)]@gov.scot**>

**Subject:** RE: Invitation to give evidence to Health, Social Care and Sport Committee  
- 20th May

Hi **[Redacted-Section 38(1)(b)]**

Just to flag that Mr Gray is unable to attend Committee on 20 May – I have sent an email this afternoon to let them know and asked if they can provide an alternative date which we will prioritise in the diary. I'll keep you updated.

**[Redacted-Section 38(1)(b)]**

Deputy Private Secretary to the Cabinet Secretary for Health and Social Care – Neil Gray MSP

Scottish Government | St Andrew's House, Regent Road, Edinburgh EH1 3DG |

Mob: 07**[Redacted-Section 38(1)(b)]** | Email: CabSecHSC@gov.scot

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**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

**[Redacted-out of scope information]**

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**[Redacted-out of scope information]**

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**[Redacted-Section 38(1)(b)]** (he/him) | Assistant Clerk – Health, Social Care and Sport Committee | Committee Office | The Scottish Parliament | Edinburgh | EH99 1SP

**[Redacted-Section 38(1)(b)]**@parliament.scot | [www.parliament.scot](http://www.parliament.scot)

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**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 13 May 2025 08:36  
**To:** [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>  
**Subject:** RE: Routine Submission: Right to Recovery Bill Committee Evidence Sessions and proposed approach

Hi [Redacted-Section 30(c)],

No problem, will do this now.

AB

[Redacted-Section 38(1)(b)]

[Redacted-Section 36(1)]  
[Redacted-Section 36(1)]  
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[Redacted-out of scope information]  
[Redacted-out of scope information]

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**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 13 May 2025 08:42  
**To:** Solicitor General <SolicitorGeneral@gov.scot>; Lord Advocate <LordAdvocate@gov.scot>; Legal Secretariat to the Lord Advocate <LegalSecretariattotheLordAdvocate@gov.scot>  
**Cc:** Director of Population Health <Directorofpopulationhealth@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section



**From:** [Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 13 May 2025 08:43

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** FW: Routine Submission: Right to Recovery Bill Committee Evidence Sessions and [Redacted-Section 30(b)(ii)]

I think this aligns with the content we have in the briefing and the responses to the q&a

**From:** [Redacted-Section 38(1)(b)] On Behalf Of Cabinet Secretary for Health & Social Care 2024

**Sent:** 13 May 2025 08:41

**To:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; Cabinet Secretary for Health & Social Care 2024

**Cc:** Director of Population Health ; Deputy Director - Drugs Policy ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 30(c)] ; [Redacted-Section 30(c)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 30(c)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 30(c)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]

**Subject:** RE: Routine Submission: Right to Recovery Bill Committee Evidence Sessions and [Redacted-Section 30(b)(ii)]

**This email is for the official record and confirms a Ministerial Decision. This email must be placed in the official record (eRDM) by your team in line with SG records management policy.**

Morning,

Mr Gray has fed back:

[Redacted-Section 30(b)(ii)]  
[Redacted-Section 30(b)(ii)]

Thanks,

[Redacted-Section 38(1)(b)]

**Deputy Private Secretary to the Cabinet Secretary for Health and Social Care – Neil Gray MSP**

The Scottish Government | St Andrew's House | Regent Road | Edinburgh | EH1 3DG | E: CabSecHSC@gov.scot | T: 07[Redacted-Section 38(1)(b)]

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*a note of a Ministerial meeting, must be filed appropriately by the recipient. Private Office do not keep official records of such emails or attachments. Scottish Ministers, Special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See [www.lobbying.scot](http://www.lobbying.scot)*

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[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]  
[Redacted-out of scope information]

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**From:** [Redacted-Section 38(1)(b)]  
**Sent:** 13 May 2025 15:37  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** Draft speaking note for R2R committee session

We don't have timings, but aimed for 3-4 mins

[Redacted-Section 38(1)(b)] | Drugs Policy | Health & Social Care Directorate | Scottish Government

Email [Redacted-Section 38(1)(b)]@gov.scot  
Pronouns she/her



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**From:** [Redacted-Section 38(1)(b)]@gov.scot> **On Behalf Of** Cabinet Secretary for Health & Social Care 2024  
**Sent:** 13 May 2025 15:47  
**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: CS premeet for evidence session with HSCS committee on 20th May on Right to Addiction Recovery Bill (R2R)

Apologies Folks,

Please disregard this email I can see now we already have a pre met scheduled.

Thanks,  
[Redacted-Section 38(1)(b)]

[Redacted-Section 38(1)(b)]

**Assistant Private Secretary**

Office of Cabinet Secretary for Health and Social Care, Neil Gray MSP  
The Scottish Government, St Andrews House, Regent Road, Edinburgh, EH1 3DG  
E-mail: cabsechsc@gov.scot

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**From:** [Redacted-Section 38(1)(b)] On Behalf Of Cabinet Secretary for Health & Social Care 2024  
**Sent:** 13 May 2025 15:44  
**To:** Cabinet Secretary for Health & Social Care 2024 ; [Redacted-Section 38(1)(b)]  
**Cc:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]  
**Subject:** RE: CS premeet for evidence session with HSCS committee on 20th May on Right to Addiction Recovery Bill (R2R)

Good Afternoon [Redacted-Section 38(1)(b)],

Apologies for the late response on this we were waiting for some space to clear in the diary. I will send over a diary invite shortly for the 14<sup>th</sup> May from 15:15 – 15:45. Please can you let me know who should be included on the invite.

Thanks,  
[Redacted-Section 38(1)(b)]

[Redacted-Section 38(1)(b)]  
**Assistant Private Secretary**

Office of Cabinet Secretary for Health and Social Care, Neil Gray MSP  
The Scottish Government, St Andrews House, Regent Road, Edinburgh, EH1 3DG  
E-mail: cabsechsc@gov.scot

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[Redacted-out of scope information]  
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**From:** [Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 13 May 2025 16:06

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; Spads Admin <Spads\_Admin@gov.scot>; Jennie Gollan <Jennie.Gollan@gov.scot>

**Subject:** R2R 3rd Evidence session 13th May

PO/Cabinet Secretary

Please find attached a note of the oral evidence session with Health, Social Care and Sport Committee for Right to Recovery Bill today, 13<sup>th</sup> May 2025.

Erdm copy:

Drug and Alcohol Policy - Stage 1 - Right to Addiction Recovery - 3rd oral evidence session with stakeholders - 13th May 2025 details - Objective

Best wishes,

**[Redacted-Section 38(1)(b)] she/her | Participation and Human Rights  
Integration Team | Drugs Policy Division | 07[Redacted-Section 38(1)(b)]  
Scottish Government | 3 E St Andrews House | Regent Road | Edinburgh | EH1 3DG**

**Health, Social Care and Sport Committee  
Evidence Session 13<sup>th</sup> May 2025 on the Right to Addiction Recovery (Scotland)  
Bill:**

**Panel 1:**

Kirsten Horsburgh, Chief Executive Officer, Scottish Drugs Forum;  
Tracey McFall, Chief Executive, Scottish Recovery Consortium;  
Justina Murray, CEO, Scottish Families Affected by Alcohol & Drugs

**Panel 2:**

Lee Ball, Director of Addictions, Salvation Army  
Graham Callendar, Policy and Public Affairs Lead, With You  
Jan Mair, Practice and Innovation Lead, Turning Point Scotland  
Annemarie Ward, Faces and Voices of Recovery UK

**Key themes:**

**Rights and Accountability:**

- **Elena Whitham** questioned if the Bill ensures the rights of people who use substances.
- **Annemarie Ward** emphasized the Bill's importance for accountability and criticized the current system's gatekeeping culture.
- **Graeme Callendar** and **Jan Mair** supported the Bill's intent but raised concerns about practical implementation and accountability.
- **Lee Ball** highlighted the need for accountability and resources.

**Conflict with Charter of Rights:**

- **Elena Whitham** and **Annemarie Ward** discussed potential conflicts between the Bill and the Charter of Rights.
- **Graeme Callendar** and **Jan Mair** expressed concerns about the Bill's narrow definition of treatment and its practical delivery.

**Diagnosis and Treatment:**

- **Emma Harper** and **Jan Mair** discussed the advantages and disadvantages of requiring a diagnosis before treatment.
- **Graeme Callendar** and **Lee Ball** emphasized the need for confidentiality and the potential stigma associated with the term "addiction".

**Capacity and Resources:**

- **David Torrence** and **Graeme Callendar** raised concerns about the capacity of residential rehab and detox services to meet increased demand.
- **Lee Ball** emphasized the need for additional resources and the potential impact on community services.

**Harm Reduction and Abstinence:**

- **Jan Mair** and **Lee Ball** discussed the importance of harm reduction measures and the potential for polarizing the debate.
- **Annemarie Ward** defended the Bill's focus on treatment and criticized the lack of harm reduction measures.

**Early Intervention and Prevention:**

- **Graeme Callendar** and **Lee Ball** emphasized the need for early intervention and prevention measures.
- **Annemarie Ward** argued that the Bill complements prevention efforts.

**Flexibility in Treatment Options:**

- **Gillian Mackay** and **Graeme Callendar** discussed the need for flexibility in treatment options and the potential for overly medicalizing treatment pathways.

**Financial Considerations:**

- **Paul Sweeney** and **Graeme Callendar** raised concerns about the financial implications of the Bill and the need for adequate resources.

**Legislative Process and Empowerment:**

- **Kirsten Horsburgh** and **Tracey McFall** argued that a legislative process wouldn't guarantee improvement and emphasized the need for cultural change and resourcing.
- **Justina Murray** highlighted the importance of recognizing and supporting human rights without relying on legislation.

**Conflict with Existing Standards:**

- **Kirsten Horsburgh** and **Justina Murray** discussed the potential conflict between the Bill and existing standards like MAT Standards.
- **Tracey McFall** emphasized the need for quality treatment and access.

**Diagnosis and Gatekeeping:**

- **Emma Harper** and **Kirsten Horsburgh** discussed the potential gatekeeping effect of requiring a diagnosis before treatment.
- **Justina Murray** argued that a clinical approach is too narrow and strengthens power dynamics.
- **Collaborative Working:**
- **Gillian Mackay** and **Justina Murray** emphasized the need for collaborative working and the role of the third sector.
- **Tracey McFall** highlighted the importance of joint decision-making and addressing power imbalances.

**Advocacy and Support:**

- **David Torrence** and **Kirsten Horsburgh** discussed the need for adequate provision for advocacy and support.
- **Justina Murray** emphasized the importance of strengthening existing advocacy services.

**Impact on Families and Carers:**

- **David Torrence** and **Justina Murray** raised concerns about the Bill's lack of provisions for families and carers.
- **Tracey McFall** highlighted the disconnection felt by families.

**Quality of Services:**

- **Paul Sweeney** and **Kirsten Horsburgh** discussed the potential impact of the Bill on the quality of services and treatment.
- **Tracey McFall** emphasized the importance of recommissioning services in a human rights-based approach.

**Unintended Consequences:**

- **Paul Sweeney** and **Justina Murray** raised concerns about the unintended consequences of the Bill, such as increased bureaucracy and pressure on services.
- **Tracey McFall** emphasized the need to focus on broader recovery-oriented systems of care.

**Financial Implications:**

- **Brian Whittle** and **Justina Murray** discussed the financial implications of the Bill and the need for adequate funding for third sector services.
- **Tracey McFall** highlighted the importance of discretionary funders and addressing root causes like poverty and deprivation.

### **Summary of panel member views:**

#### **Kirsten Horsburgh: (SDF)**

- Happy the Bill has created a national conversation but does not agree with a legislative process. Believes issues are about culture, capacity, and resourcing. Emphasized the need to invest in existing standards and embed lived experience.
- Criticized the Bill for gatekeeping and creating an adversarial process. Highlighted the importance of independent advocacy and workforce development.
- Mentioned that treatment is sometimes secondary to other needs like housing and benefits. Stressed the importance of building trust.
- Concerned about the Bill's lack of provision for advocacy and its potential to threaten key relationships between people and their workers.
- Highlighted the issue of data collection taking focus away from service improvement.
- Emphasized the need for a consistent relationship with professionals and the empowerment of people to try different treatments.

#### **Tracey McFall: (SRC)**

- From an SRC perspective, emphasized that legislation alone does not guarantee access to rights. Highlighted the need for addressing power imbalances and adopting a human rights-based approach.
- Agreed with Justina Murray on the need for more investment in advocacy.
- Mentioned concerns about the diagnosis of addiction being in records forever and the potential delay in intervention.
- Criticized the Bill for not adequately promoting collaborative working and for its narrow focus on clinical diagnosis.
- Highlighted the importance of joint decision-making in treatment.
- Emphasized the need to address the power imbalance and improve the quality of treatment available.
- Mentioned the importance of recommissioning services in a human rights-based way locally.
- Highlighted the issue of data systems not connecting and the potential for more bureaucratic data collection.
- Stressed the importance of recovery-oriented systems of care and the need for sustainable funding.

#### **Justina Murray: (SFAD)**

- Stated that human rights are universal and not supportive of a legislative approach. Highlighted the need for knowledge, skills, and confidence to access rights.
- Mentioned that the Bill is silent on how individuals can challenge access issues beyond legal redress.
- Criticized the Bill for its narrow clinical approach and lack of reflection on multi-disciplinary working.

- Emphasized the need for a fundamental redesign of services to build a whole system around third sector, statutory, families, and communities.
- Highlighted the potential for the Bill to divert attention and resources from existing issues.
- Mentioned the importance of trust in relationships and the Bill's potential to cement power imbalances.
- Criticized the Bill for not addressing the needs of families and carers.
- Highlighted the potential for the Bill to reduce quality and choice in treatment.
- Emphasized the need for services to recognize and respond to people's rights.

#### **Annemarie Ward (FAVOR) – involved in drafting of policy for Bill**

- Highlighted that the Bill is a matter of life and death and criticized the current system's obstructiveness and gatekeeping culture.
- Argued that the Bill is not impractical and that those opposing it are influenced by government funding.
- Stressed that the Bill provides real accountability, unlike the Charter of Rights, which she views as unenforceable.
- Emphasized the need for a diagnosis in healthcare and criticized the idea that the Bill is too narrow.
- Defended the three-week treatment timescale as a necessary accountability measure.
- Defended the Bill as a specific intervention to give a right to treatment, if desired, and not designed to tackle all aspects of people's needs.

#### **Graeme Callendar (WithYou)**

- Supported the intent of the Bill but expressed concerns about its practical implementation.
- Highlighted the importance of access to residential rehab and detox services.
- Emphasized the need for a broader definition of treatment and the importance of early intervention and prevention.
- Mentioned the challenges of meeting increased demand for services and the need for consistent standards.
- Stressed the importance of psychosocial support and the need for adequate financial resources.

#### **Jan Mair (Turning Point)**

- Echoed support for the Bill's intent but expressed concerns about its practicalities and potential as a distraction.
- Highlighted the importance of early intervention and harm reduction measures.
- Emphasized the need for a broader definition of treatment and the importance of accountability.
- Expressed concerns about the capacity and consistency of residential rehab services.
- Stressed the importance of post-treatment support and the need for explicit harm reduction measures in the Bill.

#### **Lee Ball (Salvation Army)**

- Supported the Bill's intent but emphasized the need for resources and flexibility in treatment options.

- Highlighted the importance of accountability and the need for a broader definition of treatment.
- Expressed concerns about the omission of harm reduction measures and the potential for stigma.
- Emphasized the importance of early intervention and the need for systemic focus.
- Stressed the importance of psychosocial support and the need for adequate financial resources.

### **More detailed notes:**

#### **Panel one:**

#### **Elena Whitham – I want to explore the actual right to recovery, explore, and what it means to be a rights holder and duty bearer – what’s the extent of how the Bill will realise rights?**

Kirsten Horsburgh: happy Bill has created national conversation – but do not agree that should be a legislative process. The issues around empowerment, quality, access etc are issues of culture capacity and resourcing – a legislative process wouldn’t guarantee improvement, or guarantee person centred approach. We need to fully invest into the standards that are already there, we need to embed lived experience.

Tracey McFall: from an SRC perspective, we want to be constructive – we know, because it’s in law doesn’t mean people will access this right – i.e. housing. Fundamental aspects of treatment, access and choice – we all want this. For SRC we need a range of measures to challenge power imbalance, improve current standards, create a HRBA approach and include LLE – we all want people to access rights in treatment, but just because it’s in legislation doesn’t mean it will happen.

Justina Murray: Human Rights are for everyone, they are universal, we can’t give them to each other, can recognise and support them – not supportive of legislative approach.

#### **Elena Witham – Will it enhance or run into conflict with Charter Of Rights?**

Justina Murray: Charter of Rights is helpful, sits with a suite of rights, it is helpful, but we know family members need a lot of support to understand and use their rights – just saying they have rights doesn’t help, it’s about knowledge, skills and confidence for them to access that.

Kirsten Horsburgh: part of our response was in consultation with people with LLE– for example, they are only just getting around understanding MAT Standards and feel it’s quite conflicting with MAT Standards – that it misses the real life experience of people trying to access services.

**Elena Witham - how does an individual actually challenge when they feel like they're not getting the access they require – what is the remedy for them?**

Justina Murray: the Bill is actually silent on that – what you would do to challenge that beyond legal redress – who would have time and money for this? Through existing advocacy we can support, but they do need to be strengthened. The Bill doesn't really solve that, it just adds another layer of legislation...

Tracey McFall: Justina is correct, there has been investment in advocacy, but there is not enough. To access rights, you need to know them – big gap in Scotland in people understanding their rights.

**Emma Harper - the Bill requires a health professional to diagnose and provide a treatment determinations – what are your thoughts on this requirement to receive a diagnosis before treatment?**

Kirsten Horsburgh: it is gatekeeping, it creates a system that allows it. Process creates something that is adversarial. We need to get to bottom of issue as to why people aren't getting the treatment – independent advocacy is a great point, it's not mentioned in bill, workplace and workforce development that could be taken forward.

Tracey McFall – those we have consulted with, spoke about the diagnosis of addiction being in your records forever and not all recognise the terminology. When people are in crisis there is an intervention point when people need help, need to explore whether the time to make a diagnosis would delay things.

**Emma Harper – it could prevent people coming forward? They might know they have an issue but not want to hear this?**

Justina Murray – we've done a lot of work to understand difference between alcohol and drug use and harm, we want them to know they can get help, if they are experiencing harm – returning to a clinical approach is so narrow – a tiny minority would have a clinical diagnosis of alcohol dependent, but harm is much larger at approximately 25%. It seems unnecessarily narrow, and strengthens the power dynamic.

**Gillian Mackay – does the bill adequately promote collaborative working?**

Justina Murray: No. There really isn't any reflection of multi-disciplinary working and it is pretty silent on role of third sector. All of the things around someone with substance use issues isn't discussed. It has an overly focus on a clinical diagnosis of addiction without responsibility of responding to other needs.

Tracey McFall: what we know about substance use is that its complex – medical element is one small part which needs to be wrapped around everything else. The clinician's role is to support and assist joint decision making around treatment – joint decision making is critical and this is a retrograde step.

Kirsten Horsburgh – sometimes treatment is a secondary issue to what people want, they want support with housing and benefits – once they build trust they can

consider other positive elements. We should be encouraging attendance for a wide range of reasons.

**Gillian Mackay – does the panel believe there is a way to amend the bill to reflect some of the things they've discussed? Or is it about enhancing what we have?**

Tracey McFall: we would be looking to address the power imbalance.

Kirsten Horsburgh: we are quite clear that we don't think a legislative process is right, so it feels disingenuous to support amendments.

Justina Murray: we don't support the bill, we are on same page with issues in current system, but that journey is nowhere near finished, the bill just diverts attention and resource.

**Convener (Claire Haughey): would you feel that the resources put in this bill would be better placed bolstering services like advocacy etc and other issues that play into peoples needs?**

Justina Murray: Financial memorandum quotes £28-£38 million to treatment changes alone, I would have lots of ideas how this money could improve system, even where we are currently, we must look at a fundamental redesign, money is locked into NHS services, I would like to see a service redesign which builds a whole system around third sector, statutory, families and communities, where people want to engage.

**Brian Whittle – for me, you spoke about issues and put money where it is needed. Could the bill not force parliament to consider the way we treat and fund addiction services, the bill has that ability to focus that attention?**

Tracey McFall: just because there is a legislative framework, it doesn't mean they will get access to what they need – it's a fundamental flaw, addiction complexities are not narrow, its broad, there is an issue how we are funding services – if you look at recovery communities its working, but most of the money goes into treatment – huge amount of work being done, we need to move some of that money.

**Brian Whittle – I agree with that, best impact in our communities is unseen. The reality is that third sectors are being starved of investment, I think that for me, we have to do something different.**

Tracey McFall: that's an issue around commissioning, how we commission HRBA services, there's an issue on how we commission services, rather than the solution being a legislative framework

Kirsten Horsburgh: there is an issue around data and reporting, and this emphasis on data collection, it takes services away from being able to deliver, the focus is taken away from service development and improvement, we should use our data for service improvement rather than performance management. Part of that is fully embracing and utilising people with LLE. I would disagree with nothing has improved. The policy intent is welcomed, the major issue is the lack of urgency, and

the need to fully embrace of that – more things in more areas is required and comes with more resource requirements.

Justina Murray: we are tripping over very progressive legislation and policy, not only in England but also Scotland, but what is written down isn't what is felt in communities – but that doesn't mean more legislation is the answer – we have more paperwork . We need laser focus on implementation.

Kirsten Horsburgh: Scotland has no shortage of inquiries. Evidence sessions , reports, we share frustrations in this.

**Joe Fitzpatrick – we agree that to be successful we need to be person centred – you've touched on that. The bill, procedures, does it help or hinder a person centred approach. If not this legislation, what helps?**

Tracey McFall: The bill doesn't cover that, not just about person centred, trauma, choice and control, access, not much more to add, it doesn't touch on this, we have NES work, MAT standards to work on that, its very narrow in current form.

Justina Murray: there is that relationship of trust that is built up, the bill does misappropriate that language of rights and individuals as it just cements the power imbalance already there, there are good person centred docs already there, the patients charter and a campaign = its ok to ask' the bill doesn't add anything that's already there. It takes time to build up those positive relationships – in the bill it's like there's an event; of diagnosis and treatment happens. Working with people, it's a process, not a one off meeting.

Kirsten Horsburgh: key thing for people is that relationship with their worker. Down to those key relationships where people are being heard and their views are being acted on. Worried this legislation threatens this relationship – creating the adversarial process with the procedures.

**David Torrence – does the bill include adequate provision for advocacy?**

Kirsten Horsburgh: it's a key thing that is missing, its been developing over last few years, there has been more emphasis, but its still not enough, it is lacking in the bill.

Justina Murray: in an idea world we wouldn't need it, but we know from our research, that families feel it's not a level playing field...

Kirsten Horsburgh: we have similar conversations with people who use drugs. We know treatment is a protective factor – they see it as a risky process in engagement with a treatment service, shouldn't be like that

Tracey McFall: massive opportunity with charter to develop advocacy.

**David Torrence – does the bill address the needs of families and carers?**

Justina Murray: caused frustration and anger with families. We met with Douglas Ross some years ago, he was very understanding, we though corrections would be

made, but when we saw bill as presented, families are not mentioned once. It doesn't mention family. It flies in the face of other positive written commitments made in rights respect recovery, the promise, charter of rights, which is for people affected by substance and families have been deeply involved in the process.

Tracey McFall: broader policy context, PHS evaluation of NM and audit Scotland, peoples panel report, lots of evidence of families feeling disconnected

### **Paul Sweeney – quality of services. Standards/ what impact could the implementation of bill have on quality of services and treatment**

Kirsten Horsburgh – we don't believe a legislative process will help. A large part is support to the workforce. Large workloads and therefore can't provide quality of service to people. The way we deliver and design services needs to be with people with LLE. Look at different ways of service provision. Last five years of mission, it's been a missed opportunity on how we deliver our services. Stigma needs addressed at all levels. We need to be mindful some people experiences doesn't automatically challenge stigma, and make sure we don't exacerbate it

Tracey McFall – we have an unpaid workforce in Scotland, thousands of volunteers. This is about a workforce that is doing a lot of work that is unpaid, it's very important. The legislation won't improve services, it's about recommissioning services in a HRBA way locally

Justina Murray – when we spoke to people about the bill. This pressure to come up with a treatment determination in a tight time frame, would reduce quality and choice rather than opening up what people need. Need to open up questions around what is choice for women, rural areas as well. Worry people would provide anything rather than the right treatment because they are under that legislative duty.

### **Paul Sweeney: What are unintended consequences of Bill?**

Justina Murray: families were cynical whether that full range of services would be offered, they don't have all of these options for services on their doorstep, how would this work when there is limited support available?

Tracey McFall – we have data systems that don't connect up and see cradle to grave picture. How much more data will we be gathering and what will it do? We are gathering a lot of data, but what is it telling us? We may end up with more bureaucratic collection ...services say they don't want to collect more data, but work with people in community and support

### **Paul Sweeney: Risk of gaming the system?**

Kirsten Horsburgh: we've seen this in policies and processes – we were there when heat standards were introduced, people had to be in treatment in 3/4 weeks. To manage capacity, people were saying they were getting treatment when they were getting preparatory work. This is obviously what happens when people don't have capacity. We've done research on MAT standards. Until we can be honest about the

problems that are happening, we are never going to address the issues. We need to focus in on peoples true experiences or they'll never improve

Tracey McFall – we need to be careful of more resources into treatment end. Less money into broader recovery oriented systems of care. This unintended consequences are important.

**Sandesh Gulhane – the one piece of data matters is the drug deaths. Three times higher than next country. Is it not important that families going into battle could go into it armed with a right in legislation?**

Justina Murray: Theres no mention of rights in the bill of families. In contravention with the carers act...

**Sandesh Gulhane: surely this could be an amendment?**

Justina Murray - the bill doesn't add anything that is already there, it doesn't add anything, it undermines person centred and trauma informed approach...

**Sandesh Gulhane: But that isn't happening**

Justina Murray: The change we want to see is service seeing themselves as duty bearers – where services need to respond to peoples accessing rights

**Sandesh Gulhane – what if there was a bill that guaranteed the right to have a GP appointment within one week, surely that would be positive?**

Kirsten Horsburgh: I want to add some real scenarios from people – when we've been doing consultation with people...it goes back to missing the reality of people's lives. If they attend a treatment service, already feeling quite vulnerable, which is declined, the reasons are given. The bill is so unrealistic for people for the situation we are in...it is unrealistic to expect people to seek legal redress....

**Sandesh Gulhane – there is no clear way for holding public authorities accountable.**

Justina Murray – there is an implementation and accountability gap – ideally you want to resolve it there and then, you don't want to go through years of complaints process, stage 1, 2 or three, taking someone to court, its beyond resources of most people.

What we want to emphasis is changes we need is the interactions – services recognising people have rights and meeting them in this way. All of us are saying its not happening just now, but the bill doesn't provide this. Other things such as advocacy and the charter of rights could help this.

Tracey McFall – clear from people, when they are vulnerable, the last thing they want to do is see a lawyer and get legal redress. What you'll find is they'll disengage...

Kirsten Horsburgh – that process, they're at increased risk of death

**Brian Whittle – it was framed that you come in and request a treatment, and that's what you'd get, but surely you'd get advice from health professional?**

Justina Murray – you might come in with one presenting needs, but then have other needs, might be situations i.e, when people are on methadone and they want buprenorphine, but they already have rights on patients charger to have a second opinion, choice etc.

Kirsten Horsburgh – people have often have been in services for a long time, and have tried many treatments, and know what's best for them – from feedback people feel there's a strong abstinence focus, and harm reduction is missing. People will need different treatments at different times. HPs will give advice, but often people will know what they want.

**Brian Whittle – for me what is lacking is that consistent relationship with the professional...**

Kirsten Horsburgh– I think people should be more empowered to try different treatments, as with for example someone going to GP for depression, there's lots of options in different areas. For example there's a shift people going into stimulants. People sometimes think there's no point as no treatments for stimulants.

**Brian Whittle – wanting to come to funding and resource allocation and additional costs that might not be accounted for?**

Justina Murray – they were concerned pressure to deliver this thing wouldn't be met by NHS services which then they'd expect third sector to pick up, but with no mention of finances - I think there would be lots of unfunded costs

Tracey McFall – no mention to back end of costs...

**Brian Whittle – has any work been done on positive impacts both personally and financially of a system that works well?**

Tracey McFall: lots of work we could do, but I think there will be some findings from PHS NM evaluation. What we don't have is a clear picture of where money is going for recovery systems of care. This year there is an opportunity to focus not just about treatment but recovery.

Those drug deaths would be higher if it weren't for the work that was happening in our communities, there needs to be some focus on this.

Kirsten Horsburgh – the last thing we want to do is pit different services against each other, we need ever treatment harm reduction, resi rehab, recovery, we need the whole – alcohol treatment, massively important but underfunded. Its not just about level of funding, but about length. Services aren't sustainable in short term funding

**Brian Whittle – my hope would be the bill, forcing the positive way in which we bring third sector into this. For me to deliver the bill would require all of the**

**services, force governments to properly fund, that's the only way this way will work**

Justina Murray – there's nothing in the bill that talks about that – it's all about NHS services, and the health professional and individual, nothing in the bill that commits to broader funding – our fear is that the bill would suck up broader funding and put it back into NHS which is not necessarily what people want. It would have reverse effect

**Brian Whittle - my point is the bill would reverse that**

Justina Murray the bill is all about statutory services – there's nothing in it that talks about that?

Tracey McFall – there are discretionary funders in Scotland, CORRA, Robertson trust, they need to be brought into mix –  
To do

Something around justice system in this, does this right follow me when put into prison

Kirsten Horsburgh – we are always going to be firefighting until we address root causes, poverty, deprivation, and take a longer-term view. When are we ever going to address the upstream work

**Sandesh Gulhane – how can we protect the community spaces that are doing great work?**

Kirsten Horsburgh – why is it that DA easy pickings, onus needs to be on local leaders to not discriminate – we know vulnerable people are least likely to complain. I'd like to look at how we address that locally in decision making procedures.

Justina Murray – I think it's difficult as third sector CEO to say oh we should account for every penny. It's not always transparent where all the investment has gone. You talked about evidence based services that are closing – proving things work doesn't protect you. Community link workers are an unsung heroes, people who had already lost their jobs but were still on the conference it feels that no matter how we prove ROI it doesn't protect us when budgets are being cut.

**Convenor – does this bill address the issues that you've just vocalised**

Justina Murray – No.

Tracey McFall – Currently no.

Kirsten Horsburgh – Still don't think legislative approach is right.

## Panel 2

### **Elena Whitham – Will the provisions in the Bill ensure the rights of people who use substances are realised?**

Annemarie Ward: the organisation I work for is grounded in evidence and rooted in experience, and in hope and action – the rights people should have are not being experienced when they come forward for treatment, or, in the system. I'm here as someone who has walked the path of recovery, beside 1000s of people. The Bill is a matter of life and death, not abstract. From our advocacy I've learned the system is very obstructive. We know this because we have stood toe to toe with people when they're trying access services. We have fought tremendous bureaucracy. Its not cost, clinical judgement – it's a culture of gatekeeping.

Graeme Callendar – We support over 15000 people over various stages in their journey. We can get behind the intent of the bill, where we come from are the practicalities, we are not sure if the Bill as it is currently written – access to resi rehab and detox – most of our work is about getting people to these services in the first place. We are broadly supportive of the intent, but concerned around the practicalities.

Jan Mair: I would echo that exactly – we are in support of the intention of the bill, our org works with people that aren't getting into treatment, those who aren't ready, people need access to treatment, im not convinced this bill is the right way to do it. A slight worry for us that it might be a distraction. Many people were involved in the consultation of the charter of rights, the NC, which seems to do many of things without problems, in fact its broader, my worry is it might be a distraction from something that's already in train

Lee Ball – we work with people that aren't even at the door of treatment. Theres different reasons for that, people may have poor prior experiences etc. we do support the ability for someone to have their rights enshrined, and justify why treatment isn't provided. And that's a lot of responsibility on the system that is already stretched, which would need to be resourced.

### **Elena Whitham – to what extent the charter will conflict or compliment the charter – we don't have the Human Rights Bill which would underpin**

Annemarie Ward – the claim is that the bill is impractical is not a serious concern – those that are raising the concerns are commissioned by SG, they are funded by government, and embedded, this bill shifts power for them, that's not a distraction its democracy A charter isn't enforceable, it's a poster on a wall, it offers no redress, no accountability,

People are saying this bill is a distraction same people that haven't delivered for people.

None of our clients have heard of MAT standards, rehab isn't an option – a charter isn't enough, the bill is a real method of accountability. It's a distraction because it disrupts bureaucracy.

**Elena Whitham thinking about the collaborative and Charter of Rights, I share the concerns that its not enforceable as it might have been, taking that on board, do you think the bill complements or contradicts the charter?**

Graeme Callendar – I think the bill as presented – it feels a narrow definition on what is treatment. As a third sector who receives money from LA – we aren't responsible for prescribing. We come across challenges for people wanting reduce prescription on RR> we are supportive of intent. We wonder how it will be practically delivered. Weve got the charter and proposed legislation. I'm not clear whether this bill and charter, could fall down if it's not implemented. But with charter it does feel collaborative. With this bill its felt more challenging to engage with the key topics.

Jan Mair – I would agree with agree, I'd prefer the legal underpinning for the charter of rights what I like about the bill is the accountability, we want that accountability. Where we are working with people who aren't near treatment, they are a long way from it, this bill, because it focuses just on treatment, it doesn't give rights at earlier stage, what the charter does

Lee Ball – when you speak to staff and service users, they ask for accountability, we need to be careful of legislation tripping over each other. WE are concerned of omission of explicit HR they need to know before they come to treatment, need to considered before.

Annemarie Ward – let me respond to accusation that it offers narrow treatment – this is totally disingenuous., those pushing that line aren't neutral, they don't engage with bill, or inform their stakeholders or distribute our myths busting, they haven't engaged with it. They're confused but haven't spoken to us. Its manufactured. It defines treatment as it exists in NHS Scotland. The charter of rights, darling of services, it has no teeth and cant be enforced. It's a PR exercise.

This charter is not more collaborative, its written by those that don't collaborate with the bill. The charter is embraced because it asks nothing of the system.

**Brian Whittle – you discussed the bill not talking about pre-treatment. Would you agree if we get people to seek treatment and then not get it, is destructive – because the bill says if y ou access treatment, you have the right to get that, is that not important**

Lee Ball – it takes courage to access treatment. We are concerned about definition of treatment and when it begins. When will time be counted from that point?

**Emma Harper– advantages or disadvantages of requiring a diagnosis before entering into treatment?**

Jan Mair – we are concerned of the idea people needing a diagnosis – unnecessary barrier. A lot of people don't want or need a diagnosis, but need the treatment in its

broadest sense. There are many people who have serious issues with alcohol and cocaine, but they are not physically dependent, so the word and diagnosis. It would put people off, where often people need to come and talk about problems. Its more than just a health problem, it's a social problem, related to communities, initially it can be a barrier to support. We might focus energy on all of those with physical dependence away from those using in different pattern,

Graeme Callendar – very similar. It was a key thing, the diagnostic part. People come cos they need help, we don't wait for a diagnosis to happen before we support, often on same day. Occasions were you need a diagnosis. A lot of people that are at risk of overdose, they might need and should be no delay.

Other issues is upskilling of HP's, that they all need to become skilled in how to make a diagnosis. Lastly, a need to be confidential and addiction to be on medical records. A lot of people work. If the bill progresses it needs to be confidential

**Emma Harper – I am a nurse and have worked with people with substance use. Does the bill need to change then?**

Lee Ball addiction is a loaded term, its seldom a single issue, to give a diagnosis of that one thing without everything else is narrow. A diagnosis is a help or hindrance depending how its used. People have a right to privacy, being on medical issue is a risk. Id ask you to consider this term, its too narrow. Its often loaded, with stigma, negativity. Language defines our reality so we need to be careful.

**Emma Harper – protection of anonymity, this is where language of addiction is a problem...**

Lee Ball – it can increase, go up, down, it's a moveable issue, to define it as one moment in time, is narrow, we need to be careful to pigeonhole

Annemarie Ward – let's cut through noise, claiming its stigmatising is narrow. Every healthcare starts with diagnosis , they don't die because of a diagnosis addiction, they die because of lack of treatment. If HPs can't give a diagnosis, where are we. Don't use workforce failings to cover this up.

**Sandesh Gulhane – if we were to amend the language of addiction – we need to say you have something, what should the term be?**

Graeme Callendar ; treatment is there, for us its always been about access, we understand importance of clinical process, sometimes it's critical when other things are going on. A lot of people we speak to don't need a medical intervention, they need mutual aid, other support, it feels narrow to me-

**Sandesh Gulhane – it's a member's bill. My question was what wording you would use?**

Lee Ball – it's a person's right to want treatment – it's a difficult thing. We reduce deaths, without clinical work. I think if we move this forward, we should ask those in services, what word would you like

**David Torrence how confident are you that resi and detox services can meet increased demand?**

Jan Mair – I don't think we have enough capacity through different services. What's more important is we need a consistency of standards. Just because you are accessing resi services doesn't mean it's the same in one part than in other part of country. I'm not convinced we've got a capacity of a consistent standard throughout country

Graeme Callendar – I've seen people go through RR, for some it's not worked, i.e not right time or service. we do pre and post support / We are seeing demand skyrocket, we are seeing pinch point in systems. Every RR service is different, focus and selection, I suppose that's another thing we need to factor in. I don't think they have enough capacity

Lee Ball: Peoples caseloads are ging up, stress and strain is going up, we are at capacity, there needs to be additional resources if this is ging forward. We also don't want funding for one area at the cost of another. The person has the right to be informed and involved, and decide pathway as collaborative process

**David Torrence – how concerns are you that focus on RR could take away from community services**

Lee Ball – we are concerned, the evidence base for HR is huge, but what's also really important , some people want detox and rehab, and we welcome this, but it should never be at the expense of other things.

Its very difficult, especially when you are homeless, of thinking you can have a life away from drugs, its terrifying. So we need to support broad

Jan Mair – abstinence and harm reduction are not in conflict. Most people in abstinence have had a period of both. And those who have been in Resi rehab going through a decision of controlled drinking/drugs. I welcome the acknowledgement in the bill, but unless we spell out the harm reduction measures, my fear is we will privilege the abstinence based measures. We need them both named in the bill ,it's part of person centred care.

Lee Ball – I think the omission of harm reduction has the potentially to polarise the debate. Everyone has the right to choose their modality. We need to be careful we don't blame

Annemarie Ward – no one tells harm reduction services to watch their tone – when we talk about resi rehab, not to get carried away as if the subject is dangerous. Nothing in this system works for everyone, only RR and detox are treated as radioactive. The bill doesn't take focus away from other pays, gives a legal footing to every treatment.

I won't be softening my tone, civility cannot come at the expense of truth.

**Brian Whittle - Weve heard a lot about being able to coordinate treatment with other needs. Can the bill help with this?**

Graeme Callendar – instils a right to treatment but not anything else, not receiving mental health, counselling, perhaps it's about making amendments, I don't know how this bill will help sort other aspects of people's needs. For many peoples its housing, relationships, it's that they want to deal with that before addiction

Lee Ball – we are having an debate, treatment is a wider thing, its not just a clinical process not just in itself, it needs to be wider.

**Brian Whittle – how will the bill support a longer term recovery?**

Graeme Callendar – simply, it just needs to be in there and it needs to be explicit, if it's not set out, how will it be delivered. It might be a question of how that interacts with other policies.

Lee Ball – so much of what we consider is treatment is counted in the community, there is the potential for that, but needs to be counted.

**Brian Whittle – would you accept that by forcing treatment rights this will force change?**

Jan Mair – it has potential but it would need to be explicit, that follow on support, wraparound support. The post treatment, what is often involves is other parts of system, community housing, employment, it needs to explicit, otherwise money goes into one side and not in others.

Annemarie Ward – the idea money will be removed from one part of treatment into others – it wont happen, people will get the treatment they need. They're worried their branch of treatment will lose money. Surely we should get behind people getting help rather than protecting our own interests.

**Elena Whitham – if we get the totality of someone's journey right, we could then prevent a lot of the harm we see. I'm wondering if this right could realise that at an earlier stage. Could this bill realise that, or not?**

Jan Mair – yes, if this could be in the bill. I don't want to treatment in the bill out of the bill, but what we want as well is those upstream things, someone drinking hazardously, say if someone could get harm reduction much earlier on , it would perhaps mean harms are protected, upstream is important, that's why it feels that there's a lack of harm reduction spelled out here.

Lee Ball – quite often things that are not say are not done. There needs to be an explicit point about working upstream. That's where it all begins, it needs to be done at that point.

**Elena Whitham how do we ensure someone has the support they need upstream?**

Annemarie Ward - of course this bill won't support housing or rebuilt communities and broken benefits – but it will ensure that when they say they're ready it will guarantee any bill deemed appropriate – it doesn't undermine mat, close services, it protects them as a legally provided treatment. It's not about taking options away, it's about people getting to choose what recovery looks like.

Graeme Callendar – as its written it doesn't talk about early intervention and prevention. It speaks about narrow treatment, it doesn't say how it will do early intervention. If it goes forward it needs to be made explicit.

Lee Ball there needs a systemic focus.

**Gillian Mackay – can a I follow up on the potentially limited flexibility of treatment options, it may overly medicalise or standardise treatment pathways. How could it be amended**

Graeme Callendar - we were disappointed to see key bits of the work we do not mentioned. I know there is the catch all phrase at the end, but it's so vague. I think we need to be more specific on what treatments and what combinations are available, that's helpful, people need more than one thing

Lee Ball also about understanding role of community, it's not defined by a specific time, it goes on.

Jan Mair: what we need is a much wider definition of treatment, or a response to problematic drug and alcohol use, so that we are acknowledging the importance of working with people – they might not be ready to make changes but need support

Annemarie Ward – the claims that there is no prevention in the bill misunderstands the bill – it's a health rights bill , focusing on access to treatment because its broken. The problem is when they need help the door is locked, it doesn't cancel prevention, it complements it. Its not flawed because it doesn't try to fix everything. I don't know why people keep referring to housing etc, its outside of the scope if this bill, I'm concerned its deliberate conflation...

**Gillian Mackay – people have said the requirement for in person treatment will place barriers – would the panel support flexibility in the bill to reduce those barriers**

Lee Ball – I worry people would be excluded from this method of treatment. I think we do absolutely need to be as creative as possible and involve people, the staff, families, I agree with that.

Graeme Callendar – needs to be provisions of bill for online, telehealth, our services work in rural areas and in person would be difficult

Annemarie Ward – this isn't true, it doesn't require in person requirement, a qualified healthcare professional must make the assessment, it gives a right treatment not how services must engage

**Sandesh Gulhane – a narrow members bill should not look on the entire journey. Its focusing on people at the ned who say they need medical intervention . Would it help those seeking treatment?**

Graeme Callendar – in your narrow definition, yes. All we can do as service providers is share our experiences. We are advocates for the people we support, everything we have said is that all aspects of treatment are considered, that there are no unintended consequences. We don't want unintended consequences, that's all.

Lee Ball – we believe there is there potential for the bill to do as you suggest, what I do have direct experience of , people will struggle to advocate for themselves, it's one thing to give someone a right, but another for them to be able to use it.

Annemarie Ward – calling it too narrow is saying it just does one job too well. Some people don't like that. It gives a people a right. That's not narrow, that's targeted. We've had strategies that say they deliver everything and do nothing. If the scope of the bill makes people uncomfortable is it finally gives accountability and that's what's being resisted here.

**Sandesh Gulhane – there's discussion about how the bill would create a power imbalance but also that people are not getting the treatment they need. Why do you think the bill would create further power imbalances.**

Lee Ball – the omission of harm reduction, explicitly could fuel reduction harm reduction. Stigma already exists, the idea that this bill would just

Graeme Callendar – people will tell us about the negative experiences they have, mostly within wider services, and the focus of the bill on NHS health services, the concerns come from that you might have right, but those attitudes and treatment might not change.

**Sandesh Gulhane – do you think there is a top down bad attitude that comes from health professionals?**

Lee Ball - yes, we have experienced this.

Graeme Callendar – it varies where you go – there is so much pressure and strain, how could it not be...but yes I've seen some.

Lee Ball there is potential in the bill for them to call it out, but who is going to empower them to challenge.

Annemarie Ward – some people say it would assert the power dynamics – and I say, exactly, it should. Right now they can say no, without any consequences. If someone says a person needs treatment, they cant block it, due to budget, or opinion, or gatekeeping.

Jan Mair: I'd like to pick up on Lee's point – if this Bill has a narrow definition of the options of what are available, that will steer people into what they think they can ask for, and we need advocacy to ensure people can get that broader package

When we talk about Health professional, this could be someone who doesn't have much experience in substance use and does not know what is available. We could use the principles from the self-directed support act. This build in collaboration between health professional and person seeking support, if we could have something like that, it would help;

**Paul Sweeney – I want to turn to issues of timescales and treatment availability within 3 weeks. There have been some queries on this timescale. Do they think the requirement allows sufficient flexibility for preparatory steps etc, or would that fall within the 3 weeks?**

Annemarie Ward – the fact people are quibbling over 3 weeks maximum just shows that there is no timescale at all – people can wait a long time and there's no accountability. It says you can't be left beyond that. If its delayed beyond three weeks they get a route to challenge. It's a legal safeguard not a clinical prescription. The MAT standards same day prescribing, who is getting that, our clients haven't heard of it, never mind accessing it. Lets not pretend we are meeting tighter deadlines already.

**Paul Sweeney – is there a way to actually define the three week period adequately, i.e. the need to do preparatory work, can we define that, if people are in that period, that it includes this period?**

Annemarie Ward – Absolutely, if we can't offer a treatment plan in 3 weeks, what are we doing. Its been resisted because it holds people accountable for delays. Some people never get treatment at all.

**Paul Sweeney could the drafting be tightened a bit?**

Graeme Callendar – the 3 week target has been in for as long as I've been in the sector – there are fundamental challenge in how that is being delivered. I think it is the bare minimum, and I think that's maybe not what was explained fully in the Bill, sometimes it can be delivered in same day. I think its important to be reflected in Bill. Sometimes there are waiting lists, unless we have a huge increase of capacity, I don't know how we get round that. The most important thing is that people see someone, and treatment begins, irrespective of what that is. Its good there is a timescale, but its been a well known timescale for a long time.

Jan Mair: a 3 week wait for RR , its appropriate and we welcome that, but for some, its needed immediately, we wouldn't want the three weeks to become a barrier, and wondered if this could become more nuanced and making it clearer for different types of treatment. I.e. could we have a legal requirement in this Bill for MAT to be at same day? That's what we are looking for.

Lee Ball – we need to ensure that same day treatment isn't deprioritised as the result of another timescale coming in. we also need to consider what constitutes treatment

– it always starts from the get to, defined by the relationship you develop when you walk in the door, the relationship with worker. We need preparatory work, some need to go straight to detox, it needs to clear what defines treatment, that needs to be clearly spelled out.

### **Paul Sweeney – Would that signal the demand and standards needed?**

Jan Mair: Need to avoid issues with treatment target

Annemarie Ward: three week maximum not barrier. People are being left for years with no progress. It is a safety net not a waiting period. Deadline not a delay...

Lee Ball: three week time limit if we don't resource correctly it will put pressure on frontline staff. It needs to be resourced

### **Paul Sweeney: Is the content of the Bill suitably flexible?**

Graeme Callendar: change in types of substance use, more poly substance use. Make sure that people can be fully supported even if not alcohol or opiates.

Lee Ball: not always a medical route to support, need psychosocial support to be explicit in Bill

Jan Mair: echo that. Careful distinction of treatment needs as means different things to different people.

Lee Ball: stabilisation understood in different ways, Bill policy memo states it is with aim to reduce use, this is not always what people want or understand it to be

Annemarie Ward: happy for definition to be made in the Bill

### **Paul Sweeney: financial memo: are costs appropriate?**

Graeme Callendar: welcome consideration of financial support, not clear if it is accurate, Need to make sure money is enough.

Lee Ball: is we don't pay now we will pay later elsewhere. Also need to take account of the work that third sector do

Annemarie Ward: people are dying. Bill is not demanding new treatments. Just establishing rights. It will force the money to follow the need. Scrutiny is not done for other things that are being funded like MAT Standards and third sector orgs.

**Claire Haughey (Convenor): the requirement for in person meeting is in section 2.1(d) in the Bill. Sure member in charge will reflect in that when gives own evidence.**

**From:** [Redacted-Section 38(1)(b)]@gov.scot> **On Behalf Of** Cabinet Secretary for Health & Social Care 2024

**Sent:** 14 May 2025 09:26

**To:** [Redacted-Section 38(1)(b)]@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; Jennie Gollan <Jennie.Gollan@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Subject:** RE: Invitation to give evidence to Health, Social Care and Sport Committee - 20th May

Hi [Redacted-Section 38(1)(b)]

The Committee have confirmed they can accommodate the time change to 12:00 – grateful if you can confirm the names (and titles) of supporting officials for this meeting during the course of today and I'll share with the Committee.

Many thanks

**[Redacted-Section 38(1)(b)]**

Deputy Private Secretary to the Cabinet Secretary for Health and Social Care – Neil Gray MSP

Scottish Government | St Andrew's House, Regent Road, Edinburgh EH1 3DG |

Mob: 07[Redacted-Section 38(1)(b)] | Email: CabSecHSC@gov.scot

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[Redacted-out of scope information]  
[Redacted-out of scope information]

**From:** [Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 14 May 2025 12:27

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: Urgent action required: Drugs FMQ - Update due 3pm

Hi [Redacted-Section 38(1)(b)]

I've also updated the R2R lines

Thanks

[Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)]

**Sent:** 14 May 2025 12:15

**To:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]

**Cc:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]

**Subject:** RE: Urgent action required: Drugs FMQ - Update due 3pm

Hi [Redacted-Section 38(1)(b)],

With thanks to [Redacted-Section 38(1)(b)] as well, I can confirm we've updated the FMQ to cover the media stories.

Thanks,

[REDACTED-SECTION 38(1)(B)]

**[Redacted-Section 38(1)(b)] I Drugs Policy Division I Scottish Government I 3 E  
St Andrews House I Regent Road I Edinburgh I EH1 3DG**

**From:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 14 May 2025 11:06

**To:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)]@gov.scot[Redacted-Section

38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** Urgent action required: Drugs FMQ - Update due 3pm

**Importance:** High

Good morning all

Please see the below ask from the FMQ teams **[Redacted-out of scope information]**

Info is also requested on committee yesterday and the evidence given regarding the right to recovery bill

If you could add to the doc linked below by **1400 today** to allow time for clearance.

'Drugs Policy FMQ - 15 May 2025 - VERSION TO EDIT' -

[https://erdm.scotland.gov.uk/documents/\[REDACTED-SECTION 30\(C\)\]/details](https://erdm.scotland.gov.uk/documents/[REDACTED-SECTION 30(C)]/details)

Thank you all

**[Redacted-Section 38(1)(b)] I Policy Officer I Mission Support Team I Drugs Policy Division I Scottish Government I 5 Atlantic Quay I 150 Broomielaw I Glasgow I G2 8LU**

**From:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 14 May 2025 10:53

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]

<[Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy

<Deputydirectordrugspolicy@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]

<[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section

38(1)(b)]@gov.scot>; First Minister FMQs <FirstMinisterFMQs@gov.scot>; PQ/FMQ

Team <pq/fmqteam@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section

38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section

38(1)(b)]@gov.scot>

**Subject:** Drugs FMQ - Update due 3pm

**Importance:** High

Hello

Thank you for this week's brief for FMQs. Overall the brief is looking good, just a couple of quick asks

- **[Redacted-out of scope information]**
- Can we also get some information on committee yesterday and the evidence given regarding the right to recovery bill
- **[Redacted-out of scope information]**

Can we get an updated brief back by 3pm today please. Happy to discuss on teams as useful

**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**  
**[Redacted-out of scope information]**

Thanks

**[Redacted-Section 38(1)(b)]**

**[Redacted-Section 38(1)(b)]** | She/Her | Senior First Minister's Questions Officer,  
Scottish Government | 4th Floor, St Andrew's House | 07**[Redacted-Section 38(1)(b)]**

----- Preparing First Minister's Questions (FMQs) (sharepoint.com)-----  
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**From:** [Redacted-Section 38(1)(b)]

**Sent:** 14 May 2025 17:40

**To:** Jennie Gollan <Jennie.Gollan@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** FW: Briefing pack

Hi Jennie

PO advised that CS would like to have a hard copy of this by COP tomorrow, with your sigh off.

Could you have a look at the opening remarks (main priority), and the Q&A in the briefing from pages 46 – 60 (if you have a chance) and get back to us tomorrow afternoon (3-4pm?) with any comments so we can make any changes and get it to PO before CS leaves for the day?

Many thanks

[Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)]

**Sent:** 14 May 2025 15:20

**To:** Cabinet Secretary for Health & Social Care 2024 ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; Laura Zeballos ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 30(c)]

**Subject:** RE: Briefing pack

Hi [Redacted-Section 38(1)(b)]

Please see attached briefing pack, also attached is formatted opening remarks and letter from Douglas Ross to FPAC. Please note that hot topics and Q&A will be updated again to reflect any changes between now and committee day also including any feedback from CS.

I will send erdm links separately, I'm having tech issues with it at the moment!

Many thanks

[Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot> **On Behalf Of** Cabinet Secretary for Health & Social Care 2024

**Sent:** 14 May 2025 13:51

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>; Laura

Zeballos <Laura.Zeballos@gov.scot>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**@gov.scot>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**@gov.scot>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**@gov.scot>; **[Redacted-Section 30(c)]** <**[Redacted-Section 30(c)]**@gov.scot>

**Subject:** RE: Briefing pack

Apologies the document was not attached.

Thanks,

**[Redacted-Section 38(1)(b)]**

**[Redacted-Section 38(1)(b)]**  
**Assistant Private Secretary**

Office of Cabinet Secretary for Health and Social Care, Neil Gray MSP  
The Scottish Government, St Andrews House, Regent Road, Edinburgh, EH1 3DG  
E-mail: cabsechsc@gov.scot

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**From:** **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**@gov.scot> **On Behalf Of** Cabinet Secretary for Health & Social Care 2024

**Sent:** 14 May 2025 13:51

**To:** **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**; **[Redacted-Section 38(1)(b)]**; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**@gov.scot>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**@gov.scot>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**@gov.scot>; Laura Zeballos <Laura.Zeballos@gov.scot>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**@gov.scot>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**@gov.scot>; **[Redacted-Section 38(1)(b)]** <**[Redacted-Section 38(1)(b)]**@gov.scot>; **[Redacted-Section 30(c)]** <**[Redacted-Section 30(c)]**@gov.scot>

**Cc:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Subject:** RE: Briefing pack

Copying in other colleagues.

Can we please have this brief finalised and sent over to PO by **15:00** at the latest.

Many Thanks,

**[Redacted-Section 38(1)(b)]**

**[Redacted-Section 38(1)(b)]**  
**Assistant Private Secretary**

Office of Cabinet Secretary for Health and Social Care, Neil Gray MSP

The Scottish Government, St Andrews House, Regent Road, Edinburgh, EH1 3DG  
E-mail: cabsechsc@gov.scot

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**From:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 14 May 2025 11:39

**To:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Cc:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Subject:** Briefing pack

Here you are.

**[REDACTED-SECTION 38(1)(B)]**

Whole Systems Unit Head  
Drug Policy Division  
Directorate of Population Health  
Scottish Government

**From:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>

**Sent:** 14 May 2025 18:11

**To:** [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: Briefing pack

[Redacted-Section 38(1)(b)] – as promised, coming back with minor comments on material for committee next week. In that vein speech attached with minor suggestions; pack to follow. Apologies but I could not access the link in the chat.

For wider benefit next steps as follows:

- PO confirming to clerks re official support this evening
- PO looking for Jennie to review the speech and, if possible, the QnA – to confirm content with overall tone and approach that is suggested. [Redacted-Section 38(1)(b)] you have already emailed Jennie with that ask
- We've a bit of time for final review of/updates to pack – I'll come back before I go re a few points where additional info would be helpful – grateful if teams could input in light of that and [Redacted-Section 38(1)(b)] will coordinate overall
- Final clearance – [Redacted-Section 30(c)] however we'll want to be comfortable that all material/figs etc are up to date (On that [Redacted-Section 38(1)(b)] – analysts likely will want sight of any new material)
- Confirmation expected from committee re key themes for Tuesday's session
- Finally, bit of formatting etc and signposting to content

Thanks for input to this so far and in anticipation of action through tomorrow

Laura

Laura Zeballos

Deputy Director – Drugs Policy  
Population Health Directorate  
07[Redacted-Section 38(1)(b)]

[Redacted-Section 36(1)]  
[Redacted-Section 36(1)]  
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[Redacted-Section 36(1)]  
[Redacted-Section 36(1)]  
[Redacted-Section 36(1)]  
[Redacted-Section 36(1)]

[Redacted-out of scope information]





**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 15 May 2025 16:01  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: ADP Co-Ord Survey

Thanks [Redacted-Section 38(1)(b)]

I think we also lost quite a bit to a too many cooks and accidental deletions situation. And not all of it was tracked.

I will go on a bear hunt...

**From:** [Redacted-Section 38(1)(b)]  
**Sent:** 15 May 2025 15:59  
**To:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]  
**Cc:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]  
**Subject:** RE: ADP Co-Ord Survey

Hiya [Redacted-Section 38(1)(b)],

I think we had something in the briefing pack on this (in the section starting p21), but it didn't survive the hasty hatchet yesterday...

I didn't know where it had come from. It didn't come from us. When I looked at it last thu/fri, the only stuff there was Survey background and Workforce responses to it. I then added and tidied Top Lines to talk about Governance/PDF aspects. Yesterday, I shoved in the screeds on ADP responses to the Bill and some (woeful) headline background.

It might have been Analysts (copied) who added the original material in, or it might have been [Redacted-Section 38(1)(b)] (copied), but I've not got a copy of what existed in that space before it was tracked-out I'm afraid.

Sorry I can't be more help.

Cheers,

[Redacted-Section 38(1)(b)]

*Alcohol and Drugs Partnerships Support Team*

*Pronouns: He/Him | Working Pattern: Tue-Fri | Drugs Policy Division | Working Pattern: Tue-Fri | Directorate for Population Health | Scottish Government | 1<sup>st</sup> Floor (Rear), St Andrew's House, Regent Road, Edinburgh, EH1 3DG | T: 0131 24[Redacted-Section 38(1)(b)] M: 07[Redacted-Section 38(1)(b)] | E: [Redacted-Section 38(1)(b)]@gov.scot | W: www.gov.scot*

*Please note that whilst you may have received this email from me outwith normal working hours, unless otherwise clearly stated, there is no expectation that you should respond immediately. I am conscious that your chosen flexible working hours may not match my own.*

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 15 May 2025 15:33  
**To:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** ADP Co-Ord Survey

Hi all

Laura was asking for some additional lines for herself regarding the ADP co-ordinators survey, particularly around them being critical of governance? Could you share something by Monday morning for me to add to her additional info pack for supporting Cab Sec at the committee evidence session for R2R next week?

Many thanks  
[Redacted-Section 38(1)(b)]

[Redacted-Section 38(1)(b)] | Drugs Policy | Health & Social Care Directorate | Scottish Government

Email: [Redacted-Section 38(1)(b)]@gov.scot  
Pronouns she/her



**From:** [Redacted-Section 38(1)(b)]

**Sent:** 15 May 2025 16:32

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;

[Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>;

Jennie Gollan <Jennie.Gollan@gov.scot>; Spads Admin <Spads\_Admin@gov.scot>

**Subject:** Briefing for HSCS Committee Evidence Session on Right to Recovery (Scotland) Bill 20 May 2025

PO/Cabinet Secretary

Please find attached a briefing for the HSCS Committee Evidence Session on Tuesday 20 May

Opening remarks will be shared once cleared with SpAds.

An agenda, and any details on likely themes of questioning will be shared once received from committee clerks.

If you require any additional information please get in touch.

Many thanks

[Redacted-Section 38(1)(b)]

Draft 2 - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary details - Objective

[Redacted-Section 38(1)(b)] | Drugs Policy | Health & Social Care Directorate | Scottish Government

Email: [Redacted-Section 38(1)(b)]@gov.scot

Pronouns she/her





**From:** [Redacted-Section 38(1)(b)]

**Sent:** 15 May 2025 17:41

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 30(c)] <[Redacted-Section 30(c)]@gov.scot>; [Redacted-

Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-

Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section

38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section

38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section

38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>; Jennie Gollan

<Jennie.Gollan@gov.scot>; Spads Admin <Spads\_Admin@gov.scot>

**Subject:** RE: Briefing for HSCS Committee Evidence Session on Right to Recovery (Scotland) Bill 20 May 2025

**Importance:** High

Please find attached opening remarks.

Drug and Alcohol Policy - Right to Recovery Bill - Cab Sec Evidence to lead Committee - Opening remarks ([Redacted-Section 30(c)])

If you could provide hard copies of this and previous attachments to Cab Sec for this evening that would be appreciated.

Many thanks

[Redacted-Section 38(1)(b)]

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-out of scope information]



**From:** Health, Social Care and Sport <HSCS.committee@Parliament.Scot>  
**Sent:** 15 May 2025 17:15  
**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>  
**Cc:** Health, Social Care and Sport <HSCS.committee@Parliament.Scot>  
**Subject:** PUBLIC PAPERS: Health, Social Care and Sport Committee meeting – Tuesday 20 May 2025

Good afternoon,

Please find enclosed the link to the public papers for next week's Health, Social Care and Sport Committee meeting, which has been confirmed for a **10:40am** start in public on Tuesday 20 May 2025: Health, Social Care and Sport Committee 15th Meeting, 2025 | Scottish Parliament Website

Your evidence session is the 4<sup>th</sup> item on the agenda, and we expect your session to start at **12:00pm**.

The intended themes to be discussed during your session are as follows:

- Theme 1 – Duty to secure delivery of the rights established by the Bill
- Theme 2 – Charter of rights for people affected by substance use
- Theme 3 – Enforcement of rights
- Theme 4 – National service specification for substance use support services
- Theme 5 – Multi-disciplinary team
- Theme 6 – Clinical decision making and the need for a diagnosis
- Theme 7 – Reporting requirements
- Theme 8 – Estimation of levels of substance dependence and financial implications

**The meeting will be held in Committee Room 3 of the Scottish Parliament, please arrive by 11:50am.**

Please do let me know if you require any further information in advance of Tuesday.

Kind regards,  
**[Redacted-Section 38(b)(1)]** (she/her)  
Committee Assistant  
Health, Social Care and Sport Committee

\*\*\*\*\*

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**From:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Sent:** 16 May 2025 14:02  
**To:** [Redacted-Section 38(b)(1)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>  
**Cc:** [Redacted-Section 38(b)(1)]@gov.scot>; [Redacted-Section 38(b)(1)] <[Redacted-Section 38(b)(1)]@gov.scot>  
**Subject:** RE: Amended speech

Thanks – see suggestions in attached – one section to add a few words and one new suggested para I'd be grateful if you could review.

Tx

L

Laura Zeballos

Deputy Director – Drugs Policy  
Population Health Directorate  
07[Redacted-Section 38(b)(1)]

**From:** [Redacted-Section 38(b)(1)]  
**Sent:** 16 May 2025 13:18  
**To:** Deputy Director - Drugs Policy  
**Cc:** [Redacted-Section 38(b)(1)] ; [Redacted-Section 38(b)(1)]  
**Subject:** Amended speech

Hi Laura

I have amended the speech, and attached as word document if you want to cast your eye on it before it goes up.

**[Redacted-Section 38(b)(1)] | Drugs Policy | Health & Social Care Directorate | Scottish Government**

Email: [Redacted-Section 38(b)(1)]@gov.scot  
Pronouns she/her



**From:** [Redacted-Section 38(b)(1)]@gov.scot>

**Sent:** 16 May 2025 14:53

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot> [Redacted-Section 38(b)(1)] <[Redacted-Section 38(b)(1)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 38(b)(1)] <[Redacted-Section 38(b)(1)]@gov.scot>; [Redacted-Section 38(b)(1)] <[Redacted-Section 38(b)(1)]@gov.scot>; [Redacted-Section 38(b)(1)] <[Redacted-Section 38(b)(1)]@gov.scot>; [Redacted-Section 38(b)(1)] <[Redacted-Section 38(b)(1)]@gov.scot>; [Redacted-Section 38(b)(1)] <[Redacted-Section 38(b)(1)]@gov.scot>; [Redacted-Section 38(b)(1)] <[Redacted-Section 38(b)(1)]@gov.scot>; Jennie Gollan <Jennie.Gollan@gov.scot>; Spads Admin <Spads\_Admin@gov.scot>

**Subject:** RE: Briefing for HSCS Committee Evidence Session on Right to Recovery (Scotland) Bill 20 May 2025

PO/Cabinet Secretary

Please see attached:

- Updated briefing pack per email below and pre-meet this morning
- Updated opening remarks per pre-meet this morning. (please note due to timings that the amendments have not been cleared by SpAds. **Jennie** if you could do this and let me know if any amendments need to be made on Monday?)
- Letter from Douglas Ross to FPAC responding to questions raised in evidence session
- Summary of third sector evidence session 13 May

Many thanks

[Redacted-Section 38(b)(1)]

Draft 2 - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary  
[Redacted-Section 30(c)]

Drug and Alcohol Policy - Right to Recovery Bill - Cab Sec Evidence to lead  
Committee - Opening remarks [Redacted-Section 30(c)]

Drug and Alcohol Policy - Stage 1 - Right to Addiction Recovery - 3rd oral evidence  
session with stakeholders - 13th May 2025 [Redacted-Section 30(c)]

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-out of scope information]

[Redacted-out of scope information]

**RIGHT TO ADDICTION RECOVERY (SCOTLAND) BILL – HEALTH, SOCIAL CARE AND SPORT COMMITTEE EVIDENCE SESSION**

<b><i>Date and Time of Committee Appearance</i></b>	20 May 2025, 12:00 – 13:00
<b><i>Where</i></b>	Scottish Parliament, Room TBC
<b><i>Purpose of Evidence session</i></b>	To express the Government’s position on the Right to Addiction Recovery Bill (Scotland) Bill.
<b><i>Official Support Required</i></b>	Laura Zeballos, Deputy Director – Drugs Policy Morven Davidson - SGLD
<b><i>Comms Support/Media handling.</i></b>	None – officials will prepare reactive lines in case of media queries.

## Briefing Contents

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<b>Annex B</b>	<i>Speaking note/opening remarks – (approx 3 mins max)</i> Attached as a separate word document	
<b>Annex C</b>	<i>Contents Page – all pages to be numbered</i>	<i>p 6</i>
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<b>Annex F</b>	Q&A <span style="float: right;"><i>p 74</i></span> (based on likely questions from committee)
<b>Annex G</b>	<b>Douglas Ross letter to Finance and Public Administration Committee with repose to questions on financial memorandum</b>
<b>Annex H</b>	<b>Memorandum to Committee December 2024</b>

## **Annex A – Committee Session Agenda**

1. Decision on taking business in private
2. Employment Rights Bill (UK Parliament legislation)
3. Subordinate legislation
- 4. Right to Addiction Recovery (Scotland) Bill**
5. Employment Rights Bill (UK Parliament legislation)
6. Right to Addiction Recovery (Scotland) Bill (in private)

**Annex B – Speaking Note / Opening Remarks**

**Attached separately**

## Annex C –

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## ANNEX D

### Summary page – Right to Addiction Recovery Bill

#### Hot Topics:

- The need for a clinical diagnosis and treatment determination by a medical professional.
- The absence of a person centered, multi-disciplinary approach – there is undue emphasis on abstinence-based treatments.
- The interaction of/lack thereof of interaction with existing commitments, such as the Charter of Rights and the MAT standards.
- Human Rights – the delay of the Human Rights Bill and whether this would act as an interim measure to implement rights for people who use drugs
- How rights are ensured by the Bill e.g Accountability – who would be accountable for failure to deliver the measures committed to in the Bill
- Financial feasibility of the bill

In line with the **[Redacted-Section 30(b)(i)]**

#### Key Points

#### **We support the stated outcomes this Bill seeks to achieve and welcome the committee's scrutiny.**

- Every life lost is a tragedy, and we must never become numb to the impacts of the drug and alcohol related death statistics. I do not take the responsibility of overseeing the government's response to this lightly.
- As set out in the Government's response to the Committee's call for evidence, the Government is supportive of the ambitions of the Bill. It is important that we do all we can to tackle the harms caused by alcohol and drugs, and a rights based, person centred approach to providing support is key. We would note some areas of concern including how the Bill would operate in practice, the impact on existing services, and whether the additional costs as estimated in the financial memorandum are accurate.
- We look forward to engaging with the Stage one process and will consider the evidence gathered carefully.
- We support the stated outcomes of the Bill - indeed our existing approach to tackling the harms caused by alcohol and drugs, including through the £250m National Mission commitments, works to get people into the treatment and recovery that is right for them, while also supporting them to address other social and economic needs.
- The Charter of Rights, launched last year by the National Collaborative, is a guide to adopting a Human-Rights Based Approach. It enables individuals to understand and realise their rights and supports public bodies to adopt a human rights based approach to decision making.

- This was developed through extensive consultation with people affected by substance use and with people responsible for design, delivery and monitoring of substance related support services.
- We are committed to embedding this in our work and engaging with partners across the drug and alcohol sector to support them.
- The Charter has received international acclaim including from the UN High Commissioner for Human Rights as an excellent example of embedding a human rights-based approach into drug policy
- The National Mission is due to come to an end in early 2026. We are currently **developing a refreshed strategic approach that responds to the alcohol and drug crisis with equal weighting**. This approach is being developed with key stakeholders from both alcohol and drug sectors, as well as lived and living experience.
- The National Mission on Drugs has made progress, but deaths and harms from alcohol and drugs remain too high and the Scottish Government is committed to retaining focus.
- We are committed to following an evidence-based approach to support those affected by substance use, and we have been listening to the views of experts, including those with lived and living experience and their families, in the committee's scrutiny of the Bill.
- It is vital that we continue to listen to the voices of those closest to the issue.
- From stakeholder reactions there are several concerns that have not been addressed by the Bill as introduced and we look forward to the lead committee's assessment of the evidence submitted.

### **Overview of the Bill**

- The Bill creates a 'right' for individuals with a diagnosis of "addiction" to alcohol or drugs to (1) receive a treatment determination carried out by a relevant Health Professional and; (2) be provided with the treatment which has been determined as appropriate by the Health Professional within 3 weeks;
- Section 1(5) sets out several treatment options which may be provided to individuals. This includes, but is not limited to residential rehabilitation, community-based rehabilitation, residential or community-based detoxification, stabilisation services, substitute prescribing services or any other treatment which the relevant health professional deems appropriate.
- Section 2 sets out procedures for determining the appropriate treatment. It provides that a patient may request any of the treatments listed in Section 1(5) and the health professional is duty bound to consider the appropriateness of each treatment option. In terms of section 3, treatment may not be refused on the grounds of cost, ongoing criminal proceedings, medical history of mental illness, ongoing alcohol or substance use. The only permitted ground for refusal is an assessment by a health professional of the best interests of the patient.
- Section 2 imposes further duties on Health Professionals when making a treatment determination. These include explaining each of the treatment options listed in section 1(5); ensuring that the individual is involved in decision-making; having an in-person meeting before a determination is made; providing a written explanation

and access to a second opinion when decisions go against the individuals' preference;

- Section 3(1) Requires that treatment is made available within three weeks of the appropriate treatment being determined;
- Section 4 confers a duty on Scottish Ministers to secure delivery of the rights required by the Bill. Scottish Ministers may confer functions on other bodies, such as Health Boards, local authorities, and joint integration boards and the bill provides that Scottish Ministers must produce a code of practice in relation to this discharge of those duties by those bodies. Ministers are also required publish and lay before Parliament an annual report setting out several statistical matters in connection with the provision of treatment.

### **Scottish Government's Position**

- Scottish Government has **[Redacted-Section 30(b)(ii)]** the Bill. Whilst supportive of the ambitions and the principle of people having access to appropriate and high quality treatment, the government has highlighted potential concerns. These are laid out in the memorandum to the committee (Annex H).
- Evidence provided during the stage 1 process has echoed those concerns, but also goes much further and has in many cases been explicitly critical of the Bill itself or the need to legislate in this area in general.
- **[Redacted-Section 30(b)(ii)] [Redacted-Section 30(b)(i)]**
- During the evidence sessions there has been a focus on understanding costs of the Bill, how the Bill could be enforced, and how accountability would work, as well as how the Bill aligns with existing policy and practice, and its impact on the workforce.
- Questions have also arisen around the process for determining the appropriate treatment for individuals, as well as the effect and appropriateness of legislating for additional rights for a particular group.
- **[Redacted-Section 30(b)(ii)]** support and treatment for people affected by substance use.
- The Scottish Government's position is that the bill is likely to be within legislative competence as the provisions in the bill relate to health.

## **Calls for Evidence**

### **HSCS Committee**

- A written call for views by the Health, Social Care and Sport Committee concluded in December 2024, and oral evidence sessions have been held between March and May 2025.

### **Stakeholder Views.**

**There were 122 written responses received by the deadline. Of these, 41% of responses (50) were from organisations, including health boards, third sector organisations, ADPs and Royal Colleges.**

- Most respondents (74%) said they strongly agreed with or agreed with the purpose and extent of the Bill.
- However, the majority of those in support of the Bill were individuals. Only 15 of the 78 respondents who agreed with the Bill represented organisations. Most organisations said they disagreed with the extent and purpose of the Bill.
- **[Redacted-Section 30(b)(ii)], [Redacted-Section 30(b)(ii)]**. Several third sector partners also reflected the views of their service users ensuring that the views of living experience were captured.
- Positive aspects highlighted by those in favour of the Bill included that it purportedly:
  - gives rights to people in need and offers redress if rights are not met by holding services and government to account,
  - will reduce stigma,
  - will empower individuals and ensure their voices will be heard,
  - will make residential rehab an option for everyone who wants it and that it will guarantee access to treatment in a short period of time.

**The risks and disadvantages of the Bill highlighted by those who were not in favour can be summarised as:**

- a lack of understanding of the treatment and support practices that involve partnership working across multiple services,
- lack of clarity on how resources will be managed given that health and social care budgets are finite and allocation is based on a consideration of the needs of all services (beyond drugs and alcohol),
- focuses on a medicalised model of treatment that does not consider the totality of evidence-based support that may be required,
- the need for a clinical diagnosis of addiction which will exclude many people,
- lack of clarity on recourse if rights are not met,
- that it will not, in practice, increase the rights of individuals,
- potential for increase in stigma,
- emphasis on abstinence with no clear reference to harm reduction,

- Provide rights to one group of patients which are not available to others,
- Residential rehab providers Abbeycare, Aberlour, Alternatives Safe As Houses Residential Recovery Project, Harbour Ayrshire, Jericho Society, Phoenix Futures, are broadly supportive of the Bill's purpose and extent, and raised positives including securing access to treatment for everyone and making access to that treatment a right in law, and in purportedly driving consistency on the standard of support available and empowering individuals by involving them in decisions about their treatment.
- Other organisations which were expressly in support of the Bill are Church of Scotland, Evangelical Alliance Scotland, Carer's Trust Scotland, Change Grow Live, Dumfries and Galloway Council, Scottish Women's Convention and Salvation Army.

## Oral Evidence Sessions

### Evidence Themes

#### **The Committee asked questions on a range of issues, but there has been a particular focus on the feasibility of the bill and the following areas:**

- if and how enforcement and accountability works;
- whether the Bill can be integrated/aligns with existing policy and practice, and what the consequences of this could be, i.e. MAT Standards, Charter of Rights;
- the Bill's relationship to human rights legislation, particularly considering the sensitivities surrounding the delay of the Human Rights Bill;
- how the Bill could impact the workforce;
- whether it is helpful to require a diagnosis, and if it is desirable to legislate specifically on how health professionals determine appropriate treatment (the 'treatment determination') - which would represent a significant departure from the existing multidisciplinary approach;
- if it is desirable to legislate on a 'right' to treatment for a particular group;
- the method in which treatment is determined;
- if treatment as defined in the Bill is broad enough, and if concept of treatment in the bill includes harm reduction;
- The cost of the Bill, how cost was calculated and how demand for treatment was estimated, whether this was reasonable, if savings could be realised through the Bill;
- how the bill can adapt to changing drug landscape (polysubstance use, vaping);
- if establishing a right in legislation could improve outcomes and;
- Why deaths continue to be high.

#### **Responses have focused on similar themes to the concerns expressed above and in addition:**

- What the precise definition of addiction is and how this should be worded within the Bill.
- The requirement for a formal diagnosis to access the rights in the bill and if this would present a barrier/deterrent to those coming forward for treatment.
- The costs of funding increased legal aid for those who may seek to enforce their rights under the bill, the potential costs of Boards/Scottish Ministers defending increased litigation, and the overall impact on budgets.
- If having a statutory right to treatment is appropriate or necessary – and is singling out substance addiction the right approach
- How would accountability and enforcement would work - who is accountable for failure to comply with legislative requirements.
- Questions on the impact on the workforce; concern over additional pressures from statutory requirements on an already pressured system, members asking if potential long-term benefits of the Bill would not be a positive thing for workforce.
- Need for harm reduction to be included – Bill is not explicit enough about this.

- Is the system **[Redacted-Section 30(b)(ii)]** what the Bill is setting out – **[Redacted-Section 30(b)(ii)]** would **[Redacted-Section 30(b)(ii)]**
- Financial implications, **[Redacted-Section 30(b)(ii)]** to deliver Bill and **[Redacted-Section 30(b)(ii)]** **[Redacted-Section 30(b)(ii)]**.
- Third sector and people with living experience are **[Redacted-Section 30(b)(ii)]**

**To note:**

- Panel members **[Redacted-Section 30(b)(ii)]** – responses **[Redacted-Section 30(b)(ii)]**, **[Redacted-Section 30(b)(ii)]** on what **[Redacted-Section 30(b)(ii)]** **[Redacted-Section 30(b)(ii)]**
- **[Redacted-Section 30(b)(ii)]**.
- Many of the panel **[Redacted-Section 30(b)(ii)]**

**Sensitivities**

Annemarie Ward (AMW) of FAVOR gave evidence to the committee on 13 May 2025.

AMW is highly critical of the Scottish Government in drug and alcohol policy, including money invested in harm reduction (Thistle) and non-legislative interventions (MAT Standards, Charter of Rights).

AMW co-drafted the initial policy intent for the Right to Recovery Bill and proposed it to all parties. Douglas Ross took it on and presented as a Member's Bill.

**[Redacted-Section 30(b)(ii)]**. Input included:

- Opposition to the Bill is rooted in government funded organisations wishing to maintain the status quo out of fear that it will shift power away from them
- FAVOR offered engagement on the Bill with stakeholders, including development of a myth busting document. Other organisations have chosen not to engage with them.
- The treatments offered in the Bill are not narrow and define the treatment that exists in NHS Scotland and encompass any services or combination or services available to individuals for drug and alcohol addiction under the NHS.
- All healthcare starts with a diagnosis, the evidence regarding the bill creating increased stigma isn't valid
- The Bill doesn't take focus away from other forms of support, it gives a legal footing to every treatment
- Concerns about redirection of resource to meet the legislative requirements of the Bill are inaccurate and reflective of services being concerned that their branch of treatment will lose money
- The Bill is a health rights bill, and the focus on things like the need for more prevention etc. are potentially a deliberate conflation
- There is nothing in the Bill about requiring in person attendance (this is factually incorrect, it is section 2.1(d))

There is the **[Redacted-Section 30(b)(ii)]**.

**[Redacted-Section 30(b)(ii)]**

## HSCSC evidence session attendees

Policy analysis of the evidence given and based on officials assessment of current landscape is given in Annex C. The following table shows how the views of the stakeholders who have given evidence so far broadly align with the key themes covered in the analysis.

Who	Broad themes of comments	Key quotes
<p>Scottish Human Rights Commission Eleanor Deeming</p>	<p>Support intentions of the Bill Provisions of the bill support state compliance with human rights, particularly Article 2 ECHR (right to life) and international human rights obligations, such as Article 12 ICESCR (right to the highest attainable standard of health) Charter of Rights is a way to support people Accountability needs strengthened</p>	<p><i>the national collaborative charter draws on international guidelines on human rights and drug policy. It is intended to provide a guide to adopting a human rights-based approach in more general terms. The bill focuses on the time limits and the time standards for treatment, but the national collaborative’s work on a human rights-based approach to substance use goes wider. Obviously, it focuses on access to treatment, but it also sets out human rights around other things, such as freedom from arbitrary arrest or detention and the right to a private and family life. The human rights framework also goes into the rights of the families of people who are experiencing substance use.</i></p> <p><i>On justice and accountability, one of the areas where the bill could be strengthened is the accountability gap. It is silent on how people who seek treatment can challenge decisions and access justice if they do not receive treatment in line with the obligations in the bill or the wider human rights obligations in the area.</i></p>
<p>Public Health Scotland Dr Taea Shivaji</p>	<p>Support intentions of the Bill Would not add to what is already happening Narrow treatment options How will it align with MAT Standards – there are areas of tension</p>	<p><i>Although we, in Public Health Scotland, agree with the vision, the ambition and the principles that underpin the proposed legislation, we are concerned about whether it would deliver a difference on the ground. There is also the risk of unintended consequences, and we welcome the opportunity to explore that today.</i></p> <p><i>A final consideration would be to think about how treatment options reflect a pathway to recovery rather than a single intervention. For example, alcohol detoxification could be considered as a treatment option. Someone who is dependent on alcohol would engage with a medical service to clear alcohol from their body, and that would be</i></p>

	<p>Treatment is not a single intervention/recovery is not linear</p> <p>Resource is not available</p> <p>Focus on compliance over supporting people</p> <p>Risk to other services due to need to meet legislative requirements</p> <p>Workforce pressure</p>	<p><i>supervised to ensure that they did not have seizures or experience other complications. They would then require on-going treatment to address the root causes of their alcohol dependency. If that support was not provided, there would be a risk of relapse and complications. We need to consider how we can ensure continuity of care and the expectation of continuity of care within the treatment options that are offered</i></p> <p><i>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 therefore need to provide services in a way that is accessible to those people and that responds to those concerns.</i></p> <p><i>on whether there is a danger of a focus on compliance restricting treatment options, I think that one of our key considerations is the need for adequate resource in the system to be able to offer high-quality treatment. From all the work that we have done, that is what people who work in the system want to offer, but it requires adequate resourcing and a supported workforce. If there is a legal expectation of a right to certain types of treatment, but inability to provide such treatment due to inadequate resourcing, the risk is that it will not only demoralise the public and result in trust being lost in what we are providing, but demoralise our workforce, too..</i></p>
<p>Law Society of Scotland</p> <p>Hilary Steele</p>	<p>Narrow treatment options</p> <p>Resource is not available</p> <p>Need for diagnosis is exclusionary</p> <p>Risk to other services due to need to meet legislative requirements</p> <p>Duty in the bill to discuss treatment options with patient runs counter to</p>	<p><i>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.</i></p> <p><i>The question then becomes who would be liable if the patient does not get access to the treatment that they require or, more importantly, that they request. Who would be responsible for that? Would it be the health board or the GP who is recommending treatment? Potentially, a variety of healthcare providers would be accountable,</i></p>

	<p>decision of UKSC and current practice</p> <p>Accountability and enforcement not clear</p>	<p><i>because the bill would allow diagnosis to be given by pharmacy prescribers, nurse practitioners and medical professionals in the NHS and in GP practices.</i></p> <p><i>It is difficult to see how a right to, for example, residential treatment can be enforced if there is a lack of residential facilities available. I struggle to see how a right to treatment could be enforced in the current situation.</i></p>
<p>Former Chair, Royal College of Psychiatrists in Scotland</p> <p>Dr Peter Rice</p>	<p>Need for diagnosis is exclusionary</p> <p>People need support who may not fit criteria for diagnosis</p> <p>Narrow treatment options</p> <p>Treatment is not a single intervention/recovery is not linear</p> <p>Risk to other services due to need to meet legislative requirements</p> <p>Workforce pressure</p>	<p><i>With regard to the day-to-day work with patients, diagnosis in and of itself is not a particularly crucial step. Most people who come for treatment will already recognise the nature of their problem and will be looking for a solution to it.</i></p> <p><i>The bill is right to acknowledge the importance of such work [broader support options not requiring diagnosis], 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.</i></p> <p><i>I also recognise, from discussions with policy makers over the years, that the idea of simply finding a bag of money from the invest-to-save approach does not really work.</i></p>
<p>Social Work Scotland</p> <p>Lindsay Turfus</p>	<p>Would not add to what is already happening</p> <p>Ignore current multi-disciplinary approach</p> <p>Medicalised</p> <p>Workforce pressures</p> <p>Current frameworks (Charter of Rights, MAT Standards) are broader</p>	<p><i>From a multidisciplinary perspective, it is really important that there is choice. I totally agree that a person should be informed, and it would be good to see a duty to ensure that they are informed of all their choices. However, we already have something similar in the MAT standards, and the role of advocacy is important as well.</i></p> <p><i>One of the comments that was made by my colleague who wrote our submission was about cross-cutting legislation. We need to look at things such as how we work with the Adult Support and Protection (Scotland) Act 2007. The revised guidance takes a lot of account of the impact of trauma and substance use, which is really important. We need to have that flexibility in relation to working with our multidisciplinary colleagues. We also need to understand that it is not as straightforward as going into recovery.</i></p>

	<p>Third sector are equal partners – this isn't recognised in the Bill</p>	<p><i>There is that period in between, when we need to stabilise somebody, which I do not feel is reflected.</i></p> <p><i>Our overall concern is that these things are obviously already available, and the challenge is that we do not have enough resource to cope with the demand for them.</i></p> <p><i>I do not see anything in the bill that would strengthen what we have at the moment. With the MAT standards, people have a choice about where their care comes from, and some of our third sector colleagues are providing really good services, with online access to assessments and so on.</i></p>
<p>Royal College of General Practitioners in Scotland Dr Chris Williams</p>	<p>Does not align with current practice Danger in unrealistic expectations Workforce pressures Current frameworks (Charter of Rights, MAT Standards) are broader</p>	<p><i>We would be worried if GPs were acting simply as gatekeepers. We know that a lot of information and support is made available to people so that they do not need a formal diagnosis, which means that they can recognise patterns in their behaviour or circumstances, or friends or family might point those things out to them.</i></p> <p><i>I do not know that it is helpful; it does not seem to sit alongside the other frameworks that we use in our shared decision making on healthcare.</i></p> <p><i>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.</i></p> <p><i>Looking at the lists in the bill and thinking of the wide spectrum of different presentations and circumstances, I find it difficult, as a clinician, to see how that all ties together under a three-week target, especially if guarantees are being promised around that. I do not understand quite how those guarantees would be effective.</i></p>

		<i>It is one thing to recognise that there are gaps in the services that we provide to people, but it is another to try to build up services that we know are in demand and are clinically effective, widely appreciated and successful. It is yet another thing entirely to promise access to something that is not available or would not be suitable for some people</i>
COSLA Eddie Follan	<p>Support intentions of Bill</p> <p>Narrow treatment options</p> <p>Medicalised approach</p> <p>Need for diagnosis is exclusionary</p> <p>How will it align with MAT Standards</p> <p>Risk to other services due to need to meet legislative requirements</p> <p>Ignore current multi-disciplinary approach</p> <p>Workforce pressure</p>	<p><i>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.</i></p> <p><i>We are concerned that the definition of “treatment” is medicalised and abstinence-focused and that it overlooks the importance of harm reduction. I know that there is debate about harm reduction and recovery, but we do not see those two things as being mutually exclusive; we see the whole package.</i></p> <p><i>As it stands, the bill does not align with the MAT standards and possibly conflicts with them. Members might want to look at how the bill can be aligned with the work that we are doing around the MAT standards, because it does conflict with that a bit.</i></p> <p><i>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></p>
Addiction Services NHS Fife Dr Sue Galea-Singer	<p>Would not add to what is already happening</p> <p>Need for diagnosis is exclusionary</p> <p>People need support who may not fit criteria for diagnosis</p>	<i>I do not think that the bill will make a huge amount of difference, because what it stipulates is already being done. It stipulates that treatment begins within three weeks, but we already stick to targets, in collaboration with the patient, to arrive at a care package that is suitable for them and that allows them to make choices. That is already being done, and adding a legal aspect to that might have unintended consequences rather than benefits.</i>

	<p>Ignore current multi-disciplinary approach</p>	<p><i>The key thing is that treatment should not be seen as a prescription. Treatment is whatever the patient needs. There needs to be provision of wraparound care. For example, if a patient needs housing more than anything else, getting them housing is the most important aspect. We see a lot of high-need and complex-needs patients, who often present opportunistically because they are in such a dire state. They are short of money and cannot eat. Basically, their only option is to come in for treatment. Working with that opportunistic approach, we get them in to see what their need is for further treatment.</i></p> <p><i>The need to have a diagnosis so that you can say that there is a treatment determination would have unintended consequences. A diagnosis is something that develops as you get to know the person you are treating. You find out much more, and it is often not just about one diagnosis; there might be a number of diagnoses with a number of needs.</i></p> <p><i>diagnosis is only a tool and it should not be a barrier to accessing treatment.</i></p> <p><i>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.</i></p> <p><i>If you put in place a legal requirement to provide detox, it goes against the ethos of preparing the patient to have a more positive outcome from, and experience of, treatment. Otherwise, you are setting people up for failure.</i></p> <p><i>You are absolutely right—the system is not working. However, I am not sure that the bill addresses that. That is the point that I have tried to make: the system needs to be oiled, and we need to work better together. We did so during Covid, and we succeeded</i></p>
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		<i>to a degree, although there were still a number of deaths. We can do this if we work better together, but I am not seeing anything in the bill that would make that happen</i>
Public Health NHS Lothian Flora Ogilvie	Rights should be universal Need for diagnosis is exclusionary People need support who may not fit criteria for diagnosis Medicalised approach Should focus on early interventions	<i>To add to what has already been said, 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</i>  <i>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.</i>
Aberdeenshire Health and Social Care Partnership Gillian Robertson	Ignores current multi-disciplinary approach Narrow treatment options Need for diagnosis is exclusionary Should focus on early intervention Workforce pressure	
Dundee Alcohol and Drug Partnership Pamela Dudek	Support intentions of Bill Does not align with current practice Narrow treatment options Would not add to what is already happening	<i>However, if we limit the focus to people coming in, getting a diagnosis and getting treatment through a health professional, that goes against some of the good work that is already going on and the good access that we provide.</i>  <i>The journey is very individual—you have to work with people where they are at. I am not against diagnosis if that is the right thing for the person and it means that you can formalise the treatment plan for them, but the issue is much bigger and broader than that. Of all the people I would see in a year in my clinics, I would put only about 15 per</i>

	<p>Current frameworks (Charter of Rights, MAT Standards) are broader</p> <p>People need support who may not fit criteria for diagnosis</p>	<p><i>cent through a residential route, and we would work with the rest of them where they were at with their families.</i></p>
<p>Glasgow Alcohol and Drug Partnership</p> <p>Kelda Gaffney</p>	<p>Support intention of Bill</p> <p>Treatment options narrow</p> <p>Need for diagnosis is exclusionary</p> <p>Treatment is not a single intervention/recovery is not linear</p> <p>How will it align with MAT Standards</p> <p>Risk to other services due to need to meet legislative requirements</p>	<p><i>There are two things about the charter of rights that I will point to in relation to supporting the bill. 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. As I said, it is really important that all the partners—including those in mental health, criminal justice, homelessness, housing, social work and health and social care partnerships—are around the table.</i></p> <p><i>The system is not perfect, but we have reached a point at which people are feeling more comfortable with the services. There is more support, including from the third sector and recovery communities. There are lots of building blocks around people, and the networks are really good. If we started to use medical language, it would feel like a backward step.</i></p> <p><i>concern about disruption to the MAT standards was one of the strongest pieces of feedback that we received from our reference groups and people with lived experience across the country.</i></p> <p><i>there is a naivety to the idea [of fewer readmissions to treatment], because making harmful use of or being dependent on drugs and alcohol is not a linear process. People do not go through recovery from here to there and make a final stop.</i></p> <p><i>I would like to quickly follow up on that. As far as the financial memorandum and the Glasgow ADP's response to it are concerned, I would say that I totally understand the</i></p>

		<p><i>principles of the bill and why those are being pushed forward, but, as you know, we have to work within our budgets, and there are concerns that no cognisance has been taken of the impact on other parts of the service. What will happen when people need mental health support?</i></p> <p><i>We have to work to a budget, and that will be the same for my colleagues. The response on the financial memorandum that was submitted by our finance colleagues included concerns about the pressure that the bill would place on other aspects of the system and of care. I must be clear that our reference panels and our lived experience consultation also raised some concerns about that, not from a financial perspective but because of stigma if there was an impact on other parts of the service.</i></p> <p><i>Our ADP has responded to say that we do not necessarily see the bill bringing any additional long-term financial savings. We might see more people going through treatment, care and recovery, but that is cyclical for a lot of people, if not for everyone</i></p>
<p>East Ayrshire Alcohol and Drug Partnership Liam Wells</p>	<p>Support intentions of Bill</p> <p>Current frameworks (Charter of Rights, MAT Standards) are broader</p> <p>Workforce pressure</p> <p>How will it align with MAT Standards</p> <p>Treatment is not a single intervention/recovery is not linear</p>	<p><i>Harm reduction saves lives. I am old enough to remember when the harm reduction approach was instituted in the United Kingdom by the UK Government in 1982 and 1983, as a direct response to the HIV/AIDS epidemic. It saved countless lives during that period, via needle exchange and, ultimately, methadone, and it continues to save countless lives.</i></p> <p><i>The challenge in the bill for me is probably organisational and administrative. I am sure that you have heard that the national mission survey of staff suggested that staff are already significantly under pressure and feeling overwhelmed.</i></p>
<p>Informal engagement with people with lived experience</p>	<p>Potential to empower individuals and ensure they receive necessary care</p> <p>Support should also address immediate needs beyond substance use</p>	

	<p>Harm reduction is essential and more effective for some than abstinence</p> <p>Family members are crucial to the recovery process</p> <p>Community and peer support are essential</p> <p>Third sector and lived experience organisations should be equal partners</p> <p>Investing in treatment and recovery will save money in the long term</p> <p>How does the Bill align with MAT Standards</p> <p>Bill is vague about the types of treatment included</p> <p>Diagnosis can be exclusionary and stigmatising</p> <p>Services do not have the capacity to deliver</p>	
<p>Scottish Families Affected by Alcohol and Drugs (SFAD)</p>	<p>Rights are universal</p> <p>Accountability and enforcement not clear</p> <p>Treatment options narrow</p> <p>Ignores current multi-disciplinary approach</p>	<p><b><i>Official report not yet published, will insert quotes when available</i></b></p>

	Does not address needs if family and carers	
Scottish Drugs Forum (SDF)	<p>Legislation is not the right response</p> <p>Current frameworks (Charter of Rights, MAT Standards) are broader</p> <p>Treatment options narrow</p> <p>Treatment is not a single intervention/recovery is not linear</p> <p>Risks damaging therapeutic relationship</p>	
Scottish Recovery Consortium (SRC)	<p>Legislation alone does not guarantee rights</p> <p>Need for diagnosis is exclusionary</p> <p>Treatment options narrow</p> <p>Ignores current multi-disciplinary approach</p>	
FAVOR	<p>Bill is matter of life and death</p> <p>Is a health rights Bill, other concerns raised are not valid</p> <p>Provides real accountability</p> <p>Specific intervention to give right to treatment</p>	
With You	Support intent of the Bill	

	<p>Access to the right treatment is essential</p> <p>Treatment options and definition seems narrow</p> <p>Services are already under strain</p> <p>Need for resources to support if Bill passes</p> <p>Borad range of support options is needed</p>	
Salvation Army	<p>Support intent of the Bill</p> <p>Accountability and enforcement not clear</p> <p>Treatment options and definition seems narrow</p> <p>Need for resources to support if Bill passes</p> <p>Borad range of support options is needed</p>	
Turning Point	<p>Support intent of the Bill</p> <p>Concerned about workforce pressures</p> <p>Importance of post treatment support</p> <p>Treatment options and definition seems narrow</p>	

	Accountability and enforcement not clear	
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## **Finance and Public Administration Committee**

The Finance and Public Administration Committee held both a written call for views in December and an oral evidence session with the Member in Charge in March 2025.

### **Written responses**

Nine responses to the call for views were published, these were from Alcohol and Drug Partnerships and Health and Social Care Partnerships (5); national organisations (2); other health services (1); and COSLA.

Respondents did not consider that the costs and savings in the Financial Memorandum, nor the margins of uncertainty on cost/timescales were accurately set out;

- savings would not be realised, because there would not be a reduction in staff training costs or net savings from more people being released from care
- costs of delivering the Bill would fall on a broader range of services than cited in the Bill;
- capital investment was not considered adequately;
- cost of treatments could increase,
- as well as legal costs because of a potential increase in litigation, and
- training costs were poorly calculated in the Bill.

A key concern is that due to the absolute statutory nature of the 3-week provision and potential increased demand, spare capacity would be required to cope with any potential spike in demand. There was concern that other budgets could be jeopardized and resources diverted to fund the required capacity to ensure that statutory obligations are met.

All respondents that would have a key role in delivery of the Bill stated that they would not be able to meet the costs of the Bill, citing the Scottish Government as responsible for funding.

There were few areas of positive support for the content and framing of the financial memorandum. One example was a general and high-level agreement on the point of purported cost-effectiveness of investment into the drug and alcohol services, with the citing of Dame Carol Black's Independent Review of Drugs and the conclusion that for every £1 spent, there would be a £4 saving.

There was one respondent (Alcohol Focus Scotland) who agreed in part with the methodology used to calculate the additional investment required to meet the ambitions of the Bill. However, this was also qualified by then stating that the calculation of estimated cost was based on limited data available and concluded that the cost estimates in the financial memorandum "fall short of what is required to ensure equitable access to all of those requiring support".

### **Oral Evidence Session**

FPAC held an oral evidence session with the member in charge on 11 March 2025.

Questions from the committee focused on:

- Concerns raised in the call for evidence that the financial memorandum underestimated the costs required to deliver the Bill and where the budget would come from
- Health boards work with finite budgets, a legislative need to provide treatment to one group could result (unintentionally) on diverting resource from other areas within health
- Capital investment required that was not included in the financial memorandum
- Potential costs beyond health boards which would not be covered by the increased funding laid out in the financial memorandum, eg. Local Authorities, social work
- Ensuring equitable service for rural areas
- Recruiting and training sufficient staff to meet increase service demand
- Hidden demand and the uncertainties of accurately predicting increased service uptake
- The principle of save to spend, referencing Dame Carol Black's report stating 'for every £1 spent...£4 is saved
- Whether the 50-66% increase in completed treatments is feasible
- Whether the Bill would have a positive impact on deprived communities
- Is the Bill fiscally sustainable given meeting the provisions would be demand led

#### **Further evidence requested by committee**

**The member in charge was asked to provide further information to the committee on the costs of the Bill (including costs to other budgets, such as social work), potential savings as cited through Dame Carol Black's report on drugs; capital investment costs; international comparisons (of similar approaches); how the Bill should be funded from the SG budget, and the Audit Scotland Report .**

- Douglas Ross provided a letter (included in Annex G) to the Finance and Public Administration Committee, published 6<sup>th</sup> May, which provides additional commentary on the Financial Memorandum accompanying the Right to Addiction Recovery (Scotland) Bill. However, there is limited additional analysis, and it largely restates previous content and methodology without presenting new evidence or clarity.
- The letter did not seek to revise the proposed cost of delivery of the Bill of £28.6 million to £38.2 million annually, and did not provide new financial evidence, modelling, or clarity to support the cost assumptions in the Bill. The absence of cost breakdowns and lack of fresh analysis means it contributes little to the scrutiny of the financial implications of the Bill.
- No further detail of the **composition of the potential benefits** was provided, with no clarity on the potential financial 'savings' rather than wider economic and social benefits. While all benefits are important, the Committee had been particularly interested in savings which could reduce financial pressures.

- No additional details were provided on **wider social work costs** faced by local authorities out with drug and alcohol funding, an issue which has been in response to the Financial Memorandum consultation.
- The estimate of **capital expenditure** increases (an additional £641,250 to £855,000 per annum for building new facilities) was based on previous capital expenditure on residential rehabilitation as a share of the estimated increase in total costs presented in the Financial Memorandum. There was also a statement that SG expansion to 650 beds/1,000 publicly funded placements may provide enough capacity to meet increased service provision with no additional capital investment required.
- The letter also confirms that: (1) no other country has implemented a comparable legal right to addiction recovery; (2) the member is unable to draw on the Audit Scotland 2024 report to offer direct support for the cost estimates in the Bill, and (3) suggests cutting the size of the devolved civil service to generate savings to fund the Bill.

## ANNEX E

### 1. DRUGS AND ALCOHOL STRATEGIC OVERVIEW

#### National Mission Aim

- The five year National Mission to reduce drugs deaths and improve lives was announced in January 2021. The National Mission strategic plan was published in August 2022 outlining our approach via six key outcomes and six cross cutting priorities.
- In 2023, a Cross-Government Plan in response to the Drug Death Taskforce was published, acknowledging the need for a holistic approach to joint issues including mental health, justice, employment and housing and homelessness.

#### Summary of performance to date

- Drug misuse deaths are still much more common than they were in 2000. After adjusting for age, the rate of drug misuse deaths were 4.2 times as high in 2023 than in 2000.
- The latest official NRS statistics published in August 2024 show that in 2023, there were 1,172 drug misuse deaths registered in Scotland, **an increase of 12% (121 deaths)** compared with 2022.
- Reports published throughout 2024 include the Alcohol and Drug Partnership Coordinator Survey (18 February 2025), Audit Scotland Report (September 2024) and the People Panel Report (January 2025). They show that there is broad agreement on the approach that the National Mission is taking.
- Key achievements according to these reports include:
  - The roll out of naloxone
  - The establishment of the Thistle Facility
  - Focus on rolling out the MAT standards
  - Increase in funding for residential rehabilitation placements
- The reports also consistently point to areas where the National Mission is missing opportunities:
  - The need for increased focus on prevention and more joined up services and smooth referral pathways.
  - Complexity of the landscape making governance and accountability of services difficult
  - Uncertainty over long-term funding
  - Slow progress with action on stigma and workforce.
  - A need to ensure that Lived and Living Experience inclusion is not just a 'tick box' exercise.
  - The need to put alcohol on the same footing as that of drugs.
- The Audit Scotland Report also highlighted the impact of the investment made by the Scottish Government since 2021 and highlighted the leadership shown as an achievement.

- The recent ADP Coordinator survey cited leadership as an area where the Scottish Government needs to improve.

### **Achievements/actions already taken**

- Supported Glasgow in opening the UK's first official **safer drug consumption facility** – which the international evidence tells us can help save lives.
- Progress made with the Home Office to support the establishment of Scotland's first **drug checking facilities** in Glasgow, Dundee and Aberdeen along with a national testing laboratory.
- Provided **£13m funding each year to community and grass-roots** organisations, supporting over 300 projects across Scotland and over 33,000 people.
- We have made **£38m available via multi-year grant agreements to expand residential rehab capacity** – 8 projects across Scotland will provide at least 140 more beds to the 2021 baseline by 2025/26, boosting the current rehab capacity in Scotland.
- Widened access to **life-saving Naloxone** with more than £4m having been allocated since the start of the National Mission. A total of 30,346 take home naloxone kits were issued in the financial year 2023/24. According to the latest statistics (PHS quarterly report, 4 March 2024), an estimated **79.1% of people** at risk of opioid overdose have now been provided with a lifesaving kit. All frontline police officers carry it for emergency use. We continue to engage with our partners to monitor naloxone stock levels, providing funding to secure additional supplies and replace kits approaching their expiration dates
- **Supported connection and community-** whether that's through recovery communities, family networks or groups for people experiencing harms- and put them at the heart of our response through the **National Collaborative's Charter of Rights for People Affected by Substance Use**
- Continued to improve the **whole-system response** for people experiencing substance use and their families, including women and people with multiple and complex needs, through cross-government collaboration and stakeholder engagement to implement our **families framework, Mental Health and Substance Use joint-working protocol and Standards for Young People.**

### **Future Drug and Alcohol Approach – Post 2026**

- The National Mission is due to come to an end in early 2026.
- We are currently **developing a refreshed strategic approach that responds to the alcohol and drug crisis with equal weighting.** This approach is being developed with key stakeholders from both alcohol and drug sectors, as well as lived and living experience.
- The National Mission on Drugs has made progress, but deaths and harms from alcohol and drugs remain too high and the Scottish Government is committed to retaining focus.
- The next approach will be published in early 2026 ahead of the conclusion of the National Mission.

- After 5 years working in an emergency response to the drug death crisis, it is time to move to sustainability and embedded long-term change and progress.
- Ministers are keen that we **build on the work of the National Mission and take an evidence-based approach, whilst being adaptive to new challenges.**
- We are not starting from a blank slate. We have multiple recommendations from the Changing Lives Report, Audit Scotland Report and Scottish Parliament People's panel report. In addition, the Charter of Rights will help set the principles.
- We are currently in the process of gathering stakeholder reflections of the National Mission and our delivery of the Alcohol Framework; to understand what has gone well and what not so well; and on what challenges lie ahead.

## 2. CHARTER OF RIGHTS

- The Charter of Rights has been mentioned in written and oral evidence and raised by committee members.
- In evidence stakeholders have mentioned it as providing a more comprehensive approach for people affected by substance use than the Bill.
- The Charter does not create new rights to people, but to aims to ensure that universal rights can be understood and realised by all.

## BACKGROUND

- The National Collaborative, driven by the Change Team (a group of 15 people with direct and indirect life experience of substance use) has developed a Charter of Rights for People Affected by Substance Use. This has involved extensive consultation with stakeholders including people with lived and living experience and was complemented by a series of workshops between the Change Team and people in leadership roles (duty bearers) from a range of services and sectors (e.g. health, housing, social security, criminal justice, inspectorate, and the ombudsman).
- The Charter draws from the International Guidelines on Human Rights and Drug Policy which sets out best practice as identified by the UN. It draws together a existing rights in ECHR and international law as they relate to substance use. Whilst the Charter itself is not legally binding, the rights referred to are. The Scottish Government, through the range of services and treatment it currently supports, complies with its domestic and international human rights obligations.
- The Charter supports people access and realise those rights and enables public bodies to adopt a human rights based approach to decision making.
- The Charter aims to support people to advocate for high quality treatment for drug and/or alcohol use and for access to support for other aspects of their lives. It also aims to support people designing, delivering and monitoring services to ensure services are provided in a manner that respects the rights, agency and dignity of people affected by substances.
- For these reasons, it strengthens other areas of the National Mission which focus on improving people's experiences of services, for example the implementation of the Medication Assisted Treatment (MAT) Standards, workforce development, and work to improve connections between substance use services and other services, such as mental health, housing, and the Whole Family Approach Framework.
- The Charter is a more inclusive and empowering framework. It acknowledges the complexity of substance use and promotes a full spectrum of care interventions based on rights, choice and lived experience. While the Right to Recovery Bill is well intentioned, it is narrow in scope and may unintentionally exclude or harm people who do not follow an abstinence-based recovery model or receive a formal diagnosis, which the bill requires in order for people to access the rights in the bill. The Charter explicitly aims to reduce stigma and discrimination whereas the Bill risks stigmatising people who use substances further.
- The Charter outlines seven key rights from both national and international law, drawing on the International Guidelines on Human Rights and Drug Policy and

describes how these rights practically apply to people affected by substance use and how people can effectively claim those rights. In this context one of the most important rights for people is Article 12 of ICESCR right to the highest attainable standard of physical and mental health and it is essential for everyone, but it can be difficult for people to claim as it has not yet been incorporated into our domestic law.

- The rights in the Charter are universal rights which should be available for all but are often inaccessible for people affected by substance use. The Charter aims to make clear how these rights should be applied in the specific context of people affected by substance use. The rights cover all aspects of a person's life, because people affected by drugs and alcohol are more than just a diagnosis, and they have the right to have their rights respected in all areas of their lives.
- The Charter also provides information on feedback, advocacy and complaints. The Toolkit provides practical guidance around applying a Human Rights-Based Approach and includes the PANEL principles and FAIR model, to support duty bearers in decision making in delivering these rights, and rights holders in knowing what their rights are and how to claim them.

### **Global interest**

The Charter, recognised as the first of its kind in the world by the UN Office of the High Commissioner for Human Rights, will help ensure people know their rights and the support they can expect to receive, and that people who use drugs and alcohol, and their families, are treated with dignity

Cabinet Secretary invited by Office of the Commissioner for Human Rights (UNCHR) to a side event at the Commission for Narcotic Drugs in March this year. The UN Governing Body on Drug Policy called "Promoting Health based responses at National Level through UN system co-operation."

Cabinet Secretary also invited to a side event at the World Health Assembly (Governing Body of the WHO) as an example of "National Implementation of the International Guidelines on Human Rights and Drug Policy."

### **Key quotes**

*It is essential to include those most affected by drug use disorders in all decisions, policies and laws. The Scottish Charter of Rights for People Affected by Substance Use is an example of a policy developed through a multistakeholder process, reflecting the unique needs of different groups, including people who use drugs. I hope it can serve as inspiration to other countries around the world.*

*Volker Turk – UN High Commissioner for Human Rights (May 2025)*

### **Timeline**

- Dec 2024: Publication and launch of Charter of Rights for People Affected by Substance Use.
- Nov 2024: Analysis of consultation feedback on draft Charter published, along with 'You said, We did'.

- January to June 2024: Public consultation enabled communities to feedback on the Charter. This was complemented by a series of workshops between the Change Team and duty bearers from a range of services and sectors (e.g. health, housing, social security, criminal justice, inspectorate, and the ombudsman). Learning and recommendations taken from these two processes informed the final Charter of Rights.
- Dec 2023: Draft outline of a Charter of Rights published.
- Nov 2023: Analysis Report was published which analysed evidence of people's experiences.
- May to Aug 2023: "community conversations" across Scotland gathered evidence of people's experiences and challenges in seeking support for substance use.
- Dec 2022: Roadmap published, which set out the plan for developing a Charter of Rights.
- Jan 2022: Professor Alan Miller appointed as independent chair of the National Collaborative.

**The National Collaborative is led by Human Rights expert, Professor Alan Miller, driven by a Change Team of people with life experience of substance use, and supported by a wider network of organisations, groups and individuals. The FM and Cabinet Secretary for Health and Social Care supported the launch of the Charter of Rights, alongside the UN Office of the High Commissioner for Human Rights and the National Collaborative in December 2024.**

- The vision is to integrate human rights – by adopting a human rights-based approach - into drug and alcohol policy, leading to better outcomes for people affected by substance use.
- A Charter of Rights for People Affected by Substance Use and supporting Toolkit have been co-designed with the Change Team and through extensive consultation with people affected by substance use and with people responsible for design, delivery and monitoring of substance related support services.
- The Charter and Toolkit will support people to realise their rights and support duty bearers to continuously improve the availability, accessibility, acceptability and quality of their services.
- The Charter re-emphasises the shift from a criminal justice approach to a public health approach. It describes key rights which are drawn from both domestic and international law, which were identified as being the most relevant for people affected by substance use and describes the ways in which these rights should be met.

## TOP LINES

**The Charter of Rights for People Affected by Substance Use was launched in December 2024 by the National Collaborative.**

- We will ensure that the provisions contained in the Charter are reflected across drug and alcohol policy and that the rights of people affected by substance use are considered in broader government policy.

- Separate reporting or monitoring requirements are not envisaged as the realisation of the rights should not be separated from policy and services that are supporting people affected by substance use.
- However, to support the broader, cross-sectoral buy in that is required to implement and embed the Charter, the Scottish Government is engaging with stakeholders including key duty bearers to understand how we can support implementation.

### 3. HUMAN RIGHTS BILL

#### BACKGROUND

- The Human Rights Bill has been mentioned by multiple stakeholders as offering more rights to people affected by substance use than the Bill
- It is also highlighted by stakeholders that the HR Bill would deliver universal rights and not single out specific groups as having rights not available to others

**The Human Rights Bill seeks to incorporate 4 UN Treaties into Scots law, within the limits of devolved competence, and to recognise the right to a healthy environment. One of the treaties – the International Covenant on Economic, Social and Cultural Rights (ICESCR) – contains a right to the highest attainable standard of physical and mental health.**

- The Bill was originally due to be introduced in the 23-24 parliamentary year. However, following the election of the UK Government in the summer of 2024, Ministers decided to take additional time to work collaboratively with stakeholders and to engage with the UK Government to further develop and refine proposals, and to seek to address some of the challenges devolution poses to incorporating legislation. Ministers have committed to taking forward the Bill in the next Parliamentary session, subject to the outcome of the 2026 election.
- **[Redacted-Section 30(b)(ii)]**

#### TOP LINES

**The Scottish Government is committed to protecting, promoting and advancing human rights in Scotland.**

- We will use the remainder of the session to work collaboratively with stakeholders to further develop and refine proposals for the Human Rights Bill, with the intention of taking forward legislation in the next Parliamentary session.
- We want to use this additional time to work constructively with the UK Government to seek to address the challenges that the constraints of the devolution settlement - as highlighted by the 2021 Supreme Court judgment on the UNCRC Bill - bring for the scope of the Bill's proposed duties.
- We plan to publish a discussion paper that sets out our approach to the Human Rights Bill, to support constructive engagement with stakeholders in the period ahead.
- We will also continue to develop and deliver several activities aimed at embedding human rights awareness and practices in our public services, preparing for eventual Bill introduction and commencement.

#### 4. DRUG AND ALCOHOL SERVICES WORKFORCE

- **Potential pressure on workforce as a result of the Bill has been raised in evidence**
- **General consensus is that the workforce in drugs and alcohol and health and social care in general are under significant pressure already, and an additional statutory burden presents risks of burnout**
- **It is acknowledged that retention and recruitment into the drugs and alcohol sector is a challenge and has been a focus of work to support the workforce within the National Mission**

#### TOP LINE

**Workforce challenges are complex. This complexity inevitably impacts upon the pace at which improvement can be delivered.**

#### BACKGROUND

**As part of the National Mission Evaluation, PHS published the Alcohol and Drug Frontline Staff Survey Report in May 2024. 56% of respondents 'felt under pressure in their role a lot of the time or all the time' and 43% respondents 'felt at risk of burnout in their role a lot of the time or all the time'.**

- Scottish Government's Drugs and Alcohol Workforce Action Plan 2023-26 includes many of the recommendations for change outlined in PHS frontline survey.
- Two resources to support the drug and alcohol workforce have recently been published:
  - January 2025: The online '**Learning Directory**', complementing the **Knowledge and Skills Framework** by increasing the accessibility of training opportunities across the sector.
  - April 2025: The **Drugs and Alcohol Workforce Knowledge and Skills Framework** which sets out the knowledge and skills expected of the workforce.
- Further resources are planned for 2025, focusing on supporting people with lived experience of substance use who also work in the drug and alcohol services sector. It is recognised that this group within the workforce faces challenges that require support:
  - **Two Employability Toolkits**. One to support more people with lived and living experience to pursue careers within the sector, and one aimed at employers seeking to support people with lived and living experience in their workforce.
  - **Guiding Principles** to allow organisations to provide effective workplace support to employees with lived experience.

#### **SG response to drug and alcohol workforce challenges (lines to take)**

- Our Drugs and Alcohol Workforce Action Plan sets out the actions that the Scottish Government is taking to deliver a skilled, resilient workforce.
- Over recent months the Scottish Government has achieved a number of actions outlined in the Action Plan, notably: the creation of a learning directory to communicate and signpost training opportunities to the workforce and developed

a Drugs and Alcohol Knowledge and Skills Framework – defining competencies for workers who care for people affected by substance use.

- In coming weeks, the Scottish Government will finalise and publish two employability toolkits to support people with lived and living experience to pursue careers within the sector and publish 'Guiding Principles' to allow organisations to provide effective workplace support to employees with lived experience.
- This work has been done in partnership with key stakeholders across the drug and alcohol workforce and through consultation with people affected by substance use.
- Following publication we will begin extensive engagement with partners and stakeholders to encourage promotion and implementation of these initiatives.
- Workforce actions are being delivered through a phased approach to help achieve optimal results.
- Timescales for the delivery of each phase are set out in the workforce action plan and progress remains on track.

### **Staff Wellbeing and workforce planning**

- There is a clear need for improved data capture to inform drug and alcohol workforce planning. We are undertaking a comprehensive workforce mapping exercise to facilitate a more accurate understanding of the scope of the workforce. We will then seek to build upon this to better understand the changing support the workforce may need, and resources required. This work will contribute to attempts to improve the workforce and service planning.

## 5. HEALTH AND SOCIAL CARE WORKFORCE

### TOP LINES

- Under the SNP, NHS staffing is up by 34,394.1 Whole Time Equivalent (to 161,456 Whole Time Equivalent), or 27.1%, (Sept 2006 to Dec 2024), representing 13 consecutive years of staffing growth.
- We know growing the workforce alone does not ensure improved performance or patient safety and experience. It is through reform and diversification that we can progressively make better use of our workforce and improve the design of services; alongside our workforce we need the right tools, technology and infrastructure.
- We remain committed to delivering the National Workforce Strategy and achieving the overall vision for “A sustainable, skilled workforce with attractive career choices and fair work where all are respected and valued for the work they do”.
- As we continue with our whole system approach to NHS Scotland, we expect to see the type of roles and shape of our workforce change.
- Whilst the Scottish Government sets the strategic policy direction for the NHS in Scotland, operational matters including staffing are in the first instance the responsibility of the relevant NHS board. This will depend on the service needs of each board taking account of national, regional and local priorities, and we expect NHS boards to plan and provide safe, effective and high-quality care, in line with their statutory service provision and workforce planning responsibilities.

### **HEALTH AND SOCIAL CARE WORKFORCE WELLBEING**

#### BACKGROUND

The increased focus on health professionals to follow additional procedures in the form of treatment determinations under the Right to Addiction Recovery Bill could have a negative effect on:

- existing multi-disciplinary staff working in addiction services, who may be concerned about the long-term impact on their jobs.
- existing Health Practitioners where current workloads may already be high, who may show increased risk of burnout commensurate to increased workload and requirement to comply with statutory duties as a result.

#### TOP LINES

**We're deeply grateful for the courage and dedication of our health, social care and social work staff, who are essential to overcoming future challenges.**

- From 2024/25, Scottish Government are dedicating over £2.5 million annually to support health, social work and social care staff wellbeing.
- This funding provides our workforce with access to psychological interventions and therapies, self-service resources through the National Wellbeing Hub, and the National Wellbeing Helpline which is delivered by NHS 24.
- Registered staff also have access to confidential mental health services through the Workforce Specialist Service (WSS).

- These resources play a vital role in helping the workforce manage mental health challenges, supporting their return to work and enhancing the quality of care they can provide.

## 6. ALCOHOL AND DRUG PARTNERSHIPS

- ADPs are key strategic partners in planning and delivery of drugs and alcohol services and so would be directly impacted as a result of the Bill
- There is no specific reference to the role of ADPs within the current draft Bill
- There is no existing statutory provision for ADPs, so conferring authority or responsibility to them is not advised

### BACKGROUND

ADPs bring together a broad range of service partners to provide holistic service planning at the local level. ADP Support Teams' experience in coordinating provision and their access to local knowledge give them ideal placement in tailoring provision to need and having the flexibility to do so is pivotal.

The Bill focuses on placing a responsibility on Scottish Ministers, but the burden of ensuring that local service provision fully accounts for the range of provision demanded by the Bill will place greater pressure on those coordinating ADPs.

- Consultation responses to the draft Bill from ADPs have noted:
  - *“Although we would agree that people have the right to recover from addiction, we do not agree with the purpose or extent in this bill. The National Collaborative launched The Charter of Rights for People Affected by Substance Use on the 11th of December which addresses people’s Rights.”*  
*Aberdeenshire Alcohol and Drugs Partnership*  
*(On purpose and extent: STRONGLY DISAGREE)*
  - *“The people who suffer most harm from substance use often suffer from poor physical and mental health, they are often multiply disadvantaged, poorly served by population level services and endure significant stigma in seeking support. However, it is questionable whether a legal approach to improving access should be the preferred approach to this issue, and setting legally defined limits around the timing of access to supports does nothing to ensure that those supports are of high quality, are holistic and person centred, and reflect the rights of the individual.”*  
*Angus Alcohol and Drugs Partnership*  
*(On purpose and extent: STRONGLY DISAGREE)*
  - *“This Bill is restrictive in its scope in that it only includes people diagnosed with addiction/dependence. This excludes people who use substances that might be causing problems for themselves/family/friends and present risks even if they are not 'addictive' in a physical sense nor causing dependence. That would include people drinking at harmful levels but not dependent, and many users of stimulants and inhalants may fall into this group, as would many young people using substances in what is sometimes termed a 'recreational' manner.”*  
*Highland Alcohol and Drugs Partnership*  
*(On purpose and extent: DISAGREE)*

- *“The focus is “outdated, paternalistic, and health centric” “The Bill contains several flaws including timeframes, flexibility, and the treatment options outlined. Therefore, rather than making alterations to the Bill, it would require a major overhaul to render it fit for purpose.”*

*Perth and Kinross Alcohol and Drugs Partnership*

*(On purpose and extent: DISAGREE)*

- *“We regard the premise of establishing a right in law to addiction treatment would be detrimental in our attempts to reduce the stigma associated with drug and alcohol issues. Singling out one area of medicine is, in our view counter productive and likely to create negativity around one patient group with different standards applied to them within the budgetary framework of statutory services.”*

*Glasgow City Alcohol and Drugs Partnership*

*(On purpose and extent: DISAGREE)*

- *“We are concerned however about the equating of medical treatment with recovery. We remain unconvinced that delivery of this Bill will deliver increased numbers in sustained and long term recovery. This narrow focus on treatment fails to recognise the complexity of problematic drug and alcohol use and the elements and antecedents that characterise it such as adverse childhood experiences, adult trauma and poor mental health. Any ‘addiction treatment’ must be accompanied by a range of additional supports in order that the individual can fully engage in recovery in order that they are “enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society”. We there recommend that the Bill acknowledges the role of the third and voluntary sector in the provision of treatment and support.”*

*East Ayrshire Alcohol and Drugs Partnership*

*(On purpose and extent: DISAGREE)*

- *“The comments convey that respondents do not view this as being a good use of public money. The costs set out make it difficult to understand what the exact impact would be at a local level. However, one response stated, “just committing more funding to something does not address some of the systematic barriers we have with regards to accessing support i.e. residential rehab and availability of beds.””*

*North Ayrshire Alcohol and Drugs Partnership*

*(On purpose and extent: DISAGREE)*

- *“The right to access healthcare already exists. Furthermore, the bill does not take into consideration a range of existing legislation that supports individuals’ rights to access healthcare. The bill suggests a rights based approach. Existing legal frameworks are in place to support this already not widely known or used within treatment services.”*

*Mid and East Lothian Alcohol and Drugs Partnership*

*(On purpose and extent: NEUTRAL)*

- *“The treatments listed are very medical orientated and does not take into account the fact that often drug and alcohol problems are closely linked to environmental factors (poverty, deprivation, trauma, physical health etc).*

*Without taking into account all these factors and solely focussing on medical treatment it is unlikely for stability to be achieved causing more harm to the individual.”*

*Orkney Alcohol and Drugs Partnership*

*(On purpose and extent: NEUTRAL)*

- *“The Bill in its current format does not necessarily take a Trauma-informed approach to substance use. By default, it suggests that access to treatment, and a lack of rights is a primary contributing factor to Scotland’s drug death crisis, and substance use overall. It does not consider, the other myriad underlying complexities, and contributing factors of substance use disorder.”*

*Falkirk Alcohol and Drugs Partnership*

*(On purpose and extent: NEUTRAL)*

## **TOP LINES:**

### **General**

- ADP Co-ordinators are vital partners in the delivery of the National Mission and our wider work on alcohol and drug treatment.

### **Key findings from the Evaluation of the National Drug Deaths Mission: Alcohol and Drug Partnership coordinator survey 2024 include:**

- A substantial portion of ADP coordinators feel that there is scope to improve governance and accountability arrangements, including through better coordination of reporting requirements and action to improve buy-in from (some) local statutory partners.
- Findings also suggest that wellbeing concerns are a key issue for a sizeable portion of ADP coordinators. Actions to help address this would need to involve national and local stakeholders.
- Across the different work packages of the PHS National Mission evaluation, a relatively consistent narrative is starting to emerge, of (perceptions of) positive impacts alongside scope to address missed opportunities

### **National Mission**

- It is encouraging to hear that those working hard to coordinate activity at the local level have noted the positive effects of the National Mission.
- The Scottish Government recognises the scale of the task for all those partners working to bring about positive change and will endeavor to continue to guide and support their collective efforts.

### **Governance**

- Scottish Government officials are working with COSLA and in consultation with service delivery partners to revise the Partnership Delivery Framework to provide a more comprehensive and clear foundation for the operation of Alcohol and Drugs Partnerships and the expectations of delivery partners.

### **Workforce pressures**

- The ADP coordinator survey reveals wellbeing concerns as a key issue for a sizeable portion of ADP coordinators. We take this seriously and are working with local and national partners to address this.

- In the coming months we will finalise and deliver four key workforce actions:
  - A Workforce Knowledge and Skills Framework will set out the knowledge and skills expected of the workforce.
  - An online 'Learning Directory' which will complement the Knowledge and Skills Framework, increasing the accessibility of training opportunities across the sector.
  - Employability Toolkits to support more people with lived and living experience to pursue careers within the sector.
  - Guiding Principles to allow organisations to provide effective workplace support to employees with lived experience.

## 7. PRIMARY CARE - GPS

- |   |
|---|
| <ul style="list-style-type: none"> <li>• GPs would be one of the health professionals expected to make diagnosis and treatment determination as part of the Bill</li> <li>• Currently some GPs are signed up to the Enhanced Drug Service and will be involved in treatment support; others routinely refer patients to specialist services.</li> </ul> |
|---|

**GPs are often the first people we go to when we want help with our health, and it is most people's expectation that their GP will help them find the support that is right for them.**

- GPs are routinely involved in a patient's treatment if the main problem is alcohol related. Practices may have multi-disciplinary teams who can provide direct support, but patients could be referred to specialist services where appropriate.
- The successful implementation of MAT Standard 7 (All people have the option of MAT shared with Primary Care) will see better joined up working between drug treatment services with broader Primary Care, to help address the wider health needs of people who use drugs.
- People who use drugs and alcohol share everybody's common right to access healthcare and are potentially more likely to have wider health needs. Primary care - and general practice and community pharmacy in particular - is well placed to help address these needs and tackle health inequalities in local areas.
- Some GPs who are signed up to the Enhanced Drug Service will be involved in treatment and support when a patient presents with a drugs problem. However, many GPs will not be under contract for this service and so will routinely refer patients to specialist services where they will be supported in line with the MAT standards.
- GPs who have signed up to the enhanced service should and will know what the MAT standards mean for their patients as part of this service.
- All GP Registrars will undertake training on addressing alcohol and drugs harms as part of the curriculum requirements within GP Specialty Training.
- Where the Practice is involved in treatment, this is often provided through the Practice Nurse or Mental Health Nurse, which helps provide joint support for substance use and mental health care.



## 8. TREATMENT

- The Bill currently does not make mention of the MAT Standards or how it would align in practice
- Stakeholders have highlighted that MAT Standards go further than the Bill in scope and aim
- ADPs highlighted that in consultation with LLE groups there was concern expressed about how the Bill would interact with MAT Standards
- ADPs also expressed concern on the impact a further change in practice would affect staff who have been under significant pressure to adapt to and embed the MAT Standards

## MAT STANDARDS

### TOP LINES

#### **Easy and timely access to good quality treatment is key and has been our top priority since the launch of our National Mission.**

- Rolling out the MAT standards is a key component of the Scottish Government's approach to alcohol and drugs. The standards reinforce a rights-based approach for people who use drugs and the treatment they should expect, regardless of their circumstances or where they are.
- The MAT standards emphasise the importance of allowing people to make informed choices about the type of medication and help available to them.
- Making this help available and giving people an informed choice is an essential part of respecting a person's rights and dignity.
- The PHS MAT Standards Implementation and Support Team (MIST) have an vital role, including:
  - assisting with the integration of a human rights-based approach throughout substance use services
  - Supported exploratory work around the potential integration of measurement of some of the MAT standards into the drug and alcohol information system (DAISY).
  - Supported the development of an audit questionnaire for psychologically informed treatments through the MAT 6 thematic group and LPASS members (Lead Psychologists in Addiction Services Scotland).
- MIST plans to undertake a mapping of services, current data collection and reporting arrangements, to advance implementation of MAT standards across Scottish prisons. This exercise will contribute towards continuity of MAT delivery and care across ADPs and all Health Boards areas receiving people released from prison. They are hosting knowledge exchange events and the MAT justice toolkit for prisons will be published in the next three months.

- Fundamental to the MAT Standards is ensuring access to same day prescribing, for some this is a prescription for opioid substitution therapy, it is important to ensure that any new approaches, legislative or otherwise work in concert with this.

## **BACKGROUND**

The PHS 2023/24 National Benchmarking Report on Implementation of the MAT Standards, published in July 2024, provided an assessment of progress with implementation of the MAT standards. This was based on process and numerical evidence submitted by each ADP. This was then scored to construct a red, amber, green, blue (RAGB) assessment, and a snapshot against the implementation of each of the standards was created.

In 2023/24, for MAT standards 1–5, 90% were assessed as fully implemented (RAGB blue and green).

For MAT standards 6–10, 91% were assessed as RAGB provisional green (evidence that implementation was beginning).

The RAGB score blue (evidence of sustained implementation and ongoing monitoring) was allocated to two ADPs for MAT 4 and one ADP for MAT 3.

### **MAT STANDARD 1: All people accessing services have the option to start MAT from the same day as the presentation.**

- In the 2023/24 PHS Benchmarking Report, 23 out of the 29 areas were assessed as having fully implemented the criteria for making Same Day Access available, with 6 out of 29 ADPs having partially implemented this standard.
- From the progress reports submitted quarterly to the SG, it is reported that same day prescribing is now established in most areas. This includes access to drop-in clinics, and out of hours cover in many areas. Much of this access is now through third sector partners and community pharmacies – widening the range of options for people.
- In rural areas where clinics are not available every weekday, some services are innovating with other services such as community pharmacies as well as non-medical prescribers.

### **MAT STANDARD 2: All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.**

- This was assessed as meeting the criteria in 28 of the 29 ADP areas, with one area partially implementing this standard.
- The standard asks local services to have Buprenorphine available as a choice option and it is now on all local formularies – so it is available throughout Scotland.
- With regular reporting from areas, we are aware that some areas are reporting problems in accessing funding to provide Buprenorphine, which is more expensive than Methadone.
- Given that Scottish Medicine Consortium has accepted Buprenorphine, it is expected that Health Boards and Integration Authorities will make it, or an equivalent SMC-accepted medicine, available on their local formulary for routine prescribing.

Therefore, Buprenorphine, as with all other medicines, should be met from local prescribing budgets.

**MAT STANDARD 3: All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.**

- In 2023/24, the standard was assessed as sustained implementation (RAGB blue) in one ADP area, fully implemented in 25 ADP areas and partially implemented in 3 ADP areas.
- Non-Fatal Overdose pathways, data sharing agreements and data capture processes were all in place, with some areas including support for the use of non-opioids as part of their treatment pathways.
- Outreach workers were liaising more closely with statutory services such as housing and justice services. This allows treatment services to identify people who would benefit from support more quickly.

**MAT STANDARD 4: All people are offered evidence-based harm reduction at the point of MAT delivery.**

- This standard was assessed as sustained implementation in 2 ADP areas, fully implemented in 25 ADP areas and partially implemented in 2 ADP areas
- Harm reduction equipment was routinely available in most service settings and many areas also make immunisation treatments accessible on site as well as sexual health advice.

**MAT STANDARD 5: All people will receive support to remain in treatment for as long as requested.**

- This standard was assessed as fully implemented in 27 ADP areas and partially implemented in 2 ADP areas.
- A total of 28 ADP areas achieved the benchmark of 75% of people retained in care for six months.
- The Benchmarking Report illustrated progress that had been achieved through improvements in the use of individual care plans, as well as offering more flexible opening times. Assertive outreach, in response to someone disengaging from care, had also helped deliver improved retention rates and helped people receive care for longer.
- Improvements in availability of home testing and access to more drop-in clinics particularly in urban locations also proved helpful.
- Many more partnership agreements and standardised referral processes are now in place to aid inter-agency co-operation, and some areas are testing an unplanned discharge pathway in partnership with community pharmacy.
- ADPs initially concentrated on treatment options for opioids as these were, and still are, the most common drug detected in drug death toxicology, but services are expanding to include treatments like psychosocial care for people who use cocaine.

**MAT STANDARD 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.**

- This standard was jointly assessed with MAT standard 10 and was partially implemented in all 29 ADP areas. Areas were able to demonstrate that they had a service delivery plan, including training programmes for the workforce and were gathering experiential evidence from those people using the services. Some areas have psychologists in post and psychological care is embedded, with support, supervision and training in tier 2 psycho-social interventions for all staff, but many have been unsuccessful in recruiting psychologists. This had resulted in holding back progress against this standard.
- In a few areas third sector support was being used successfully considering the shortages in some key professional areas.

**MAT STANDARD 7: All people have the option of MAT shared with Primary Care.**

- This standard was partially implemented in all 29 ADPs and is another area of focus for the final period of the National Mission.
- Many areas are piloting Advanced Nurse Practitioners based in GP practices to deliver on this standard. Other areas are making more use of community pharmacies or third sector partners

**MAT STANDARD 8: All people have access to independent advocacy and support for housing, welfare and income needs.**

- This standard was partially implemented in all 29 ADP areas. This means that ADP areas had commissioned (or engaged with) independent advocacy services and had advocacy training plans in place for staff.
- Most areas had a relevant advocacy service in place, with staff training provided by REACH Advocacy training.
- Some advocacy services are based within a service location, multi-agency staff had been trained, including mental health staff in some places, and a few areas had an advocacy service based in their local prison.
- Scottish Government has provided £192,000 continued funding to REACH Advocacy for the delivery of Human Rights Based Approach training to service providers.
- CORRA awarded funding to REACH Advocacy of £480,000 to deliver MAT Standards awareness workshops and the organisation's own Advocacy Practice Award over 24/25; 25/26; 26/27;

**MAT STANDARD 9: All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.**

- This standard was partially implemented in all 29 ADP areas. There were documented procedures for joint working in care available for people with co-occurring mental health and substance use conditions.

- Several areas had managed to collocate mental health and substance use services, many had at least established an interface protocol, and some had managed to ensure joint appointments for people with co-occurring conditions.
- Local co working with the third sector had been established in some areas and a new SPS Prison Health Strategy setting out clear aims for supporting those in custody with their mental health needs.

**MAT STANDARD 10: All people receive trauma informed care.**

- This standard was jointly assessed with MAT standard 6 and was partially implemented in all 29 ADP areas. Trauma informed care is fully embedded and routinely available in most areas, with plans to further develop, and people with lived and living experience had become fully involved in service design and delivery.

**9. ACCESS TO TREATMENT IN REMOTE AND RURAL AREAS**

**There are unique challenges faced by remote and rural areas. These include lack of prescribing capacity, the logistics of same day prescribing, lack of GP shared care and workforce pressures.**

- The Public Health Scotland based MAT Implementation Support Team (MIST), continue to provide support and assistance to remote and rural areas to share best practice and aid them in mitigating barriers faced.
- A number of collaborative and innovative actions to combat barriers of rurality include:
  - Increased use of non-statutory services, informal local networks and peers to engage and support people, thus freeing up capacity to deliver rapid access and ensuring that staff can work at highest level within their banding.
  - Utilising generic primary and secondary care staff and settings to deliver care for example when weather disrupts usual access.
  - Development of more generic pathways for all drugs and alcohol referrals (given in many places the same staff deal with these issues).
  - Some areas now have formal arrangements with other Health Boards to utilise guidelines (Shetland and NHS Grampian), and to share expertise (Western Isles and Borders).
- Some areas have also demonstrated ways in which teams have maximised access and choice through technology, travel and different models of care, such as:
  - Offering a choice of venues to be seen at; such as GP practice, home and community hubs, as well as settings to deliver care when weather disrupts usual access.
  - High use of self-referral and telephone, 'tele-health' technology such as NEAR ME.
  - Wide use of bus passes, taxis and third sector volunteers to take people to appointments.

## 10. MENTAL HEALTH

- Mention has been made in evidence that priority for people is not always addressing substance use, this includes support for mental health before or alongside any support or treatment
- The shared protocol is designed to ensure joined up service to allow people to access either and receive both

**Our vision is a joined-up healthcare system where people with co-occurring mental health and substance use conditions get timely access to the help they need.**

- The Medication-Assisted Treatment Standards and the Mental Health Strategy set a clear expectation that people with co-occurring mental health and substance conditions should have access to high-quality and integrated care.
- We are working to improve care for people with co-occurring mental health and substance use conditions by supporting areas to implement a new gold-standard protocol that sets out how these services should work together.
- The protocol will help to set strong local foundations, empower the workforce and embed clear lines of accountability. We will work with service users, clinicians, local areas and national organisations to deliver this vision.
- We have commissioned Healthcare Improvement Scotland to lead on this work and to provide tailored support to local areas as they adapt the gold-standard protocol to their local circumstances.

### Shared Protocol

**We have set out how we will achieve our vision of a a joined-up healthcare system where people with co-occurring conditions get timely access to the help they need.**

- We have commissioned Healthcare Improvement Scotland with three years of funding to lead on the creation and implementation of a gold-standard protocol across the country.
- There are three phases to the plan: first, we have put together a gold-standard protocol which sets out how mental health and substance use services should work together to provide joined-up care.
- The second phase is all about implementation. Healthcare Improvement Scotland are working with local areas to help them adapt the protocol to local circumstances and then support them to implement it on the ground. They will do this by providing strategic change management support and facilitating the sharing of best practice.
- The final phase will be focussed on ensuring that change is sustained and that service users continue to benefit from improving services.

- The work is guided by a reference group that includes both mental health and substance use third sector organisations, the Mental Welfare Commission and COSLA. Alongside the reference group, we have a clinicians working group and a lived experience panel.
- We are committed to working with frontline staff, third sector organisations, service users and local governments to create sustainable solutions that delivers real change for service users.

## 11. HOMELESSNESS/HOUSING

- Similar to mental health, people often present with complex needs including homelessness/housing issues that are a greater priority to them than substance use
- The current person centred approach is aimed at supporting people with their needs regardless of what they are in a person centred way

**We know that people with complex needs, including substance use issues, require more than just a house, and that the provision of specialist support is crucial in the transition out of homelessness.**

- We are working to strengthen partnerships between health, homelessness and frontline services to improve outcomes for people experiencing homelessness with multiple and complex needs, including people who use drugs.
- Where someone requires support from a variety of services, it is our priority to get them into suitable accommodation first, which will allow them to access treatment and recovery communities from the security of their own home.
- The SG/COSLA Ending Homelessness Together (EHT) Action Plan includes commitments to upscale Housing First across Scotland and join up planning and resources to tackle homelessness.

## 12. RESIDENTIAL REHAB

- Whilst the policy memorandum accompanying the Bill states that the Bill is not just about residential treatment, the written evidence responses suggest that many people (individuals and organisations) interpret it as doing just that
- In the letter (at Annex G) providing further detail on the financial memorandum, the member in charge suggests that the current SG aim to deliver 650 total beds and 1000 funded places annually could meet the additional demand as a result of the Bill
- Stakeholders (medical professionals and ADP representatives) have stressed the danger of unrealistic expectations of individuals of residential treatment, whether rehab or detox and that a significant part of the support offered is about ensuring someone is fully prepared to enter rehab if it is suitable for them.
- A PHS evaluation on the residential rehab programme states that addressing the question of levels of demand for rehab poses a number of methodological challenges.

### TOP LINES

**A core pillar of the National Mission is to increase access to and the provision of residential rehab. Our vision is that residential rehabilitation is available to everybody who wants it, and for whom it is deemed to be clinically appropriate, at the time that they ask for it and in every part of the country.**

- While we know there is still more to do, the 2024 Public Health Scotland (PHS) baseline report for the Evaluation of the Scottish Government's Residential Rehabilitation Programme provides a useful snapshot of progress as we continue to expand access to residential rehabilitation across the country.
- We are encouraged to see that this first batch of data suggests that **the Scottish Government achieved its objective of 1000 people per year receiving public funding for their residential rehab placement in 2022/23**. We remain ambitious beyond this milestone and in August 2024 we announced a further £2m via the Additional Placement Fund (APF)

### KEY FACTS AND COMMITMENTS

#### **1000 publicly-funded residential rehabilitation placements per year by 2026**

- As part of their wider evaluation of the residential rehabilitation programme, Public Health Scotland (PHS) published a report in December 2024 on the number of people who started a residential rehabilitation placement between 2019/20 and 2022/23. The report shows that in 2022/23, 1,670 individuals were recorded as having started a residential rehabilitation placement in Scotland. The proportion of individuals who received public funding for their placement increased from one in three (34%) of all those who started a placement in 2019/20 to almost two in three (62%) of all those who started a placement in 2022/23. In 2022/23, the majority of individuals (1,033, 62%) started a placement which was publicly funded, compared to 637 individuals (38%) who started a placement which was solely privately funded.
- We remain ambitious beyond this milestone and in August 2024 we announced a further £2m via the Additional Placement Fund (APF), a demand led fund designed

to direct funding where it is most needed to allow ADPs to support even more people to access rehab. This fund has been renewed in 2026/26.

- Public Health Scotland's most recent monitoring report, also published in December, showed that between 1 April 2024 and 30 September 2024, 442 statutory-funded residential rehabilitation placements were approved by ADPs in Scotland.
- This is a **decrease of 37 placements** when compared to the same period in 2023 (n=479), and a decrease of 19 placements when compared to the previous six months (n=461).
- The slight drop in figures was expected based on ADP reporting during this period, and **the Scottish Government have already taken action to support more placements through the Additional Placement Fund (APF)**.
- The APF was only active for four weeks during the period covered by these statistics so its impact is expected to start being reflected in the next publication.

### **Increase residential rehabilitation capacity to 650 beds by 2026**

- The Scottish Government published a report in November 2024 which **provided an updated count of residential rehabilitation capacity** in Scotland
- The report showed that there has been a rise in residential rehabilitation capacity from an estimated 425 beds in 2021 to a maximum of 513 in 2024 – an increase of 21%.
- This report counted bed capacity as of September 2024 – since then, further beds have become available through the completing of projects directly funded by the Scottish Government.
- A total of 28 more beds have become available through the expansion of the King's Court (run by the Maxie Richards Foundation in Tighnabruaich) and the opening of Rae House, Phoenix Futures' national service in Aberdeenshire.
- A further total of 53 will follow through the expansion of Rae House's second phase, which is a Housing and Therapeutic Community Dayhab programme based in Aberdeen City
- In addition, **[Redacted-Section 30(b)(ii)]**
- The **[Redacted-Section 30(b)(ii)]**.

#### **[FOR INFORMATION ONLY]**

- **[Redacted-Section 30(b)(ii)]**.
- **[Redacted-Section 30(b)(ii)]**.
- **[Redacted-Section 30(b)(ii)]**.

## **FUNDING**

- £100m made available for residential rehab over the course of the National Mission
- Includes £38m for capacity programme, £25m uplift to ADPs (£5m per year), £170k for the Scotland Excel Flexible Framework and £2m additional placement fund for RR placements introduced in 2024/25

## **HOT TOPICS**

### **[Redacted-Section 30(b)(ii)]**

- **[Redacted-Section 30(b)(ii)].**
- **[Redacted-Section 30(b)(ii)].**

## **Pathways**

- We have commissioned Healthcare Improvement Scotland to establish six Regional Residential Rehabilitation Improvement Hubs across Scotland, which are composed of ADP representatives from areas that share a geographical proximity with one another.

## **Alcohol Related Brain Damage (ARBD) Unit**

- **[Redacted-Section 30(b)(ii)]**
- **[Redacted-Section 30(b)(ii)]**
- **[Redacted-Section 30(b)(ii)]**
- **[Redacted-Section 30(b)(ii)]**
- **[Redacted-Section 30(b)(ii)]**

## **Residential rehab demand**

- The Scottish Government has commissioned Public Health Scotland to carry out monitoring and evaluation of the Residential Rehabilitation (RR) programme.
- This includes exploring perceptions among referrers, provision of aftercare and post-residential support, demand and perceptions of rehab amongst people who experience problems with drugs, and their experiences of accessing support.
- **[Redacted-Section 30(b)(ii)]**
- PHS are currently undertaking a study to explore the feasibility of setting up a nationally representative survey to capture feedback from individuals with lived experience of using drugs.
- This research project captures individuals' experience of the support on offer across the full range of individuals' support needs. This also includes individuals' views on unmet support needs, including whether they felt they would have benefitted from residential rehab but were unable to access this.



## 13. ALCOHOL POLICY

### TOP LINES

- Supporting people impacted by alcohol is as much of a priority for us and local services as supporting people impacted by drugs.
- Through our Alcohol Prevention Framework we are reducing alcohol harm through actions on price, such as UK-wide alcohol levies and through Minimum Unit Price.
- Reviews of MUP have flagged up that it has reduced harm and saved lives. Public Health Scotland's evaluation of MUP estimated that, during the period reviewed, MUP had saved hundreds of lives and was likely to have reduced hospital admissions wholly attributable to alcohol compared to what would have happened if MUP had not been in place.
- Through our Drugs and Alcohol Strategy and through the National Mission we have also improved access to treatment and recovery. The investment through the National Mission into residential rehabilitation has benefited a significant number of people impacted by alcohol.
- We are currently engaging with alcohol support service partners to develop a new strategic plan to further improve alcohol treatment and recovery.
- The strategic plan will take forward the implementation of the Charter of Rights through a National Specification for alcohol and drug services and will lead to a set of care standards for services to improve outcomes for those affected.
- We are expecting the UK Government to publish Alcohol Treatment Guidelines, to support the improvement of alcohol treatment in Scotland the guidelines and the our forthcoming National Specification will provide clarity for people on what they can expect from treatment and recovery services. These will both also help services provide the highest quality of healthcare for people affected by substance use.

## 14. NATIONAL MISSION FUNDING

### Background

#### FUNDING COMMITMENTS MADE SINCE START OF NATIONAL MISSION

- £250 million additional funding (compared to 2021 levels) over 5 years – on track.
- £65 million over 5 years for grassroots organisations through the Corra National Mission Funds – on track.
- Total funding has more than doubled from £70.5 million in 2014/15 to £160 million in 2025/26.
- Between 2021/22 and 2023/24 ADP funding increased from £106.5 million to £112.9 million – a six per cent increase in cash terms.
- Over £3m a year funding made available to key third party organisations to deliver key priorities.
- £100m made available over the course of the National Mission for Residential Rehabilitation (this includes funding that is already counted in the ADP allocation).

### TOP LINES

**The total 2025/26 funding for alcohol and drugs has been increased by £2.5m compared to 2024/25 and now totals around £160m including health board baseline funding.**

- This includes maintaining £112m funding for Alcohol and Drug Partnerships, continuing to fund grassroots organisations through £13m via the Corra Foundation, and supporting a wide range of activity - including supporting residential rehabilitation and making £2.3m available to support the Thistle Centre Safer Drug Consumption Facility.
- This adds to our significant investment over the past four years, meaning that I am confident we will meet the National Mission commitment of £250m additional funding over 5 years.
- The September 2024 Audit Scotland report on drug and alcohol services recognises a doubling of investment in alcohol and drug services since 2014/15, from £70.5 million to £156 million in 2024/25. As part of a committed £250 million investment in the National Mission in this Parliament.

### FUNDING HOT TOPICS

#### 25/26 BUDGET NEGOTIATIONS: ADDITIONAL FUNDING FOR ALCOHOL AND DRUGS.

##### BACKGROUND

- The draft 2025/26 drugs budget received criticism for not delivering a real terms increase in funding.
- This position changed during budget negotiations with a £2.5 million uplift applied. Lines are provided below.

## LINES

### **The additional £2.5m funding to support work around both alcohol and drugs will allow us to go further and build on our National Mission.**

- The additional £1m funding for Aberlour will allow more women and infants to receive the support they need during this crucial period.
- The additional £1.5m of funding for broader alcohol and drug services will allow us to support even more people to achieve their own recovery.
- Women who use substances can face unique, gender-specific challenges when accessing treatment and support, especially during the perinatal period. This is why we are committed to taking a gendered approach in all of our efforts and ensuring that women and their infants can access the right services for them, when they need them.

## LONGER-TERM FUNDING

### BACKGROUND

- The People Panel report and Audit Scotland report called for more longer-term funding for drugs and alcohol services to provide stability for both organisations and people receiving support.
- This is a criticism across other parts of SG-funded activity, but especially in sectors where there is a high reliance on the third sector to deliver essential services.

## LINES

### **We fully recognise the importance of multi-year funding which is why we launched the National Drugs Mission Funds – a five-year funding commitment, administered by the Corra Foundation, to offer multi-year funding to third sector and grassroots organisations which provided much needed assurance to these vital frontline services.**

- Any funding beyond 2026 for drug and alcohol work will need to be in line with Fairer Funding principles, with a view to providing longer term funding where appropriate to do so, and dependent on future Scottish Budget provision available for drugs and alcohol.
- We are delivering against our commitment to develop a Fairer Funding approach for the third sector by providing more multi-year funding to organisations delivering frontline services and tackling child poverty.
- We greatly value the third sector's strategic role in enabling the transformation
- and delivery of person-centred services for the people of Scotland and recognise that the Sector needs clarity and stability to secure its resilience and to grow its capacity.

## COST-EFFECTIVENESS OF THE NATIONAL MISSION

## BACKGROUND

- [Redacted-Section 30(b)(ii)]
- [Redacted-Section 30(b)(ii)]
- [Redacted-Section 30(b)(ii)]
- [Redacted-Section 30(b)(ii)].
- Lines on the PHS economic evaluation are provided below.

## LINES

### **We have invested money where the available evidence tells us it will have most impact, and will continue to take an evidence-based approach.**

- PHS is undertaking an independent evaluation of the National Mission. As part of this they have commissioned an external study of how National Mission funds have been allocated and spent, and the benefits which that expenditure has (or is likely to have) delivered.
- The study has a number of different research objectives including a summary of existing review-level evidence on treatment effectiveness and cost-effectiveness for treatments in scope, as well as an overview of evidence gaps.
- The external research team are formulating a considered (i.e. being clear about limitations) and reasoned (i.e. being clear about the underlying rationale) response to the question of whether the National Mission funds have been spent on effective and cost-effective drug treatments.
- This research will be used to inform the wider evaluation of the National Mission The Evaluation will be published in 2026.

## ALCOHOL SPECIFIC FUNDING LINES

### BACKGROUND

- Since the Audit Scotland report in September 2024 there has been ongoing criticism of the amount of alcohol-specific funding compared to drugs. Lines are provided below.

### LINES

#### **I am committed to tackling alcohol-related harm on an equal footing to that of drugs.**

- Our budget in 2025/26 of around £160m is for both alcohol and drugs, and our substantial investment supports services which are often delivered in tandem on the front line. Residential Rehab services are for both people experiencing problem alcohol and drug use. The latest (December 2024) PHS monitoring report on statutory funded placements indicated that about half (53%) of the placements

were for people with problem alcohol use and a further 18% with an alcohol and drug co-dependency. These proportions were broadly in line with previous periods

- Furthermore, while there are some programmes supported through the additional National Mission funding which are specifically for drugs – such as naloxone and SDCF – other programmes support services for both alcohol and drugs.
- Similarly, we have some dedicated programmes of work which are focused purely for alcohol treatment and recovery such as the Managed Alcohol programme which is a long-term residential care service run by the Simon Community.
- We are working with partners and stakeholders to develop a national specification for alcohol and drug treatment in Scotland. It will build on the forthcoming UK Clinical Guidelines for Alcohol Treatment which will support the improvement of alcohol treatment in Scotland, mirroring the use of the Orange Book Guidelines for drug treatment.
- Moreover, the forthcoming Alcohol Treatment Guidelines will provide support for alcohol treatment, similar to the Medication-Assisted Treatment Standards for drugs.
- The Scottish Government has also taken concrete preventative action including continuing and increasing the world-leading Minimum Unit Pricing.

## 15. DATA COLLECTION

- The challenges in identifying the additional costs related to Bill has come up repeatedly in committee
- Member in charge is using this as justification for the figures in the financial memorandum, suggesting they are as valid as any others from the data available
- Member in charge and supporting committee members have suggested that the Bill would generate better data collection

### PHS Prevalence Estimate:

- Pivotal to understanding how to approach this national emergency, is an understanding of the scale and shape of the problem in as “real-time” a fashion as possible.
- PHS are working on our behalf to better understand this.
- In March 2025 Public Health Scotland published their latest report on the Estimated Prevalence of Opioid Dependence in Scotland. The estimated number of people with opioid dependence in Scotland in 2022/23 was **43,400**. This represents an **estimated prevalence of 1.23% of 15-64 year olds**.
- Whilst the current estimate relates only to problem opioid use, PHS propose to expand its application to other drugs and alcohol as part of further development.

### Drug and Alcohol Information System (DAISy)

- In order to better understand whether we are meeting need and to account for activity, we also need to understand the scale and shape of services being delivered. PHS are also working on our behalf to better understand this.
- The Drug and Alcohol Information System (DAISy) is a treatment database, developed by PHS to track and provide data on characteristics of service users and patterns of uptake.
- It is a unique source of data on people accessing treatment for problematic substance use and provides insights into their drug and alcohol use, health and social circumstances at the point when they contacted services for treatment. It has been in full operation since April 2021 and there have been two annual publications detailing their Overview of Initial Assessments for Specialist Drug and Alcohol Treatment. PHS continue to build on the functionality of DAISy and plan to implement various changes to improve on data compliance, local and national reporting, incorporation of data related to key strategic aims (including MAT benchmarking Reporting), and improved analysis of treatment outcomes.
- Due to its scope, DAISy does not capture the full breadth of services available to people in Scotland. For instance, GP support, community work or peer support services that do not report to DAISy.
- **[Redacted-Section 30(b)(ii)].**
- **[Redacted-Section 30(b)(ii)].**
- **[Redacted-Section 30(b)(ii)]**
- **[Redacted-Section 30(b)(ii)]**

- **[Redacted-Section 30(b)(ii)]**

- **[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(b)(ii)]**

- Public Health Scotland is conducting an independent evaluation of the National Mission. **[Redacted-Section 30(b)(ii)]**the evaluation consists of**[Redacted-Section 30(b)(ii)]**, **[Redacted-Section 30(b)(ii)]**.
- One of the primary purposes of the evaluation is **[Redacted-Section 30(b)(ii)]** – in order to **[Redacted-Section 30(b)(ii)]**
- The evaluation includes a number of **[Redacted-Section 30(b)(ii)]**

## 16. HARM REDUCTION

### BACKGROUND

#### Top lines

- The proposed Right to Recovery Bill lacks concrete reference to harm reduction initiatives. This Government's approach to harm reduction has always been evidence led.
- The introduction of a naloxone programme, the establishment of the UK's first safer drug consumption facility, alongside the desire to establish drug checking facilities, all come with an international evidence base.
- While some of these initiatives may seem innovative or new to us in Scotland or the UK, they are commonly used in multiple countries around the world.
- These initiatives are also proven to save lives. If it weren't for the provision of naloxone in Scotland, our drug-related death figures would undoubtedly be higher than they currently are.
- Likewise, even in the first 4 months of the Thistle operating in Glasgow, there have been 30 medical emergencies where staff have been able to intervene. Had those happened in people's houses or on the street, these could have ended in a fatality.
- Since the beginning of the National Mission we have invested over £4 million in widening access to Naloxone, including a substantial investment in our emergency services.
- The latest data indicates that Police Scotland colleagues have now administered naloxone on 650 occasions since 2021, again undoubtedly saving lives in the process.
- We know that an estimated 79.1% of those at risk of opioid overdose have been supplied with a naloxone kit (as at the end Q2 2024/25).

#### TOP LINES

### SAFER DRUG CONSUMPTION FACILITIES

- The pilot safer drug consumption facility, The Thistle, started supporting its first service users on Monday 13 January.
- This facility, the first in the UK and backed by £2m of Scottish Government funding, is now one more tool available to us as we seek to reduce the levels of drug deaths across Scotland.
- Published data from Glasgow HSCP web page (up to end April) reports that the service has now been accessed by 246 people and has overseen 2,010 injecting episodes.

**The decision to locate the Thistle where it is was due to existing issues relating to public drug taking already in the area and significant amounts of drug paraphernalia being left discarded as a result.**

- I can appreciate the concerns that have been raised by local residents

- At the moment, and as was confirmed by Superintendent Joanne McEwan when she attended a Westminster Scottish Affairs Committee meeting last week (7 May), there are no concerns in relation to increases in anti-social behaviour in the locality.
- Needle uplift operations are ongoing that address local concerns, with plans underway to expand the availability of needle disposal bins beyond the city centre to other affected areas.
- The facility has encouraged anyone finding needles or other paraphernalia to contact Glasgow City Council via the Health and Social Care Partnership's website - who will arrange for them to be collected within 24 hours.

## **NALOXONE**

- Scotland was the first country in the world to introduce a national naloxone programme and since 2015 anyone working in commissioned drug treatment services has been authorised to provide take home naloxone kits to members of the public.
- The aim is to increase the numbers of kits in general circulation and provide easier access to members of the public requiring to provide initial medical treatment to persons suspected of having suffered an opioid overdose.
- Following recent changes to UK wide legislation, we will continue to work closely with the other UK administrations to identify the best ways in which access to naloxone can be simplified and widened.

## **DRUG CHECKING**

- We are committed to delivering drug checking facilities which would enable us to respond faster to emerging drug trends by testing drugs currently in circulation.
- We will continue to work with partners to implement these facilities across all our pilot cities as soon as possible.
- The local testing sites in Aberdeen, Dundee and Glasgow have submitted their license applications to the Home Office.

## **DRUG CHECKING NATIONAL LABORATORY AT DUNDEE UNIVERSITY**

- We understand that Dundee University has explained that the Leverhulme Research Centre for Forensic Science will continue to operate until external research funding comes to an end next year, and has entered into consultation with affected staff.
- While the university is responsible for its own operational and staffing decisions, we would expect them to adhere to Fair Work principles and ensure meaningful engagement to ensure that affected staff are treated fairly.
- The Scottish Government and Scottish Funding Council will continue to offer support to the University to ensure that it fully explores all options available to maintain their significant research capability and expertise, while it develops a Plan to mitigate its financial challenges.

- Drugs Policy officials are working with colleagues from the Leverhulme Centre to understand the potential impact any decisions around funding may have for establishing a national testing laboratory at the University as part of the wider drug checking pilot.

## 17. DRUG DEATH STATISTICS

- Sandesh Gulhane in particular has asked panel members if the current rate of drug related deaths is acceptable
- It is likely that the rate of drug related and alcohol specific deaths will be questioned, alongside the questions on the efficacy of the National Mission and related work on alcohol

### BACKGROUND

#### NATIONAL RECORDS OF SCOTLAND STATS, 2023 DEATHS (PUBLISHED AUGUST 2024)

- In 2023, there were 1,172 drug misuse deaths registered in Scotland, an increase of 12% (121 deaths) compared with 2022.
- People in the most deprived areas of Scotland are more than 15 times as likely to die from drug misuse compared to people in the least deprived areas.
- There were 479 drug misuse deaths where cocaine was implicated, an increase of 29% (108 deaths) on 2022 when there were 371 such deaths.
- However monitoring information from Police Scotland and Scotland's Rapid Action Drug Alerts and Response (RADAR) early warning system show decreases in suspected deaths throughout 2024.

#### DRUG RELATED DEATHS AND HARMS – LATEST DATA

- April 2025 – Rapid Action Drug Alert and Response (RADAR) data shows an increase in drug-related harms in early 2025 compared to the previous quarter:
- Suspected drug deaths (December 24 – February 25): 17% increase on previous quarter. 251 suspected drug deaths, 21 **per week over the period. Lower than same period of both 2022 and 2023.**
- Naloxone administration incidents (**December 24 to February 2025**): **Similar to the previous quarter. Incidents are at a lower level than the same period of both 2022 and 2023.**
- Drug-related emergency department attendances (**December 2024 to February 2025**): **9% decrease on previous quarter and also down compared with the same period in 2022 and 2023.**
- Drug-related hospital admissions (**October to December 24**): **19% decrease on previous quarter, similar to same period in 2022 and lower than same period in 2023.**
- Intelligence suggests the drug supply remains highly toxic and unpredictable, requiring ongoing vigilance and a heightened response. Significant disruptions and adaptations in the heroin and benzodiazepine markets, appear to be influencing levels and patterns of harm.

#### Top Lines

**While this publication records a quarter-on-quarter rise in suspected drug deaths, it also notes the year-on-year fall. This level of deaths remains hugely concerning and demonstrates the need for us to be taking the actions we are.**

- This Government has never been more committed to continue its efforts to reduce harm and deaths caused by drugs and the investment seen through the National Mission will continue to save and improve lives affected by problematic drug use.
- We continue to monitor the situation and are working hard to respond to the growing threat from polydrug use, including 'street benzos' and cocaine, and from highly dangerous synthetic opioids like nitazines in an increasingly toxic and unpredictable drug supply.
- Such synthetics increase the risk of overdose, hospitalisation and death and are being found in a range of substances.

### **Changing Drug trends**

- We are aware of reports of an increase in fatal and near fatal overdoses in people using heroin in recent weeks. We will continue to monitor the situation and work with partners including Public Health Scotland, the Scottish Ambulance Service and Police Scotland.
- We urge people to exercise caution and to follow guidance issued by both Public Health Scotland and Scottish Drugs Forum. Because of the strength of synthetic substances, we would also urge people to carry extra life-saving naloxone kits.
- It is important that we can be responsive to new patterns of substance use to ensure that support options are available to people regardless of the substances that they use,

## 18. STIGMA

- The potential for the Bill to result in an increase in stigma has been raised – as it singles out people with a diagnosis of addiction for an absolute right to treatment within a specific timeframe
- Stigma is also raised as a reason why people who are affected by substance use and who could benefit from support and treatment may not seek diagnosis thus excluding them from the rights laid out within the Bill

## BACKGROUND

### **Stigma was recognised in the Drug Deaths Taskforce report *Changing Lives as one of the four drivers of drug related harms and deaths in Scotland.***

- Stigma is acknowledged as a significant barrier to people affected by substance use in accessing services, employment, education and training, navigating other aspects of health and social care, and housing.
- The Charter of Rights explicitly mentions stigma as a barrier to people realizing the highest attainable level of physical and mental health.

There is a risk that the Bill could increase in stigma by:

- The requirement of a diagnosis of addiction for the provisions in the Bill to apply is likely to exclude people as a result of the stigma attached to substance – this might be viewed informally by the public as a requirement of diagnosis to access support/treatment, which could dissuade people from seeking support and further isolate/alienate those who will not or cannot risk the stigma of ‘addict’.
- It could create an unnecessary barrier to support, because of the need for a diagnosis and the views of a health professional for the Bill to apply.
- Many people might be dissuaded from such an approach; women with children, those in employment, or in public professions, those without a GP or those who would not access GP support. It is very formal, high-threshold support. Evidence supports the value of low-threshold intervention.
- The term ‘addiction’ is contested and not liked by all and is argued to imply moral failing. The Scottish Government view is that everyone who needs support should have access to it, irrespective of whether they meet criteria of drug addiction.
- Key partners have developed alongside people with LLE, preferred terminology for example ‘dependence’ and ‘substance use disorder’ rather than addiction, abuse or misuse.
- It should also be noted that in Scotland ‘drug dependence’ is more commonly used clinically, to denote the physical dependence on drugs.

## TOP LINES

**Tackling stigma is fundamental to ensuring people get access to help and support that best meets their needs and those of their loved ones.**

## KEY FACTS AND COMMITMENTS

- In the latest ADP Survey (12 November 2024 – separate to the ADP coordinator survey) - all ADPs included stigma in at least one written strategy or policy but were less likely to include stigma in communication strategies, drug or alcohol deaths and harms action plans and community action plans
- Tackling stigma is a cross-cutting priority and fundamental to ensuring people get access to help and support that best meets their needs and those of their loved ones.
- The Stigma Action Plan (published January 2023) outlines priorities in addressing this. We have since taken a co-design approach to delivering on the ambitions of the plan and have commissioned a Design Team and research to be undertaken this year – this work started in April 2024.
- This work will draw together and build on the many initiatives already underway to challenge stigma and discrimination both in Scottish Government and beyond, within a coherent and focused approach.
- Our Workforce Development plans will seek to tackle the stigma experienced by those engaging with the services and those delivering services.
- The Charter of Rights is also key to tackling stigma by ensuring that people affected by substance use have access to same universal rights as everyone.

## FUNDING

- We have invested over £3 million in making sure that people with lived and living experience are genuinely at the heart of all our work on the National Mission
- This has been achieved through CORRA funding to grassroots and community organisations, funding allocated to ADPs to support meaningful participation of people with lived and living experience in decision making and finding SDF to deliver lived experience engagement groups across the country.

## [REDACTED-SECTION 30(B)(II)]

- [Redacted-Section 30(b)(ii)]
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## KEY ACTIVITIES AND STATS

The stigma action plan was published as part of the Cross Government Response to the Drug Deaths Taskforce on 12 January 2023

Support and treatment reduce alcohol and drug deaths - stigma prevents people from accessing the treatment and support they need and are entitled to.

Tackling stigma is a cross cutting priority of our National Mission on drugs.

Co-design of the interventions began in April 2024

## Annex F – Q&A (based on themes of committee questions)

### Theme 1 – Duty to secure delivery of the rights established by the Bill

#### Context:

Under section 4 of the Bill, Scottish Ministers are under a duty to “secure the rights conferred” by the Bill. Section 4 requires Scottish Ministers to make regulations setting out “the arrangements that are in place” to comply with that duty. Regulations under this section may confer functions on various bodies, such as Health Boards, Local Authorities, and IJBS.

This was raised in the memorandum:

- “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.”
- “As a more technical point, Section 4(2) is framed as a power for the Scottish Ministers to lay draft regulations setting out arrangements which are in place or are to be put in place to comply with the duty to secure delivery of rights. However, there is no corresponding power for the Scottish Ministers to make regulations (and for those regulations to therefore become law) in the event that Parliament was to approve the draft.”
- “We note that section 5 of the Bill requires Ministers to report to Parliament on a range of information. Where this would require additional collation of data by public bodies and from medical records of individuals, we would invite the Committee to consider if there are any considerations in relation to GDPR or the ICO that would impact the aim of the reporting requirements.”

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#### Possible additional questions

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#### Background

[Redacted-Section 30(b)(ii)]

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## Theme 2 – Charter of rights for people affected by substance use

[Redacted-Section 30(b)(ii)]

*It is essential to include those most affected by drug use disorders in all decisions, policies and laws. The Scottish Charter of Rights for People Affected by Substance Use is an example of a policy developed through a multistakeholder process, reflecting the unique needs of different groups, including people who use drugs. I hope it can serve as inspiration to other countries around the world.*

*Volker Turk – UN High Commissioner for Human Rights (May 2025)*

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### Possible additional questions

[Redacted-Section 30(b)(ii)]

[Redacted-Section 30(b)(i)]

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### **Theme 3 – Enforcement of rights**

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### **Theme 4 – National service specification for substance use support services**

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#### **Theme 5 – Multi-disciplinary team**

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#### **Theme 6 – Clinical decision making and the need for a diagnosis**

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## **Theme 7 – Reporting requirements**

**[Redacted-Section 30(b)(ii)]**

**[Redacted-Section 30(b)(i)]**

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**Theme 8 – Estimation of levels of substance dependence and financial implications**

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**Annex G**

**Douglas Ross letter to Finance and Public Administration Committee with  
repose to questions on financial memorandum**

Attached separately

## Annex H – Memorandum to Committee

### RIGHT TO ADDICTION RECOVERY (SCOTLAND) BILL

#### MEMORANDUM FROM THE SCOTTISH GOVERNMENT TO THE HEALTH, SOCIAL CARE & SPORT COMMITTEE and THE PUBLIC FINANCE AND ADMINISTRATION COMMITTEE

##### Introduction

**This memorandum has been prepared by the Scottish Government to assist the Health, Social Care and Sport, and the Public Finance and Administration Committees in their consideration of the Right to Addiction Recovery (Scotland) Bill, introduced by Douglas Ross MSP on 14 May 2024 (the “Bill”; the “R2R Bill”).**

- We wish to be consistent in our memoranda to both committees, therefore both policy and financial considerations are outlined below.
- The Scottish Government is committed to supporting people affected by substance use by reducing deaths and improving lives and are keen to consider any interventions which could support this. As such we have conducted an analysis of the Bill within the context of the current drugs and alcohol policy landscape. We have outlined below context regarding current practice of relevance to the provisions in the Bill that we hope will support the Committee’s consideration through Stage One.

##### Consultation

- A consultation was lodged along with Mr Ross’s draft proposal and ran from 6 October 2021 to 12 January 2022 with 194 responses. The consultation included an outline of the general aims of the Bill, but no draft Bill was provided at this point to consider.
- The consultation summary indicated that 64% of respondents were fully supportive of the proposed Bill, and 14% partially supportive. Meanwhile only 11% were fully opposed and 6% were partially opposed.
- There were a range of views expressed, some relating to aspects of the proposal that are not included in the Bill as introduced. Although the responses are relevant to discussions, we invite the Committee to ensure that there is broad engagement on the content of the Bill as introduced. We have suggested stakeholders who the Committee may wish to engage with through their call for evidence at **Annex A**.

##### The Scottish Government’s Position

**The Scottish Government supports the intended outcomes of the Bill as introduced and we welcome the committee’s call for evidence and will engage fully with the committee’s consideration of the Bill.**

- The Scottish Government is committed to addressing the harms caused by substance use in Scotland, and to designing and delivering services in a rights-based way. We would note the wide range of actions being taken nationally and locally through our National Mission that deliver across areas highlighted in the Bill, as well as our public commitments already made or now being implemented.

- In December 2024 the Scottish Government supported the launch of the [National Collaborative Charter of Rights](#) for people affected by substance use. The Charter seeks to support individuals to understand their rights and the support they can expect to receive, and to support service providers to adopt a human rights-based approach.
- During 2025 the Scottish Government will further develop a national service specification for substance use support services. This will set out what service users are entitled to expect and will set out for service providers what should be available for people affected by substance use – this covers alcohol and drugs. Both the Charter and the specification have been developed with a range of stakeholders, including people with lived and living experience.
- The rights-based approach of the Charter and the specification have been developed to work alongside existing professional codes of conduct, and to take account of existing and developing clinical guidelines for alcohol and drugs which ensure that people enter appropriate forms of support.
- The Scottish Government's commitment to improvement clearly recognises that more needs to be done to ensure people affected by substance use are aware of treatment and recovery services, and that more and clearer information should be available for people, families, communities, service providers and the public.
- We consider that care and support for individuals must be at the point of need, which evidence suggests takes many forms, including medical, Community Pharmacy, Occupational Therapists, Social Workers, social care, families, third sector support including recovery communities.
- This range of support requires professional and clinical input from a wide group of professions and services, and these are recognised in the Charter of Rights and intended to be covered in the national specification. The range of services that will be covered by the national specification emphasises that health professionals play an important role but that many non-medical services also play a key role in supporting people.
- The Health and Social Care, and Public Finance and Public Administration Committees have asked a number of questions as part of the call for evidence on the Bill and these are responded to below.

### **Financial consideration**

#### **The financial memorandum estimates Year 1 costs of between £29.0m-£38.5m and ongoing costs of between £28.6m-£38.2m per year.**

- These costs are to be met by the Scottish Government (up to £9.6m), and key bodies such as Health Boards (up to £15.4m) and Alcohol and Drug Partnerships (ADPs) (up to £13.4m). The most significant component of the estimate relates to additional costs should treatment completion rates increase from 69% to either 89.3% (high estimate) or 85.4% (low estimate). This is based on stopping between 50% and 66% of early discharges and on the current Drugs and Alcohol baseline as a baseline of the total cost of treatment.
- The financial memorandum applies a broad pro-rata increase to the entire existing drugs and alcohol budget to estimate this cost.
- The current budget for Alcohol and Drugs encompasses non-clinical as well as clinical support, with varying costs depending on type of treatment and routes to

payment. In addition to this there are costs to health boards and social services for providing the wider range of services for people affected by substance use that are not paid for by the drugs and alcohol policy budget, but which are needed to ensure full support. The Committee may wish to examine if the financial memorandum takes account of these factors.

- To more fully understand the financial implications, a modelled estimate might start with estimating how many more people are likely to require support and care and of what kind. Within this, consideration might be given to both the capital costs associated with increasing capacity and variety of the overarching support offer, as well as the ongoing costs of meeting treatment, recovery and care needs, in addition to staff capacity and training requirements.
- We recognise however that it is extremely challenging to estimate demand and unmet need given the stigmatised nature of substance use – recognising that this cohort is impacted by wider societal and systemic needs beyond treatment services. For example, PHS has developed a new model for estimating the number of people in Scotland with opioid dependence - however, estimates are not currently available for populations impacted by other types of drugs, and alcohol in particular.
- In the longer term, the Bill ‘anticipates significant savings including from reduced demands on health, prison, law enforcement and emergency services and from numerous other wider societal benefits.’ We would invite the Committee to consider the extent to which a reduction in substance dependence would relieve system pressure rather than realise financial savings.
- The committee may wish to consider if the absolute nature of the right to provision within three weeks may prove challenging to the establishment and management of drug and alcohol budgets. In order to meet this provision there may be a requirement to always ensure there is available service provision in excess of need (spare capacity), with attendant costs prioritised over other areas of health and social care pressure and services where currently local decisions on resource allocation will be taken to reflect the full needs of the local population.

### **Purpose and extent of the Bill**

The Bill highlights issues including:

- People not being involved or empowered in decisions about their care.
- Lack of funding for drug and alcohol services, including residential rehabilitation
- Challenges and barriers people face in accessing services.
- A lack of clear publicly available information on the types of treatment available to people affected by drug and/or alcohol.

As noted above the Scottish Government is supportive of the intended outcomes of the Bill and will want to hear and contribute to Stage One discussion around the Bill.

Through our National Mission, the Scottish Government is working with stakeholders to help improve delivery and support for a wide range of activity to address the harms caused by substance use.

**In designing and delivering services we are committed to ensuring people are involved or empowered in decisions about their care/preferred treatment, for example through:**

- The Medication Assisted Treatment (MAT) Standards, ([benchmarking report published July 2024](#)) supported by an investment of £10m a year, aims to promote choice and agency so people can be involved in their care plans.
- Supporting the National Collaborative's Charter of Rights for people affected by substance use ([published Dec 2024](#)) which aims to empower people to understand their rights and how to identify and seek better care and support services to plan and deliver services under a human-rights based approach.
- Realistic Medicine and the Value Based Health and Care Action Plan ([published October 2023](#)) aims to support meaningful conversations between health and care professionals and the people they care for in a way which focuses on outcomes that matter to the individual. The outcomes that matter to people are not always clinical outcomes.

**Funding for drug and alcohol services, including residential rehabilitation:**

- We have made record levels of funding available to support our National Mission with a 67% increase from 2014 funding levels, through our commitment of an additional £250m over the course of the Mission.
- One of the core pillars of the National Mission is to increase access to and the provision of residential rehab. We have significantly increased the number of people being supported to access rehab. In a report published in December 2024, PHS concluded that, based on the available data, the Scottish Government reached its target of 1,000 individuals publicly funded to go to residential rehabilitation per year in the financial year 2022/23.
- To expand capacity, we have made £38m available to eight projects across Scotland. This investment increases the number of bed spaces available and widens access to specific groups and addresses geographic barriers to accessing rehab.
- As of September 2024, there was a maximum capacity of 513 residential rehabilitation beds in Scotland across 25 facilities. This is an increase of 88 beds (21%) compared to August 2021 (425 beds)<sup>1</sup>.
- Coupled with significantly increased funding for the sector, this means we are making progress towards our commitment of increasing residential rehabilitation capacity from 425 to 650 beds by 2026.

**Tackling challenges and barriers people face in accessing services, including waiting times for services:**

- We have funded Healthcare Improvement Scotland to lead on the creation and implementation of a "gold-standard" joint working protocol for mental health and substance use services to ensure that people with co-occurring mental health and substance use conditions can access high quality care.

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<sup>1</sup> [Residential rehabilitation bed capacity in Scotland, September 2024 - gov.scot \(www.gov.scot\)](#)

- The Dual Housing Support Fund was set up to prevent people having to choose between rehab and maintaining their tenancies.
- We have committed funding for the development of several projects which will support women and their families through recovery in Scotland and have set up an expert working group to improve pathways for women to access support during pregnancy.
- As part of the Proactive and Preventative Care Programme, there have been a series of local pathfinders - co-designed with people with lived experience - to support the development of the Getting it Right for Everyone practice model (GIRFE- which builds on GIRFEC, but for adult services).
- We are exploring expansion of the Scottish Recovery Consortium's Prison Recovery Project. This work has increased the reach of drug and alcohol recovery activities in the prison estate and provides recovery pathways as people return to their community.

**Ensuring clear publicly available information on the treatment available to people affected by drug and/or alcohol:**

- The Scottish Government publishes the [National Mission Annual Report](#). This outlines the activity, developments and achievements made towards the National Mission by national government, local government and third sector partners. The Annual Report also provides transparency regarding financial accounts for the National Mission.
- Public Health Scotland maintain the Drug and Alcohol Information System (DAISy), a national database that holds data about drug and alcohol services, including Prisons data, across Scotland delivering specialist tier three and four interventions. Data from DAISy provides (1) quarterly performance reporting against the 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; (2) annual statistics providing insights into drug and alcohol treatment needs and the social circumstances and behaviours of people at the point when they contact services for treatment. PHS continue to build on the functionality of the DAISy system to ensure we can record, monitor, and analyse the most relevant and robust data, which would help us to understand the uptake of, and improvement in, drug and alcohol services.
- Through the Medication Assisted Treatment Standards programme, all delivery partners were required to produce implementation plans and each area reports on progress to the Scottish Government on a quarterly basis; Public Health Scotland also publish an annual benchmarking report on the progress that Alcohol and Drug Partnerships (ADPs) in Scotland are making to implement all ten medication assisted treatment standards.
- Public Health Scotland produce a six-monthly report monitoring the number of statutory-funded residential rehab placements approved. On 17 December 2024, PHS [published](#) the first statistics reporting on the number of individuals starting a residential rehabilitation placement.
- PHS publish quarterly estimates of the number of people prescribed Opioid Substitution Therapy in Scotland ([last published 3 December 2024](#)).
- Public Health Scotland's [Rapid Action Drug Alerts and Response](#) (RADAR) is Scotland's drugs early warning surveillance system. Using innovative data collection methods, RADAR validates, assess and shares information to reduce

the risk of drug-related harm. This includes publishing accessible, up to date information on services.

- Launch of [National Residential Rehabilitation Service Directory](#) to help individuals and workers understand the types of residential rehabilitation services available and includes personal testimonies from people who have accessed residential rehabilitation.
- We recognise that despite all of this work and positive progress, change for people on the ground can feel slow. In addition, the emerging threat of synthetic substances and the potential for contamination of supply could affect an even greater number of people.
- We are confident that taking a public health approach, coordinating efforts from across Government, Alcohol and Drug Partnerships, civil society and grassroots organisations is the right one because it is informed by the experiences of people affected by substance use as well as evidence of what works. The committee may wish to consider the provisions of the Bill within the context of the activity currently being delivered by the Scottish Government, which, as we have stated, shares the intended outcomes of the Bill.
- We are committed to ensuring the best possible standards of care and support, and welcome feedback on how we take this approach forward.

### **Existing policy and practice context and Treatment determination process**

**The treatment determination process set out in the Bill where individuals presenting for drug or alcohol addiction treatment have an assessment of their needs, leading to a recommendation about appropriate services including their treatment options, is already accepted and promoted as good practice. In existing clinical practice, determinations are reached in accordance with professional codes and through UK-wide clinical treatment guidance which puts the needs of the individual at the centre of assessments and determinations.**

- The General Medical Council (GMC) guidance "[Good Medical Practice](#)" ("GMP"), which came into effect on 30 January 2024, together with six pieces of more detailed guidance, represents core guidance for all registered doctors and covers a variety of professional issues/standards including good medical practice; prescribing; decision making and consent; and confidentiality. The GMP also states that in providing clinical care, a clinician must take account of a patient's "relevant psychological, spiritual, social, economic, and cultural factors".
- There are a number of routes into treatment at present and while formal diagnosis of addiction is possible it is not required. Treatment and support are available through a variety of professions and services. Many people seek harm reduction interventions by choice, such as take-home naloxone or needle exchange, without formal diagnosis, as part of their own chosen care or recovery journey.
- Others may also not wish to have a formal diagnosis noted on their health records, and thus may not seek the proposed treatment determination, or do not feel emotionally ready to seek formal support. Reasons for not wishing to have a formal diagnosis of addiction can include stigma, fear of losing children and family, especially among women, concern about having a diagnosis recorded on medical records. This may unintentionally exclude the most marginalised in communities of people affected by substance use.

- Current care planning involves a wide range of professionals who are not considered health professionals. Implementation of the Bill as it stands would require a restructuring of how Integration Authorities and Alcohol and Drug Partnerships plan, commission and deliver service requirements, as well as how care plans are developed, and referrals are made. Much of this work is undertaken by local authority social work and social care rather than by health professionals.
- The committee may wish to consider how the proposals in the bill fit with the existing delivery framework for drug and alcohol services and what the effect of any changes may be on broader drug and alcohol support services; in addition to the extent to which section 3 of the Bill departs from existing GMC guidance and any unintended impacts for those accessing services.

**Advantages and/or disadvantages of placing a right to receive treatment, for people with a drug or alcohol addiction, in law.**

**As noted, the Scottish Government supports a person centred and rights-based approach and welcomes the launch of the National Collaborative Charter of Rights for people affected by substance use. This will be reflected in the national service specification for substance use support services that we expect to finalise during 2025. Both the Charter and the specification have been developed with a range of stakeholders, including people with lived and living experience.**

- We would invite the committee to consider the detail of how any proposed rights can be adequately enforced and how the process for recourse or remedy for people who feel their rights have not been met will operate, particularly for individuals not seeking a medical intervention.
- The Scottish Government has responsibility for the overall functioning of the NHS in its delivery of healthcare. Delivery of health services and social care services which are devolved to local authorities and integration authorities, who deliver the overall approach to healthcare, social care and social work. 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.
- As a more technical point, Section 4(2) is framed as a duty for the Scottish Ministers to lay draft regulations setting out arrangements which are in place or are to be put in place to comply with the duty to secure delivery of rights. However, there is no corresponding power for the Scottish Ministers to make regulations (and for those regulations to therefore become law) in the event that Parliament was to approve the draft.
- We note that section 5 of the Bill requires Ministers to report to Parliament on a range of information. Where this would require additional collation of data by public bodies and from medical records of individuals, we would invite the Committee to consider if there are any considerations in relation to GDPR or the ICO that would impact the aim of the reporting requirements.

**Definitions of ‘treatment’ and the range included within the Bill.**

**As set out above, estimating the levels of substance dependency across the population is challenging as many people do not seek support through formal services. Those who do engage with services often contact third sector providers.**

- In 2022/23 (the most recent data available), the estimated number of people aged 15 to 64 years with opioid dependence in Scotland was 43,400. In 2022/23, 28,855 people aged 15 to 64 received Opioid Agonist Therapy (OAT). The estimated exposure of OAT was therefore 66%, suggesting that a third of the people affected by opioid dependence in 2022/23 did not receive clinical support. A further 13% (6,078 of the estimated total) had received OAT sometime in the four years preceding but not during 2022/23. Therefore, over one in five (21%) of the total estimates population did not receive OAT at any point in the last five years (i.e. were 'unobserved').
- Support for people affected by substance use takes many forms, with a range of service providers and professions offering and defining treatment, including (but not limited to); specialist clinical treatment, psychosocial support, peer support, medication assisted treatment, counselling, mutual aid groups, recovery communities, residential rehabilitation, community-based support. This support can be offered in multiple ways via different sources including primary care, community pharmacies, mutual aid organisations, community recovery services, peer support, rehabilitation centres, national third sector organisations, faith-based organisations, and grassroots organisations.

**Timescales for providing treatment.**

- We have noted above the wide range of treatment and support that are available for those who seek support for substance use. At present, MAT Standard 1 requires availability of same day prescribing for OST. In the last annual National Benchmarking Report for 2023/24 (published in July 2024), MAT Standard 1 was evidenced as being fully implemented by 23/29 (79%) of ADP areas and partially implemented in 6/29 (21%) of ADP areas.
- Whilst we recognise that there are limitations to these statistics, we are working to ensure that everyone who requires MAT knows about it. We are also working to understand how people are experiencing MAT in order to implement improvements.

**Conclusion**

**We thank the Committee for the opportunity to contribute to the consultation and hope that this analysis will contribute to constructive discussion on the specifics of the Bill through the Committee process.**

**Annex A**

**Suggested Stakeholders and Experts to engage with during the Call for Evidence (to be renamed ANNEX A for HSCSC)**

We recommend that the Committee hears from a range of stakeholders during their call for evidence. We have included some suggestions under the following groups and would be happy to facilitate an introduction if necessary:

- Public Health Scotland
- Healthcare Improvement Scotland
- COSLA
- Integration Authorities
- Alcohol and Drug Partnership Coordinators
- Scottish Drugs Forum
- Scottish Recovery Consortium
- Scottish Families Affected by Drugs
- SHAAP
- Crew
- Recovering Justice
- **SG Advisory Groups:** National Mission Oversight Group, Workforce Expert Delivery Group, Residential Rehabilitation Development Working Group, National Collaborative, Whole Family Approach Framework Delivery Group, Children and Young People Working Group, MAT Implementation Support Team (MIST)
- **Service Providers:** NHS, Clinical Directors, SG Clinical Advisory Group, Turning Point Scotland, Simon Community, With You, Pharmacy & Community Pharmacy
- **Outside of Scotland:** Release, Cranstoun, Transform, International Drug Policy Consortium, Global Commission on Drug Policy.

<https://www.parliament.scot/-/media/files/committees/health-social-care-and-sport-committee/correspondence/2025/right-to-addiction-recovery-scotland-bill.pdf>

# **RIGHT TO RECOVERY BILL – COMMITTEE EVIDENCE SESSION – 20 MAY 2025**

## **Opening remarks**

Thank you for your invitation to give evidence to the committee on what is – as you have heard through the evidence sessions – a complex and important topic.

As I outlined in my written response to the Committee’s call for evidence, the government supports the intention behind this Bill. Supporting people into high quality treatment and support options that are right for them is the cornerstone of the government’s approach to tackling the harms and death caused by alcohol and drugs, and we have already delivered some significant improvements.

This is why we commissioned the National Collaborative and charged a Change Team with the task of creating the Charter of Rights for people affected by substance.

The Charter was launched by the National Collaborative in December, having been developed by the Change Team with significant engagement with people with lived and living experience.

I myself, along with the First Minister, attended the Collaborative's launch of the Charter and made clear our support for and commitment to the principles of a rights based, anti-stigma approach.

The Charter is recognised as the first of its kind globally, and described by the UN High Commissioner of Human Rights as an 'inspiration'. The Charter sits alongside and strengthens all our work to support people affected by drugs and alcohol, as well as across our broader aims to embed Human Rights in Scots Law.

The rights in the Charter are universal and should be available for all but are often inaccessible for people affected by substance use. The rights cover all aspects of a person's life, because people affected by drugs and

alcohol are more than just a diagnosis, and they have the right to have their rights respected in all areas of their lives.

In October, Audit Scotland published a report on Drug and Alcohol services which acknowledged that we have improved national leadership and made significant progress in tackling a long standing issue with drugs and alcohol, including increasing residential rehabilitation capacity and implementing treatment standards.

However, there is clearly more to be done. This year we will deliver a national specification outlining the services which should be available in every area of Scotland and we will continue to provide funding to support maintaining 1,000 residential rehabilitation placements. We will also shortly launch a suite of publications to support the development of the drug and alcohol workforce and to support the employability of people affected by substance use.

We are engaging widely with stakeholders on the next steps of our approach to supporting people affected by alcohol and drugs to ensure that we identify and build on successes and learning to date. We want to continue to ensure people are able to access the high quality support they want and need, that we are able to meet people where they are, and that we can remove the barriers that people all too often encounter.

My officials and I have been closely following the evidence gathered by yourselves, and that evidence will inform our decision making on the Bill, and any amendments that we may wish to bring forward, should the Bill pass the Stage one vote.

Clearly, we support the intention to ensure people have access to the right treatment and support for them. I welcome the conversation and focus that this Bill has brought to this issue, and I am encouraged by the consideration that witnesses have given and the breadth

of experience and expertise they have brought to the table.

However, as raised in my memorandum there are concerns about some of the detail in the provisions within the Bill. The concerns I raised have largely been echoed by many of the witnesses in the course of their evidence to this committee. It is clear that there is a complexity that needs to be navigated. I look forward to reading the stage one report from this committee when it is published.

I am grateful to the committee for the thorough way it has handled the scrutiny thus far and once again I thank you for inviting me to give evidence on this important issue.

**WORD COUNT 682**

**APPROX 4 mins**

**From:** [Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 19 May 2025 09:01  
**To:** DG Health & Social Care <DGHSC@gov.scot>; [Redacted-Section 38(1)(b)] [Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** R2R Shadow Bill Team <R2RShadowBillTeam@gov.scot>; [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Committee Forward Look w/c 19 May - for action 10:00 today

Hi [Redacted-Section 38(1)(b)],

Completed for R2R Bill.

AB

[Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)] On Behalf Of DG Health & Social Care  
**Sent:** 19 May 2025 08:07  
**To:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]  
**Cc:** DG Health & Social Care ; R2R Shadow Bill Team  
**Subject:** FW: Committee Forward Look w/c 19 May - for action 10:00 today  
**Importance:** High

Hello,

Please see attached committee forward look including two items for the health. Grateful if you could issue comments directly to DGO by no later than 10:00 today.

If there are any interactions with the committee regarding either of these items, please can you keep us updated.

Best wishes,

[Redacted-Section 38(1)(b)]

**Private Secretary to Caroline Lamb** | Chief Executive of NHS Scotland & Director General for Health and Social Care  
Scottish Government | Email: DGHSC@gov.scot



**Responsibility for filing key documents and communications on the record, including those sent to DG Health and Social Care and Caroline Lamb, rests with relevant policy and operational areas within Directorates. The DG Support Team does not keep official records of such e-mails or attachments.**

**From:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot> On Behalf Of Cabinet Secretariat Inbox  
**Sent:** 16 May 2025 16:46



**[Redacted-Section 38(1)(b)]** in the Parliament and Legislation Unit would be happy to discuss any questions you may have about the Forward Look exercise.

Thanks

**[Redacted-Section 38(1)(b)]**

**[REDACTED-SECTION 38(1)(B)]**

Deputy Private Secretary to Minister for Parliamentary Business

M: 07**[Redacted-Section 38(1)(b)]** E: MinisterPB@gov.scot

The Scottish Government | St Andrew's House, Regent Road, EDINBURGH EH1  
3DG

*Scottish Ministers, Special Advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See [www.lobbying.scot](http://www.lobbying.scot).*

*All e-mails and attachments sent by a Ministerial Private Office to another official on behalf of a Minister relating to a decision, request or comment made by a Minister, or a note of a Ministerial meeting, must be filed appropriately by the primary recipient. Ministerial Private Offices do not keep official records of such e-mails or attachments.*

**SCOTTISH PARLIAMENT COMMITTEES – FORWARD LOOK – SUMMARY OVERVIEW**  
**SIGNIFICANT ITEMS OF FORTHCOMING COMMITTEE BUSINESS: w/c 19 May 2025**

DATE	COMMITTEE	AGENDA ITEM	EVIDENCE
[Redacted-out of scope information]	[Redacted-out of scope information]	[Redacted-out of scope information]	[Redacted-out of scope information]
20 May	Health, Social Care and Sport	Right to Addiction Recovery (Scotland) Bill (stage 1)	Cabinet Secretary for Health and Social Care
[Redacted-out of scope information]	[Redacted-out of scope information]	[Redacted-out of scope information]	[Redacted-out of scope information]
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[Redacted-out of scope information]	of

<b>HEALTH, SOCIAL CARE AND SPORT COMMITTEE</b>	
CLOs: [Redacted-Section 38(1)(b)] – correspondence to be copied through DGHSC@gov.scot,	
20 May	[Redacted-out of scope information]  <b>Right to Addiction Recovery (Scotland) Bill (stage 1):</b> evidence from: <b>Cabinet Secretary for Health and Social Care,</b> Morven Davidson, Lawyer and Laura Zeballos, Deputy Director, Drugs Policy Division, Scottish Government
<b>Additional Comments</b>	<b>Right to Addiction Recovery Bill</b> – most committee witnesses have so far predominantly drawn out and pointed to problems with the Bill. CSHSC will be taking a neutral stance, pointing to evidence/issues heard through process so far.

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Parliament and Legislation Unit  
19 May 2025

**From:** [Redacted-Section 38(1)(b)]

**Sent:** 19 May 2025 12:12

**To:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** HSCS Committee - details

Hi Laura

Details for tomorrow:

## **Health, Social Care and Sport Committee**

**Location:** TG.60-CR3 The Fleming Room Hybrid meeting

**Date:** 20/05/2025

**Estimated Start Time:** 10:40 am

**Estimated End Time:** 1:00 pm

1. Decision on taking business in private: The Committee will decide whether to take item 5 in private.

2. Employment Rights Bill (UK Parliament legislation):

The Committee will take evidence from—

Lesley de Jaeger, Director of People and Culture, Cornerstone attending on behalf of, Coalition of Care and Support Providers in Scotland (CCPS);

Karen Hedge, Deputy Chief Executive, Scottish Care;

Dave Moxham, Deputy General Secretary, Scottish Trades Union Congress.

3. Subordinate legislation:

The Committee will consider the following negative instrument—

Human Tissue (Supply of Information about Transplants) (Scotland) Regulations 2025

**4. Right to Addiction Recovery (Scotland) Bill: The Committee will take 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, Scottish Government**

**[Redacted-Section 38(1)(b)] | Drugs Policy | Health & Social Care Directorate | Scottish Government**

Email: [Redacted-Section 38(1)(b)]@gov.scot

**Pronouns she/her**

**From**[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 20 May 2025 08:33

**To:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 30(c)] <[Redacted-Section 30(c)]@gov.scot>; [Redacted-

Section 30(c)] <[Redacted-Section 30(c)]@gov.scot>; [Redacted-Section

30(c)]@gov.scot[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section

38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section

38(1)(b)]@gov.scot>; Jennie Gollan <Jennie.Gollan@gov.scot>; Spads Admin

<Spads\_Admin@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: Briefing for HSCS Committee Evidence Session on Right to Recovery (Scotland) Bill 20 May 2025

...copying comms for awareness.

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**From:** [Redacted-Section 38(1)(b)]@gov.scot>

**Sent:** 20 May 2025 08:35

**To:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>

**Subject:** FW: Briefing for HSCS Committee Evidence Session on Right to Recovery (Scotland) Bill 20 May 2025

This attachment has the themes for the questions

**[Redacted-out of scope information]**

**From:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>  
**Sent:** 21 May 2025 13:10  
**To:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>  
**Cc:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;  
[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>  
**Subject:** RE: Committee briefing

Here's the briefing:

Draft 2 - Right to Addiction Recovery Bill - Stage 1 - Briefing for Cabinet Secretary  
**[Redacted-Section 30(c)]**

**From:** [Redacted-Section 38(1)(b)]  
**Sent:** 21 May 2025 13:03  
**To:** [Redacted-Section 38(1)(b)]  
**Cc:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]  
**Subject:** Committee briefing

Hi [Redacted-Section 38(1)(b)],

We in my team are starting to work on a briefing pack ahead of Cab Sec giving evidence to the Scottish Affairs Committee on the Thistle. To help with that I was wondering if you might be able to share a final copy of the briefing pack which went to Cab Sec ahead of committee yesterday?

Thanks,

**[REDACTED-SECTION 38(1)(B)]**

**[Redacted-Section 38(1)(b)] | Drugs Policy Division | Scottish Government | 3 E  
St Andrews House | Regent Road | Edinburgh | EH1 3DG**

**From:** [Redacted-Section 38(1)(b)]@gov.scot> **On Behalf Of** Cabinet Secretary for Health & Social Care 2024

**Sent:** 23 May 2025 14:33

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>; Minister for Parliamentary Business 2024 <MinisterPB@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: Right to Addiction Recovery Bill - Readout of SG Evidence session 20 May 2025PO

[Redacted-Section 38(1)(b)],

Thanks for providing this readout. Mr Gray has noted.

Kind regards

[Redacted-Section 38(1)(b)]

[Redacted-Section 38(1)(b)]

**Unit Head**

**Ministerial Private Office**

**The Scottish Government**

St Andrew's House | Regent Road | Edinburgh | EH1 3DG

**From:** [Redacted-Section 38(1)(b)]

**Sent:** 22 May 2025 17:22

**To:** Cabinet Secretary for Health & Social Care 2024 ; Minister for Parliamentary Business 2024

**Cc:** Deputy Director - Drugs Policy ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)]

**Subject:** Right to Addiction Recovery Bill - Readout of SG Evidence session 20 May 2025PO

POs for Cab Sec HSC and Minister for Parliamentary Business

Please find attached a readout of the SG Evidence session to Health Social Care and Sport committee on the Right to Addiction Recovery (Scotland) Bill

Drug and Alcohol policy - Ministerial - Right to Recovery Bill - note of CS evidence session to lead committee - 20 May 2025 [Redacted-Section 30(c)]

Many thanks

[Redacted-Section 38(1)(b)]

[Redacted-Section 38(1)(b)] | **Drugs Policy | Health & Social Care Directorate | Scottish Government**

Email: [Redacted-Section 38(1)(b)]@gov.scot  
Pronouns she/her



Right to Addiction Recovery (Scotland) Bill, Health, Social Care and Sport  
Committee, 20<sup>th</sup> May 2025 12:00 – 13:00

Witnesses present:

Neil Gray, Cabinet Secretary for Health and Social Care, NG

Morven Davidson, Lawyer, Scottish government, MD

Laura Zeballos, Deputy Director, Drugs Policy Division, Scottish Government, LZ

Committee Members present:

Claire Haughey, CH

Brian Whittle, BW

Elena Whitham, EW

Sandesh Gulhane, SH

Claire Mochan, CM

Gillian Mackay GM

Joe Fitzpatrick, JF

Emma Harper, EH

The Cabinet Secretary attended the session of the Health, Social Care and Support Committee to answer questions relating to stage 1 scrutiny of the Right to Addiction Recovery (Scotland) Bill.

Questions focused on SG view on the following:

- Would the Bill support people in getting access to help when they asked for it
- Are there barriers to delivery the Bill
- Potential unintended consequences of the Bill
- Human Rights and interactions with the Charter of Rights for People Affected by Substance Use
- Enforcement of the Bill
- Accountability
- How the Bill interacts with current Drug and Alcohol policy and practice including:
  - The requirement for diagnosis
  - Multi-disciplinary working
  - Confidentiality in small communities
- Potential amendments to the Bill
- Estimating the prevalence of drug and alcohol use
- The extent to which the intended outcomes of the Bill are already being met with current policy and practice

Cabinet Secretary maintained the current neutral position of the government, referred to concerns raised by others in evidence and confirmed that SG would consider the totality of evidence before making a decision on a position on the Bill for the Stage 1 debate.

**From:** [Redacted-Section 38(1)(b)]@gov.scot> **On Behalf Of** Cabinet Secretary for Health & Social Care 2024

**Sent:** 27 May 2025 10:03

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>;

[Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>;

[Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot>;

[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]

<[Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]

<[Redacted-Section 38(1)(b)]@gov.scot>; Jennie Gollan

<Jennie.Gollan@gov.scot>; Spads Admin <Spads\_Admin@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>

**Subject:** RE: Briefing for HSCS Committee Evidence Session on Right to Recovery (Scotland) Bill 20 May 2025

Hi [Redacted-Section 38(1)(b)]

Sharing the Official Report of this meeting.

[Redacted-Section 38(1)(b)]

Deputy Private Secretary to the Cabinet Secretary for Health and Social Care – Neil Gray MSP

Scottish Government | St Andrew's House, Regent Road, Edinburgh EH1 3DG |

Mob: 07[Redacted-Section 38(1)(b)] | Email: CabSecHSC@gov.scot

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**From:** OfficialReport <Official.Report@parliament.scot>  
**Sent:** 27 May 2025 09:57  
**Subject:** Health, Social Care and Sport Committee 20 May 2025

Hello,

The *Official Report* of the above meeting is now available on the Parliament's website and can be accessed by following this link: **Health, Social Care and Sport Committee 20 May 2025**.

The *Official Report* is the full and authoritative written report of what is said in public meetings of the Scottish Parliament and its committees. Further information about the *Official Report* can be found on the Parliament's website – <https://www.parliament.scot/chamber-and-committees/official-report>

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Best,  
**[Redacted-Section 38(1)(b)]**

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**From:** [Redacted-Section 38(1)(b)]@gov.scot> **On Behalf Of** Cabinet Secretary for Health & Social Care 2024

**Sent:** 28 May 2025 09:06

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>;

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[Redacted-Section 30(c)]@gov.scot>

**Subject:** RE: Summary note of Member in Charge evidence session to HSCS Committee on Right to Recovery Bill

[Redacted-Section 38(1)(b)],

Mr Gray has noted this helpful update.

Thanks,

[Redacted-Section 38(1)(b)]

Deputy Private Secretary to the Cabinet Secretary for Health and Social Care – Neil Gray MSP

Scottish Government | St Andrew's House, Regent Road, Edinburgh EH1 3DG |

Email: CabSecHSC@gov.scot

**From:** [Redacted-Section 38(1)(b)]

**Sent:** 27 May 2025 16:08

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

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Section 30(c)]@gov.scot>; [Redacted-Section 30(c)] <[Redacted-Section

30(c)]@gov.scot>

**Subject:** Summary note of Member in Charge evidence session to HSCS Committee on Right to Recovery Bill

PO/Cabinet Secretary

Please see the attached note of the evidence session today at HSCS Committee with Douglas Ross

Many thanks

**[Redacted-Section 38(1)(b)]**

Drug and Alcohol policy - Ministerial - Right to Recovery Bill - Committee Evidence with Member in charge - Summary - 27 May 2025 **[Redacted-Section 30(c)]**

**[Redacted-Section 38(1)(b)] | Drugs Policy | Health & Social Care Directorate | Scottish Government**

Email: **[Redacted-Section 38(1)(b)]@gov.scot**

**Pronouns she/her**



## Right to Addiction Recovery (Scotland) Bill HSCSC evidence session, 27<sup>th</sup> May 2025

Witnesses present:

Douglas Ross, Member in Charge of the Bill,

Alison Fraser, Solicitor, Legal Services,

Neil Stewart, Senior Clerk, Non-Government Bills Unit, Scottish Parliament.

### Key themes:

#### **Legal Right to Treatment**

- **Core Proposal:** The bill seeks to establish a legal right for individuals diagnosed with drug or alcohol addiction to access treatment within a maximum of three weeks.
- **Empowerment:** Emphasizes patient-centered care, giving individuals a voice in their treatment and a legal right to a second opinion.
- **Legal Precedent:** Concerns were raised about whether this sets a precedent for other conditions and the potential for increased litigation.

#### **Funding and Resource Allocation**

- **Budget Uplift:** Ross argues the bill won't divert funds from existing services but will require a central government fund and savings from civil service headcount.
- **Sustainability:** Questions were raised about tying future governments to a legally mandated budget increase.
- **Cost Concerns:** Critics questioned whether the financial memorandum fully accounts for potential litigation and increased service demand.

#### **Inclusivity and Accessibility**

- **Diagnosis Requirement:** Concerns that requiring a formal diagnosis could exclude some individuals and exacerbate stigma.
- **Face-to-Face Appointments:** Criticized as potentially exclusionary for rural or homeless populations; Ross is open to amending this.
- **Trauma-Informed and Psychosocial Care:** The bill focuses on medical treatment, raising concerns it overlooks broader psychosocial and trauma-informed approaches.

#### **Stigma and Human Rights**

- **Destigmatization:** Ross argues the bill helps reduce stigma by empowering individuals and recognizing their rights.
- **Human Rights Compliance:** The bill is framed as supporting compliance with human rights, particularly the right to treatment and a second opinion.

#### **Scope and Flexibility**

- **Treatment Options:** Includes a non-exhaustive list of treatments, with a catch-all clause for others deemed appropriate by health professionals.
- **Future-Proofing:** Provisions allow for updates to treatment lists and practices as medical knowledge evolves.
- **Definition of Addiction:** Based on substances that cause intoxication, which raised concerns about excluding addictions like nicotine or emerging non-intoxicating substances.

#### **Implementation and Governance**

- **Role of Health Professionals:** Broad definition includes GPs and nurse practitioners; concerns about consistency and governance.

- **Monitoring and Accountability:** Annual reporting to Parliament is proposed to ensure transparency and effectiveness.
- **Partnerships and Local Delivery:** Emphasis on collaboration with local councils and Alcohol and Drug Partnerships (ADPs), though concerns remain about integration with existing services.

### **Legal and Ethical Considerations**

- **Medico-Legal Alignment:** The Law Society raised concerns about the bill's alignment with existing legal standards, particularly around treatment discussions.
- **Litigation Risk:** Potential for increased legal action if treatment is denied or delayed, especially in cases with fatal outcomes.

### **Who said what:**

#### **Douglas Ross (Bill Proposer)**

- Advocated for a legal right to addiction treatment.
- Emphasized patient empowerment, destigmatization, and human rights.
- Argued the bill complements existing services and doesn't divert funding.
- Open to amendments on diagnosis requirements, face-to-face appointments, and treatment lists.
- Defended the bill's financial assumptions and legal implications.
- Highlighted the need for better data and accountability through reporting.

#### **Elena Whitham**

- Questioned the risk of setting a precedent and potential exclusion due to diagnosis requirements.
- Raised concerns about stigma, trauma-informed care, and rural access.
- Emphasized the importance of family involvement and community-based services.

#### **Claire Haughey (Convenor)**

- Sought clarification on the bill's scope, especially regarding diagnosis and treatment rights.
- Challenged the bill's alignment with medico-legal standards and financial implications.
- Questioned the role of partnerships and the potential for service fragmentation.

#### **David Torrance**

- Focused on implementation responsibilities and alternative redress mechanisms.
- Asked about independent advocacy and the bill's impact on local authorities.

#### **Emma Harper**

- Critiqued the bill's medical model focus and lack of trauma-informed practice.
- Raised issues about access for homeless and rural populations.
- Questioned the abstinence-based perception and treatment timelines.

#### **Joe Fitzpatrick**

- Challenged the bill's necessity given existing government strategies.
- Raised concerns about litigation risks and financial planning.
- Questioned the bill's adaptability to evolving drug use patterns.

#### **Patrick Harvie**

- Criticized the use of "intoxication" as a criterion for treatment eligibility.

- Questioned the political vs. clinical nature of treatment lists.
- Highlighted the risk of excluding future substances or addictions.

### **Sandesh Gulhane**

- Emphasized the need for better data and future-proofing.
- Questioned the bill's impact on multidisciplinary teams (MDTs) and service funding.

### **Summary of opening statement:**

- Attended all public sessions and listened to evidence and want to take opportunity to thank those who took part in sessions
- Should it pass stage one, work with witnesses to pass any changes, and extends to committee
- Specifics of the Bill are not for consideration, what should be considered more is if issues raised by the Bill are worthy for consideration.
- Stats bear repeating drug deaths doubled in ten years
- 15x higher in deprived
- Alcohol deaths higher.
- Alcohol and drug deaths rate highest in UK
- Made in Scotland and fixed in Scotland
- The current approach isn't working – this isn't a view, it's a fact
- Every 4 hours a Scot dies because of drugs or alcohol - no one can look as success.
- Real people being failed every day.
- If the bill helps one more person to survive – it will be a success – but I think it can do much more

Douglas Ross sets out provisions in the Bill:

Seeks to do away with situations where people Do not get treatment, or accessing treatment takes too long – Bill seeks to ensure they get that treatment – right to them, suits them, must be provided irrespective of cost

Bill takes nothing away, doesn't change existing services, it adds to existing services

Beyond words, sad reality is we are not doing enough – but passing R2R at stage one, we can give it the due consideration it deserves, ensure deaths not in vain, show we give due

### **Detailed questions and answers:**

**Elena Whitham – respond to Cabinet Secretary evidence in committee – right to treatment sets a precedent?**

Douglas Ross – I understand the uniqueness – but we area dealing with unique circumstances.

Cabinet Secretary said that providing treatment is unprecedented, but bill does not do that.

As others said, we need to bring forward something different and new

**Elena Whitham: do you feel this would give others facing other conditions, that they have a right to seek a legal standing, could it deprioritise spending in other ways, or level playing field?**

Douglas Ross levels playing field, people seeking treatment are not receiving it, in moving resources to other budgets, there is a projection of 28 – 38 – I've been clear it should be in SG central fund – can come from civil service head count. In my view it doesn't take money from drug services or other health services – I've found savings

**Elena Whitham - requiring a diagnosis risks being exclusionary to those seeking treatment and exacerbates stigma.**

Douglas Ross – if I can first speak about stigma – this issue was mentioned in Audit Scotland report – before bill was considered – we already have something to overcome, I agree with Cabinet Secretary that positive strides have been made. And that through this very bill we are shining a light. I don't believe bill is exclusionary – its not taking away, simply adding to treatment options. Only a particular element – the treatment element. Doesn't take away from other great services.

**Elena Whitham – you narrate how much stigma there is and in health and social care, do you think it would reduce stigma**

Douglas Ross – gives people opportunity for voice to be heard, that individual level of care, there is a gap at the moment – empowering people to be involved in their own treatment options. The bill hopefully supports compliance to human rights, have a voice in treatment options, and crucially right to second opinion. Will help to further destigmatise those because they are empowered to get treatment and support they need

**Elena Whitham – we've heard quite a bit from family members – what thought did you have to them when you were considering this bill**

Douglas Ross – it's a crucial role, that's why I met with organisations. I know they were disappointed they're not mentioned in the bill. There's nothing that prevents them attending. I didn't want to give impression that they were not included already by making it an aspect of the Bill

I am content to look at that if there is anything that should be added

Not including in the bill I didn't want it to seem there was a gap – they are part of process and would be going forward.

I have to take a narrow track for a non-Government Bill

**Claire Haughey (Convenor) – for clarification – in response to Elena Whitham on bill would be exclusionary – but its only for those who have been**

**diagnosed with an addiction – some over using wouldn't have the rights in the bill?**

Douglas Ross – doesn't take away from the rights they already have. I know diagnosis and the term has come up a lot – something I am keen to look at – if that is an unintended consequences I'm looking to address at stage 2/3 – any treatment starts with a diagnosis, - sorry, with families re Elena Whitham, there is also a code of practice to be written which would hopefully help

**Claire Haughey – the term Health Professional, who gives the determination – could be a v wide ranging term – keen to hear what you mean, should it be narrowed, or widened**

Douglas Ross – its people who at present treat peopled with drug and alcohol additions, GP, Nurse Practitioner those who prescribe treatments in bill. Picked up the concerns in committee that this could be independently GP

RCGP and RCPsych – sound governance arrangements in place for this, so I feel relaxed about this

**David Torrance – on implementation, what consideration is given to duties and functions need to be placed on other bodies?**

Douglas Ross – clearly puts onus on Scottish ministers, budget uplift needs to be done. FPAC – concerns on social work and local council. Ultimately its for SG to work with ADPs, councils to deliver that and for SG to take it forward. Its right that they are given flexibility to take on bill and deliver in a way that will be effective.

Bringing reporting back to parliament and holding gov to account will be an important element , also how it is monitored

**David Torrance – did you consider other redress outside of legal action and NHS redress**

Douglas Ross – legal action, cost will be a consideration, legal aid for some. Obviously standard options available. Important guarantee should be given if

By shining light through this bill, we are sending message this should happen, should be given, hoping this negates much of need to take it into legal spere because its in law

**David Torrance – have you given consideration to independent advocacy**

Douglas Ross – hugely important, any advocate can come along, important they can come along and be part of process. We are dealing with some of the most vulnerable people in our society

**Annie Wells – how would you ensure that Scotland's most deprived communities are aware of the bill?**

Douglas Ross deaths are much more prevalent in our most deprived communities. There is a process we will go through and funding to be allocated to make people aware of the bill. The bill is drafted by frontline experts. Special credit to Annemarie Ward and Steven Wishart, who have been driving force behind bill and change it should elicit.

So, they are aware of possibilities should it become law – there's already awareness in those frontline areas and communities.

**Emma Harper – bill doesn't incorporate trauma informed practice appropriately – can you address this issue**

Douglas Ross – goes back to narrow focus of Members Bill – I can only look at one element. Doesn't step on toes or supersede other issues. Simply looking at treatment element. Trauma informed etc will continue. Important element of overall package.

**Emma Harper – primary focus on medical model of treatment rather than broader psychosocial factors – concerns on focusing on this**

Douglas Ross wider psychosocial aspects are not affected by Bill. Treatment options are specified in bill because we are looking at this narrow element. It will not diminish other aspects of drug and alcohol treatment, will simply add.

**Emma Harper – section 2 on the procedure, in person meeting – brings me to challenges to those experiencing homelessness and in rural areas. Thoughts on requiring in person app?**

Douglas Ross – I've heard this loud and clear – put in cos I wanted to give as much support as possible, and face to face interaction important. I couldn't disagree with anything you're saying, happy to look at an amendment – don't want anything to be exclusionary

Your questioning has strong theme on rural communities, I looked at auditor general report on rural communities – provision is mixed and people can face waiting times, stigma, barriers, more to do to tailor services – this sums up what I want to overcome with this bill. I accept the in person stipulation excludes and I would change this at stage 2.

**Emma Harper do you think bill needs to have more of a balance with harm reduction rather than abstinence based approach**

Douglas Ross – I know this has come across, but catch all at end states on 'any other treatment' – and any other treatment could be added also going forward – while it may be a perception its not intended.

**Emma Harper – treatment should be within 3 weeks – when does clock start/stop ticking? When does clock start and stop ticking**

Douglas Ross – section 3.1 has a 3 week ceiling – v much a ceiling. This was rehearsed in some of the evidence, the 3 week period was chosen as that is a national standard. Try to tie in with what we have. However I know for some there is more urgency.

Clock starts when someone seeks that help – when they are requesting treatment. However it does stop and start again if they are not satisfied with the option , and starts again when they get a second opinion

**Emma Harper re your response about treatment options, and the perception that its about abstinence, your opening remarks perhaps also put forward such a suggestion, your opening remarks feeds such a perception**

Douglas Ross – first of all, with rehab, SG wants to increase rehab beds. I think if I stressed that, its because that is an area we are seeing development in the moment, I'm trying to work with SG strategies, the ambition to get us to Euro averages in gov, I feel the bill can complement – I take on this criticism, but there are elements ‘ any other treatment options’

**Joe Fitzpatrick – so what is your bill doing that SG isn't already doing**

Douglas Ross - It takes person to centre of it – they say what they would like – patient centred approach, enshrining legal right so they've got more power. Shuts down someone waiting months and years. People are not getting the treatment they want,  
And then have gov scrutinised – when you answer in parliament you are held to account.

**Joe Fitzpatrick – you're suggesting the patient should dictate their treatment pathways**

Douglas Ross – they can dictate what they think is right for them, clinician still needs to consider what is right in the orange book, if that diverges there's a right 2 second opinion.

**Patrick Harvie - the list of treatments you make clear is non exhaustive. Would any list, even a non exhaustive list, would be right way to go  
Doesn't actually increase treatments available  
Empowers people, but then what you've said would counter that  
Anything placed on list will be prioritised, and not on list wont be  
Is that not a political rather than clinical approach**

Douglas Ross – I had a dilemma, do I just say any treatment, and then its not specific enough? How do you budget that or hold accountable? If you have open ended section 5 that's more challenging.

We looked at options, but id be willing to look at amendments if a strong case can be made...its something we can add

Does that make it more political less clinical – I don't think so. Ultimately there is the catch all for 'any other treatments a health professional deems appropriate'

There is already a political approach to increase rehab beds. With the additional funding this bill provides, hopefully this would happen

**Patrick Harvie – I don't disagree with your point about investment and capacity. Do you understand – we get at stage 2/3 to debate amendments, my worry this is not our judgement to make and will inevitably have an impact of what services are and are not going to receive investment.**

Douglas Ross – no its not, I trust the doctors, to make decisions on what treatment is right, they still need to adhere to orange book, they can still say none is appropriate if that is the case.

**Claire Haughey – doesn't sufficiently recognise role of partnerships, how would Douglas Ross respond to this?**

Douglas Ross – id go back to point, this bill does not stop multi-disciplinary team working, doesn't prevent that good working. It adds treatment options in this narrow area, hope it works in collaboration and adds in toolkit

**Claire Haughey it's a standalone bill that deals with a specific group of people, that may muddy those waters, in terms of those services that need to [provide a wraparound service?**

Douglas Ross – I don't, there is an uplift in budget that would be provided in bill – its adding to not taking from other areas. The bill is important to help those in third sector, they can see if they need one of the treatments listed, they know the support will go to that person, they wont need to worry someone will be on a waiting list and then dying

**Claire Haughey – you'll have heard law Society evidence – way bill is currently drafted -doesn't align with medico legal**

Douglas Ross – in my view its not inconsistent

**Claire Haughey – you are disagreeing with law society**

Douglas Ross – obviously law society have an opinion, I don't think its inconsistent, and does not ultimately fall foul of that ruling

**Ms Fraser – worth going through what the bill provides**

Bill provides that health professional has to explain the various treatments and consider all relevant treatments – including the particular list of treatments – it's the particular list that is unusual.

In the Supreme Court decision, it wasn't about alcohol drug addiction. The question was whether the consultant was negligent by failing to discuss an option that they

didn't feel was reasonable – court heard that they didn't have to discuss a treatment that they didn't feel was reasonable – not negligent

The members bill is that all treatments in bill should be discussed, but in McCulloch it was about discussing a treatment option they didn't think was relevant

**Claire Haughey – so all treatment options should be discussed?**

**Claire Haughey and how is that different than me going to GP and saying I want that treatment, and then GP saying the options, and me seeking a second opinion**

Douglas Ross well its about getting that second opinion and then enshrining that right in law and making gov accountable there's more of a drive to get

**Claire Haughey – so its about enshrining the timescales**

Douglas Ross its about legal timescales as soon as possible and maximum of three weeks

**Emma Harper – would a liver transplant be part of the options?**

Douglas Ross that wouldn't be my understanding – that is a consequence of drug alcohol addiction – this is just looking at dealing with addiction element

The bill is specific about dealing with drug and alcohol addiction – liver failure is about a consequence

**Emma Harper – referring to a second relevant HPs – is there a hierarchy then, if first is a specialist, and second is an advanced nurse practitioner – is there a hierarchy?**

Douglas Ross – not stipulated in bill, not a hierarchy, all health professionals, are deemed medical pros as per terms of bill, one does not take precedence, or judgements deemed superior

**Sandesh Gulhane – id like to ask about data. What is the lack of data we have, how will bill help us?**

Douglas Ross huge lack of data, hampered my deliberations, caused challenge when I went to FPAC. They want precise examples, and costs.

Cabinet Secretary was open about difficulty in gathering data and assessing effectiveness

Therefore I think reporting element will provide much greater clarity, onus on orgs to report this in. annually report to be laid in parli, gov minister has to [resent and parli questions them on how they are dealing with proposals and procedures in this bill

**Sandesh Gulhane – would that help us tackle the numbers**

Douglas Ross – yes, alluded to by witnesses, shining a light, vulnerable people get their say in parliament, we need data to make good decisions, and there's a lack of data. This will help our policy making

**Sandesh Gulhane – in medicine things change quickly, would the bill prevent providing on future advancements**

Douglas Ross – there is provision in bill for SG ministers to add treatments as they wish, the code of practice can also be refreshed going forward. Important that there are the opportunities going toward, of course things will move on medically and hopefully in communities that experience deaths.

**Sandesh Gulhane – F2F apps – previous witnesses talked about difficulty getting one. What is the boil saying about the need to get a f2f app?**

Douglas Ross it is an element I'm happy to amend and change. The uplift in budget is to increase training

**Sandesh Gulhane – Multi-disciplinary working – we have current situation , where award winning service is stopped due to lack of funding, how would the bill interact with multi-disciplinary teams**

Douglas Ross – locally that's an important issue – NM has committed 160 million, seeks to increase 17 – 24% uplift. That NM is only to end of parli – we cant tie hands of future parli – but enshrining bill, we give strongest signal it needs to be prioritised going forward.

I've suggested where I find the money – ten members round the committee could find ten solution, think its vital we see that uplift in services

**Sandesh Gulhane – the bill will reduce people dying**

Douglas Ross – not a silver bullet, needs to work in tandem with other work, initiatives gov are operation and exploring. Giving people this right will ensure people won't die on waiting list, if a HP deems treatment appropriate they wont wait.

Going back to Resi Rehab on Joe Fitzpatrick s point –

Theres also Dame Carole Black report, which was about NHS England - for every 1 pound spend we save 4, money saves lives but helps our services

**Joe Fitzpatrick – landscape of drugs changing, polysubstance use – whether the bill has been suitable drafted to respond**

Douglas Ross – there are opportunities for SG to amend options available, you know as former minister the issues are different now than what they have been – its an

evolving issue, but people dying isn't changing, which is why I feel so passionate about it.

**Joe Fitzpatrick – bill talks about 3 week deadline – sometimes there's quite complex prep work required, before folk can move on, particular in abstinence based pathways – that can take much more than 3 weeks? how we square that**

Douglas Ross – 3 weeks begins from treatment being agreed with HPs = people are being told they are suitable for Resi Rehab, and they are not getting it, there are no beds available and capacity. Where **that** determinations HAS been made, they shouldn't be made to wait.

**Joe Fitzpatrick – if the determination has been made, irrespective of everything else, hey should get that treatment within three weeks and be in a rehab**

Douglas Ross – the health professional will know what works, and what is needed to get someone ready for that, if health professional determines they are ready for that, if HP determines that, they are ready for Resi rehab, they should get that in 3 weeks

**Joe Fitzpatrick – to clarify, someone going – shouldn't be expecting immediately to be in a rehab in three weeks? Because there is all that other process?**

Douglas Ross – so the course of treatment starts within 3 weeks, if the course of treatment is X, there is other work goes in advance, but once the determination is made then they should get it in three weeks.

**Joe Fitzpatrick - that is useful, because some people would have assumed, they have a right to that, they have a right to be in treatment in 3 weeks because they are ready in their minds**

Douglas Ross – also for some they will be ready in same sameday and they should have right to that, 3 weeks is a ceiling

**Emma Harper – is the bill future proofed enough to ensure that to address the changes in how people take substances**

Douglas Ross – I believe it is, as we have the provision for ministers to increase some of the provisions. In section 9 'drug; includes any 'intoxicant' covered in section 9.1. again the bill doesn't replace mat standards, mat standards are not underpinned in law, and this bill is, it provides the legal framework.

**Emma Harper – and it doesn't affect a single mum with two kids, that cant go to rehab...**

Douglas Ross – might be Resi rehab isn't right for her, or maybe efforts can be made for others to look after kids while she's there, or other treatment options are right for her, or those available under that catch all. Also, that current support available will be maintained and continued to deliver.

**Elena Whitham – rehab isn't the same across the board, have you given that thought**

Douglas Ross – yes, again its not to be overly prescriptive, elements of that could be included in code of practice, people who are entitled in the view of health professional to Resi Rehab , is that they get that in some form. Difficult in drafting, as we aren't even up to SG target of additional beds, it was a decision not to include specific choice. I agree they are varied in what they provide, this goes back in discussions with health professional and they recommend resi rehab, not a specific place.

Happy to look at, worry it adds complexities that makes it more difficult to deliver bill – we can tease out at future stages

**Elena Whitham – reality is that ADPs commission certain services to send people to, might not be in local areas, lots of competing issues. But I take your point you cant have your top 3**

Douglas Ross – treatment is top priority, then we look at options – but options will be greater if we have this bill because there will be an uplift. To deliver more facilities across the country, a lot of areas don't have these areas

**Patrick Harvie – does the bill cover addiction to irrespective of legal status?**

Douglas Ross – definition in bill, it is substances that intoxicate people and they become addicted to – prescribed drugs you can become addicted to

Alison Fraser - Definition becomes from road traffic legislation

**Patrick Harvie – I can see how its relevant in road traffic, why is it relevant to addiction recovery. Why intoxication is relevant to addiction recovery, whereas addiction, to a legal drug, wouldn't be treated in same way**

Douglas Ross – its from road traffic legislation from 1988, neither nicotine or caffeine cause someone to lose control

**Patrick Harvie – I get that, but why is that relevant to the question of treatment for recovery of addiction**

Douglas Ross – I'm not sure there is a demand for people to go into treatment for services for caffeine or smoking, they don't lose control, that was where we based the determination for substances they can be addicted to

**Patrick Harvie – well and nicotine does.**

Douglas Ross – and there are other measures gov is taking.

**Patrick Harvie – still unclear on rationale that it is 'intoxication' as such that determines the terms of the rights to access treatment under t her terms of the**

**bill. A drug may come along that is highly lethal, highly addictive, doesn't cause intoxication – new substances are coming along all the time, it does seem unclear why intoxication – clearly relevant for road safety, but not for accessing recovery services.**

Douglas Ross – comes back to what people are seeking services for, and in the majority people are seeking access in relation to drug and alcohol services -doesn't mean we can't look at point you are making, maybe gov could look at that

**Sandesh Gulhane – inconsistency – current system isn't working but we shouldn't do things to interfere. Agree with that logical inconsistency?**

Douglas Ross – I do and as I've said in my opening statement, I listened to all evidence received. Encouraged in committee, written submissions a majority were in favour

In your committee we have heard different questions. Not about general principles, but to specifics of the bill that I hope we can address through amendments should the bill get to that stage

Both your committee, in your call for evidence written responses to the bill, and my consultation had a 78% response for

In terms of inconsistencies,  
We've heard a lot of positives, for instance Cabinet Secretary

Intention of bill was one SG supports.  
Many others have said the same

Dr Sue Galea-Singer said didn't believe the bill was required because what was being suggested was being done, she then said to Brian Whittle, the provisions of the bill were not already happening across Scotland, didn't accept that, but then said the system wasn't working

Both elements that the current system works, but also that it is not working

I hope in your determination you can look in raw figures that we are not doing enough.

We are not dealing with the biggest issue was we still have record numbers dying.

**Sandesh Gulhane – I would like to go back to an answer that you don't want to tie future parliaments hands. This uplift might be shown to create more money for drug and alcohol treatment onwards.**

Douglas Ross - I've welcomed SG have been neutral, they've not said its unaffordable because of assumptions in financial memorandum, they are still willing to have eyes and ears open, that's why I think its important we can get it to stage 1, to tease out further details of what has been raised, some positive, some challenging, some that clearly need to change,

But if we shut off, send an alarming signal, that we have reached peak of our ambitions in tackling drugs and alcohol

**Claire Haughey – do o**

Douglas Ross – there's no doubt there are challenges in workforce, specific funding in financial memorandum for training for health professionals, which is an additional workload, that's why its considered in financial memorandum. It puts onus on SG to deliver through partners. COSLA supportive of intention of bill but raised issues of finance, hopefully if we can take it past stage one and eventually passed by parli, there's an indication to workforce, bodies, that we need to focus, and hopefully drive down deaths.

**Claire Haughey – in terms of specific training required, is that available at the moment, or additional things put in place?**

Douglas Ross – obviously some training available, further is needed to increase cohort as there will be increased demand. We know some people seek support and don't get it. So that's one element, the capital costs and such like going forward And there are others who will hopefully be encouraged by this, people in our deprived comms becoming aware of this legal right, if we improve awareness, I think its success if we more demand on our hard pressed workforce, because more people feel comfortable coming forward

**Joe Fitzpatrick – law society highlighted risk of significant litigation of the bill – comment on that**

Douglas Ross – if people have a right to action in the courts and qualify for any assistance, its only right that justice should be allowed to take its course, enshrining in law allows them to take it to the next level, people were concerned of costs of judicial review, I accept that that is costly and burdensome

But I accept that other avenues are available such as legal aid, and if the qualify for assistance then they should be able to use it

**Joe Fitzpatrick – specific concern law society had, unintended consequences was that if someone didn't get the treatment and something happened – surviving relatives could sue – your FM doesn't have that cost within it – they suggest it could be a consequence**

Douglas Ross – that's a consequence at the moment for someone on a waiting list – family at the moment can take civil case and civil action

**Joe Fitzpatrick – so you haven't put costs in?**

Douglas Ross – my hope is that if we put it in law, I hope that wouldn't be the case, because people would be getting the treatment within a more constrained period of time, that goes back to the capital increase that is mentioned to the finance

committee. Its currently a risk and I would hope that risk is reduced if there is more availability

**Joe Fitzpatrick – rather than bring in this bill, why don't you bring in an amendment to budget bill to say there should be an additional spend in budget bill, why didn't you do it last year?**

Douglas Ross – enshrining in law this right – we are dealing with a unique situation, we've increased budgets in past, things are getting marginally better if at all, its not just about budget, its about enshrining that legal framework, and reporting.

**Claire Haughey – you've mentioned several times there is an uplift in the budget with this bill, but that you cant tie the hands of future governments, so I'm not sure how those marry**

Douglas Ross – once its enshrined in law, the gov has to accept that going forward and would have to introduce primary legislation to take away the right and sends a strong indication of an area we need to focus on

Its not a small amount of money but its not an unachievable uplift. Everyone in here agrees its an issue that needs to be tackled, if we need to spend £38 million on an issue that is especially bad – this is our national shame, - if we cant deal with this, in this bill with the increased budget,...

**Claire Haughey – putting aside all of that – looking purely at the finances here. To put this uplift into Scottish governments budget outwith a budget bill wouldn't be tying hands of gov – because that would a legal commitment to have that legal increase in drug and alcohol budgets regardless of what party is in gov, regardless of what budget they have**

Douglas Ross – what I'm saying is that it doesn't tie the hands of future gov to then remove this from statute to pass legislation, to remove the bill.

**Claire Haughey – this legislation would have to be repealed for that budget line to come out of a budget before a budget paper is passed**

Douglas Ross – which is why it enhances the provision of the National mission

It sends a strong message that

**Elena Whitham – I know resi rehab costs tens of millions just for one facility – how will we not see a reduction in other areas – think of community rehab, harm reduction, psychosocial support, knowing how much resi rehab and crisis, and stabilisation services cost, how can we square that with all services being available**

Douglas Ross – because that capital cost is covered by SG – SG in national mission. I have taken as having being delivered, the uplift in bill doesn't need to account for that, as its in process and has already been delivered.

I haven't understated capital costs, its delivered in SG commitment for Resi rehab

**Claire Haughey – an increase in the use of beds or the availability of beds?**

Douglas Ross – the availability of beds, the capital costs in covered by SG increasing its target by march 26. Difficulty for figure is the length of time people spend in resi rehab

Capital element is not understated

(what about increased use resulting in bill?)

**From:** [Redacted-Section 38(1)(b)] <[Redacted-Section 38(1)(b)]@gov.scot> **On Behalf Of** Cabinet Secretary for Health & Social Care 2024

**Sent:** 28 May 2025 09:22

**To:** [Redacted-Section 38(1)(b)]@gov.scot>; Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 30(c)]@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; Deputy Director - Drugs Policy <Deputydirectordrugspolicy@gov.scot>; [Redacted-Section 38(1)(b)]@gov.scot>; Spads Admin <Spads\_Admin@gov.scot>; Jennie Gollan <Jennie.Gollan@gov.scot>

**Subject:** RE: R2R 3rd Evidence session 13th May

Hi [Redacted-Section 38(1)(b)],

Mr Gray is content to clear.

Regards,

**[Redacted-Section 38(1)(b)]**

Deputy Private Secretary to Cabinet Secretary for Health and Social Care - Neil Gray  
MSP

Scottish Government

E: cabsechsc@gov.scot

M: 07[Redacted-Section 38(1)(b)]

**From:** [Redacted-Section 38(1)(b)]

**Sent:** 13 May 2025 16:06

**To:** Cabinet Secretary for Health & Social Care 2024

**Cc:** [Redacted-Section 38(1)(b)] ; [Redacted-Section 38(1)(b)] ; [Redacted-Section 30(c)] ; [Redacted-Section 30(c)] ; [Redacted-Section 38(1)(b)] ; Deputy Director - Drugs Policy ; [Redacted-Section 38(1)(b)] ; Spads Admin ; Jennie Gollan

**Subject:** R2R 3rd Evidence session 13th May

PO/Cabinet Secretary

Please find attached a note of the oral evidence session with Health, Social Care and Sport Committee for Right to Recovery Bill today, 13<sup>th</sup> May 2025.

Erdm copy:

Drug and Alcohol Policy - Stage 1 - Right to Addiction Recovery - 3rd oral evidence session with stakeholders - 13th May 2025 details - Objective

Best wishes,

**Dr [Redacted-Section 38(1)(b)] she/her | Participation and Human Rights  
Integration Team | Drugs Policy Division | 07[Redacted-Section 38(1)(b)]  
Scottish Government | 3 E St Andrews House | Regent Road | Edinburgh | EH1 3DG**

**Health, Social Care and Sport Committee  
Evidence Session 13<sup>th</sup> May 2025 on the Right to Addiction Recovery (Scotland)  
Bill:**

**Panel 1:**

Kirsten Horsburgh, Chief Executive Officer, Scottish Drugs Forum;  
Tracey McFall, Chief Executive, Scottish Recovery Consortium;  
Justina Murray, CEO, Scottish Families Affected by Alcohol & Drugs

**Panel 2:**

Lee Ball, Director of Addictions, Salvation Army  
Graham Callendar, Policy and Public Affairs Lead, With You  
Jan Mair, Practice and Innovation Lead, Turning Point Scotland  
Annemarie Ward, Faces and Voices of Recovery UK

**Key themes:**

**Rights and Accountability:**

- **Elena Whitham** questioned if the Bill ensures the rights of people who use substances.
- **Annemarie Ward** emphasized the Bill's importance for accountability and criticized the current system's gatekeeping culture.
- **Graeme Callendar** and **Jan Mair** supported the Bill's intent but raised concerns about practical implementation and accountability.
- **Lee Ball** highlighted the need for accountability and resources.

**Conflict with Charter of Rights:**

- **Elena Whitham** and **Annemarie Ward** discussed potential conflicts between the Bill and the Charter of Rights.
- **Graeme Callendar** and **Jan Mair** expressed concerns about the Bill's narrow definition of treatment and its practical delivery.

**Diagnosis and Treatment:**

- **Emma Harper** and **Jan Mair** discussed the advantages and disadvantages of requiring a diagnosis before treatment.
- **Graeme Callendar** and **Lee Ball** emphasized the need for confidentiality and the potential stigma associated with the term "addiction".

**Capacity and Resources:**

- **David Torrence** and **Graeme Callendar** raised concerns about the capacity of residential rehab and detox services to meet increased demand.
- **Lee Ball** emphasized the need for additional resources and the potential impact on community services.

**Harm Reduction and Abstinence:**

- **Jan Mair** and **Lee Ball** discussed the importance of harm reduction measures and the potential for polarizing the debate.
- **Annemarie Ward** defended the Bill's focus on treatment and criticized the lack of harm reduction measures.

**Early Intervention and Prevention:**

- **Graeme Callendar** and **Lee Ball** emphasized the need for early intervention and prevention measures.
- **Annemarie Ward** argued that the Bill complements prevention efforts.

**Flexibility in Treatment Options:**

- **Gillian Mackay** and **Graeme Callendar** discussed the need for flexibility in treatment options and the potential for overly medicalizing treatment pathways.

**Financial Considerations:**

- **Paul Sweeney** and **Graeme Callendar** raised concerns about the financial implications of the Bill and the need for adequate resources.

**Legislative Process and Empowerment:**

- **Kirsten Horsburgh** and **Tracey McFall** argued that a legislative process wouldn't guarantee improvement and emphasized the need for cultural change and resourcing.
- **Justina Murray** highlighted the importance of recognizing and supporting human rights without relying on legislation.

**Conflict with Existing Standards:**

- **Kirsten Horsburgh** and **Justina Murray** discussed the potential conflict between the Bill and existing standards like MAT Standards.
- **Tracey McFall** emphasized the need for quality treatment and access.

**Diagnosis and Gatekeeping:**

- **Emma Harper** and **Kirsten Horsburgh** discussed the potential gatekeeping effect of requiring a diagnosis before treatment.
- **Justina Murray** argued that a clinical approach is too narrow and strengthens power dynamics.
- **Collaborative Working:**
- **Gillian Mackay** and **Justina Murray** emphasized the need for collaborative working and the role of the third sector.
- **Tracey McFall** highlighted the importance of joint decision-making and addressing power imbalances.

**Advocacy and Support:**

- **David Torrence** and **Kirsten Horsburgh** discussed the need for adequate provision for advocacy and support.
- **Justina Murray** emphasized the importance of strengthening existing advocacy services.

**Impact on Families and Carers:**

- **David Torrence** and **Justina Murray** raised concerns about the Bill's lack of provisions for families and carers.
- **Tracey McFall** highlighted the disconnection felt by families.

**Quality of Services:**

- **Paul Sweeney** and **Kirsten Horsburgh** discussed the potential impact of the Bill on the quality of services and treatment.
- **Tracey McFall** emphasized the importance of recommissioning services in a human rights-based approach.

**Unintended Consequences:**

- **Paul Sweeney** and **Justina Murray** raised concerns about the unintended consequences of the Bill, such as increased bureaucracy and pressure on services.
- **Tracey McFall** emphasized the need to focus on broader recovery-oriented systems of care.

**Financial Implications:**

- **Brian Whittle** and **Justina Murray** discussed the financial implications of the Bill and the need for adequate funding for third sector services.
- **Tracey McFall** highlighted the importance of discretionary funders and addressing root causes like poverty and deprivation.

### **Summary of panel member views:**

#### **Kirsten Horsburgh: (SDF)**

- Happy the Bill has created a national conversation but does not agree with a legislative process. Believes issues are about culture, capacity, and resourcing. Emphasized the need to invest in existing standards and embed lived experience.
- Criticized the Bill for gatekeeping and creating an adversarial process. Highlighted the importance of independent advocacy and workforce development.
- Mentioned that treatment is sometimes secondary to other needs like housing and benefits. Stressed the importance of building trust.
- Concerned about the Bill's lack of provision for advocacy and its potential to threaten key relationships between people and their workers.
- Highlighted the issue of data collection taking focus away from service improvement.
- Emphasized the need for a consistent relationship with professionals and the empowerment of people to try different treatments.

#### **Tracey McFall: (SRC)**

- From an SRC perspective, emphasized that legislation alone does not guarantee access to rights. Highlighted the need for addressing power imbalances and adopting a human rights-based approach.
- Agreed with Justina Murray on the need for more investment in advocacy.
- Mentioned concerns about the diagnosis of addiction being in records forever and the potential delay in intervention.
- Criticized the Bill for not adequately promoting collaborative working and for its narrow focus on clinical diagnosis.
- Highlighted the importance of joint decision-making in treatment.
- Emphasized the need to address the power imbalance and improve the quality of treatment available.
- Mentioned the importance of recommissioning services in a human rights-based way locally.
- Highlighted the issue of data systems not connecting and the potential for more bureaucratic data collection.
- Stressed the importance of recovery-oriented systems of care and the need for sustainable funding.

#### **Justina Murray: (SFAD)**

- Stated that human rights are universal and not supportive of a legislative approach. Highlighted the need for knowledge, skills, and confidence to access rights.
- Mentioned that the Bill is silent on how individuals can challenge access issues beyond legal redress.
- Criticized the Bill for its narrow clinical approach and lack of reflection on multi-disciplinary working.

- Emphasized the need for a fundamental redesign of services to build a whole system around third sector, statutory, families, and communities.
- Highlighted the potential for the Bill to divert attention and resources from existing issues.
- Mentioned the importance of trust in relationships and the Bill's potential to cement power imbalances.
- Criticized the Bill for not addressing the needs of families and carers.
- Highlighted the potential for the Bill to reduce quality and choice in treatment.
- Emphasized the need for services to recognize and respond to people's rights.

#### **Annemarie Ward (FAVOR) – involved in drafting of policy for Bill**

- Highlighted that the Bill is a matter of life and death and criticized the current system's obstructiveness and gatekeeping culture.
- Argued that the Bill is not impractical and that those opposing it are influenced by government funding.
- Stressed that the Bill provides real accountability, unlike the Charter of Rights, which she views as unenforceable.
- Emphasized the need for a diagnosis in healthcare and criticized the idea that the Bill is too narrow.
- Defended the three-week treatment timescale as a necessary accountability measure.
- Defended the Bill as a specific intervention to give a right to treatment, if desired, and not designed to tackle all aspects of people's needs.

#### **Graeme Callendar (WithYou)**

- Supported the intent of the Bill but expressed concerns about its practical implementation.
- Highlighted the importance of access to residential rehab and detox services.
- Emphasized the need for a broader definition of treatment and the importance of early intervention and prevention.
- Mentioned the challenges of meeting increased demand for services and the need for consistent standards.
- Stressed the importance of psychosocial support and the need for adequate financial resources.

#### **Jan Mair (Turning Point)**

- Echoed support for the Bill's intent but expressed concerns about its practicalities and potential as a distraction.
- Highlighted the importance of early intervention and harm reduction measures.
- Emphasized the need for a broader definition of treatment and the importance of accountability.
- Expressed concerns about the capacity and consistency of residential rehab services.
- Stressed the importance of post-treatment support and the need for explicit harm reduction measures in the Bill.

#### **Lee Ball (Salvation Army)**

- Supported the Bill's intent but emphasized the need for resources and flexibility in treatment options.

- Highlighted the importance of accountability and the need for a broader definition of treatment.
- Expressed concerns about the omission of harm reduction measures and the potential for stigma.
- Emphasized the importance of early intervention and the need for systemic focus.
- Stressed the importance of psychosocial support and the need for adequate financial resources.

### **More detailed notes:**

#### **Panel one:**

#### **Elena Whitham – I want to explore the actual right to recovery, explore, and what it means to be a rights holder and duty bearer – what’s the extent of how the Bill will realise rights?**

Kirsten Horsburgh: happy Bill has created national conversation – but do not agree that should be a legislative process. The issues around empowerment, quality, access etc are issues of culture capacity and resourcing – a legislative process wouldn’t guarantee improvement, or guarantee person centred approach. We need to fully invest into the standards that are already there, we need to embed lived experience.

Tracey McFall: from an SRC perspective, we want to be constructive – we know, because it’s in law doesn’t mean people will access this right – i.e. housing. Fundamental aspects of treatment, access and choice – we all want this. For SRC we need a range of measures to challenge power imbalance, improve current standards, create a HRBA approach and include LLE – we all want people to access rights in treatment, but just because it’s in legislation doesn’t mean it will happen.

Justina Murray: Human Rights are for everyone, they are universal, we can’t give them to each other, can recognise and support them – not supportive of legislative approach.

#### **Elena Witham – Will it enhance or run into conflict with Charter Of Rights?**

Justina Murray: Charter of Rights is helpful, sits with a suite of rights, it is helpful, but we know family members need a lot of support to understand and use their rights – just saying they have rights doesn’t help, it’s about knowledge, skills and confidence for them to access that.

Kirsten Horsburgh: part of our response was in consultation with people with LLE– for example, they are only just getting around understanding MAT Standards and feel it’s quite conflicting with MAT Standards – that it misses the real life experience of people trying to access services.

**Elena Witham - how does an individual actually challenge when they feel like they're not getting the access they require – what is the remedy for them?**

Justina Murray: the Bill is actually silent on that – what you would do to challenge that beyond legal redress – who would have time and money for this? Through existing advocacy we can support, but they do need to be strengthened. The Bill doesn't really solve that, it just adds another layer of legislation...

Tracey McFall: Justina is correct, there has been investment in advocacy, but there is not enough. To access rights, you need to know them – big gap in Scotland in people understanding their rights.

**Emma Harper - the Bill requires a health professional to diagnose and provide a treatment determinations – what are your thoughts on this requirement to receive a diagnosis before treatment?**

Kirsten Horsburgh: it is gatekeeping, it creates a system that allows it. Process creates something that is adversarial. We need to get to bottom of issue as to why people aren't getting the treatment – independent advocacy is a great point, it's not mentioned in bill, workplace and workforce development that could be taken forward.

Tracey McFall – those we have consulted with, spoke about the diagnosis of addiction being in your records forever and not all recognise the terminology. When people are in crisis there is an intervention point when people need help, need to explore whether the time to make a diagnosis would delay things.

**Emma Harper – it could prevent people coming forward? They might know they have an issue but not want to hear this?**

Justina Murray – we've done a lot of work to understand difference between alcohol and drug use and harm, we want them to know they can get help, if they are experiencing harm – returning to a clinical approach is so narrow – a tiny minority would have a clinical diagnosis of alcohol dependent, but harm is much larger at approximately 25%. It seems unnecessarily narrow, and strengthens the power dynamic.

**Gillian Mackay – does the bill adequately promote collaborative working?**

Justina Murray: No. There really isn't any reflection of multi-disciplinary working and it is pretty silent on role of third sector. All of the things around someone with substance use issues isn't discussed. It has an overly focus on a clinical diagnosis of addiction without responsibility of responding to other needs.

Tracey McFall: what we know about substance use is that its complex – medical element is one small part which needs to be wrapped around everything else. The clinician's role is to support and assist joint decision making around treatment – joint decision making is critical and this is a retrograde step.

Kirsten Horsburgh – sometimes treatment is a secondary issue to what people want, they want support with housing and benefits – once they build trust they can

consider other positive elements. We should be encouraging attendance for a wide range of reasons.

**Gillian Mackay – does the panel believe there is a way to amend the bill to reflect some of the things they've discussed? Or is it about enhancing what we have?**

Tracey McFall: we would be looking to address the power imbalance.

Kirsten Horsburgh: we are quite clear that we don't think a legislative process is right, so it feels disingenuous to support amendments.

Justina Murray: we don't support the bill, we are on same page with issues in current system, but that journey is nowhere near finished, the bill just diverts attention and resource.

**Convener (Claire Haughey): would you feel that the resources put in this bill would be better placed bolstering services like advocacy etc and other issues that play into peoples needs?**

Justina Murray: Financial memorandum quotes £28-£38 million to treatment changes alone, I would have lots of ideas how this money could improve system, even where we are currently, we must look at a fundamental redesign, money is locked into NHS services, I would like to see a service redesign which builds a whole system around third sector, statutory, families and communities, where people want to engage.

**Brian Whittle – for me, you spoke about issues and put money where it is needed. Could the bill not force parliament to consider the way we treat and fund addiction services, the bill has that ability to focus that attention?**

Tracey McFall: just because there is a legislative framework, it doesn't mean they will get access to what they need – it's a fundamental flaw, addiction complexities are not narrow, its broad, there is an issue how we are funding services – if you look at recovery communities its working, but most of the money goes into treatment – huge amount of work being done, we need to move some of that money.

**Brian Whittle – I agree with that, best impact in our communities is unseen. The reality is that third sectors are being starved of investment, I think that for me, we have to do something different.**

Tracey McFall: that's an issue around commissioning, how we commission HRBA services, there's an issue on how we commission services, rather than the solution being a legislative framework

Kirsten Horsburgh: there is an issue around data and reporting, and this emphasis on data collection, it takes services away from being able to deliver, the focus is taken away from service development and improvement, we should use our data for service improvement rather than performance management. Part of that is fully embracing and utilising people with LLE. I would disagree with nothing has improved. The policy intent is welcomed, the major issue is the lack of urgency, and

the need to fully embrace of that – more things in more areas is required and comes with more resource requirements.

Justina Murray: we are tripping over very progressive legislation and policy, not only in England but also Scotland, but what is written down isn't what is felt in communities – but that doesn't mean more legislation is the answer – we have more paperwork . We need laser focus on implementation.

Kirsten Horsburgh: Scotland has no shortage of inquiries. Evidence sessions , reports, we share frustrations in this.

**Joe Fitzpatrick – we agree that to be successful we need to be person centred – you've touched on that. The bill, procedures, does it help or hinder a person centred approach. If not this legislation, what helps?**

Tracey McFall: The bill doesn't cover that, not just about person centred, trauma, choice and control, access, not much more to add, it doesn't touch on this, we have NES work, MAT standards to work on that, its very narrow in current form.

Justina Murray: there is that relationship of trust that is built up, the bill does misappropriate that language of rights and individuals as it just cements the power imbalance already there, there are good person centred docs already there, the patients charter and a campaign = its ok to ask' the bill doesn't add anything that's already there. It takes time to build up those positive relationships – in the bill it's like there's an event; of diagnosis and treatment happens. Working with people, it's a process, not a one off meeting.

Kirsten Horsburgh: key thing for people is that relationship with their worker. Down to those key relationships where people are being heard and their views are being acted on. Worried this legislation threatens this relationship – creating the adversarial process with the procedures.

**David Torrence – does the bill include adequate provision for advocacy?**

Kirsten Horsburgh: it's a key thing that is missing, its been developing over last few years, there has been more emphasis, but its still not enough, it is lacking in the bill.

Justina Murray: in an idea world we wouldn't need it, but we know from our research, that families feel it's not a level playing field...

Kirsten Horsburgh: we have similar conversations with people who use drugs. We know treatment is a protective factor – they see it as a risky process in engagement with a treatment service, shouldn't be like that

Tracey McFall: massive opportunity with charter to develop advocacy.

**David Torrence – does the bill address the needs of families and carers?**

Justina Murray: caused frustration and anger with families. We met with Douglas Ross some years ago, he was very understanding, we though corrections would be

made, but when we saw bill as presented, families are not mentioned once. It doesn't mention family. It flies in the face of other positive written commitments made in rights respect recovery, the promise, charter of rights, which is for people affected by substance and families have been deeply involved in the process.

Tracey McFall: broader policy context, PHS evaluation of NM and audit Scotland, peoples panel report, lots of evidence of families feeling disconnected

### **Paul Sweeney – quality of services. Standards/ what impact could the implementation of bill have on quality of services and treatment**

Kirsten Horsburgh – we don't believe a legislative process will help. A large part is support to the workforce. Large workloads and therefore can't provide quality of service to people. The way we deliver and design services needs to be with people with LLE. Look at different ways of service provision. Last five years of mission, it's been a missed opportunity on how we deliver our services. Stigma needs addressed at all levels. We need to be mindful some people experiences doesn't automatically challenge stigma, and make sure we don't exacerbate it

Tracey McFall – we have an unpaid workforce in Scotland, thousands of volunteers. This is about a workforce that is doing a lot of work that is unpaid, it's very important. The legislation won't improve services, it's about recommissioning services in a HRBA way locally

Justina Murray – when we spoke to people about the bill. This pressure to come up with a treatment determination in a tight time frame, would reduce quality and choice rather than opening up what people need. Need to open up questions around what is choice for women, rural areas as well. Worry people would provide anything rather than the right treatment because they are under that legislative duty.

### **Paul Sweeney: What are unintended consequences of Bill?**

Justina Murray: families were cynical whether that full range of services would be offered, they don't have all of these options for services on their doorstep, how would this work when there is limited support available?

Tracey McFall – we have data systems that don't connect up and see cradle to grave picture. How much more data will we be gathering and what will it do? We are gathering a lot of data, but what is it telling us? We may end up with more bureaucratic collection ...services say they don't want to collect more data, but work with people in community and support

### **Paul Sweeney: Risk of gaming the system?**

Kirsten Horsburgh: we've seen this in policies and processes – we were there when heat standards were introduced, people had to be in treatment in 3/4 weeks. To manage capacity, people were saying they were getting treatment when they were getting preparatory work. This is obviously what happens when people don't have capacity. We've done research on MAT standards. Until we can be honest about the

problems that are happening, we are never going to address the issues. We need to focus in on peoples true experiences or they'll never improve

Tracey McFall – we need to be careful of more resources into treatment end. Less money into broader recovery oriented systems of care. This unintended consequences are important.

**Sandesh Gulhane – the one piece of data matters is the drug deaths. Three times higher than next country. Is it not important that families going into battle could go into it armed with a right in legislation?**

Justina Murray: Theres no mention of rights in the bill of families. In contravention with the carers act...

**Sandesh Gulhane: surely this could be an amendment?**

Justina Murray - the bill doesn't add anything that is already there, it doesn't add anything, it undermines person centred and trauma informed approach...

**Sandesh Gulhane: But that isn't happening**

Justina Murray: The change we want to see is service seeing themselves as duty bearers – where services need to respond to peoples accessing rights

**Sandesh Gulhane – what if there was a bill that guaranteed the right to have a GP appointment within one week, surely that would be positive?**

Kirsten Horsburgh: I want to add some real scenarios from people – when we've been doing consultation with people...it goes back to missing the reality of people's lives. If they attend a treatment service, already feeling quite vulnerable, which is declined, the reasons are given. The bill is so unrealistic for people for the situation we are in...it is unrealistic to expect people to seek legal redress....

**Sandesh Gulhane – there is no clear way for holding public authorities accountable.**

Justina Murray – there is an implementation and accountability gap – ideally you want to resolve it there and then, you don't want to go through years of complaints process, stage 1, 2 or three, taking someone to court, its beyond resources of most people.

What we want to emphasis is changes we need is the interactions – services recognising people have rights and meeting them in this way. All of us are saying its not happening just now, but the bill doesn't provide this. Other things such as advocacy and the charter of rights could help this.

Tracey McFall – clear from people, when they are vulnerable, the last thing they want to do is see a lawyer and get legal redress. What you'll find is they'll disengage...

Kirsten Horsburgh – that process, they're at increased risk of death

**Brian Whittle – it was framed that you come in and request a treatment, and that's what you'd get, but surely you'd get advice from health professional?**

Justina Murray – you might come in with one presenting needs, but then have other needs, might be situations i.e, when people are on methadone and they want buprenorphine, but they already have rights on patients charger to have a second opinion, choice etc.

Kirsten Horsburgh – people have often have been in services for a long time, and have tried many treatments, and know what's best for them – from feedback people feel there's a strong abstinence focus, and harm reduction is missing. People will need different treatments at different times. HPs will give advice, but often people will know what they want.

**Brian Whittle – for me what is lacking is that consistent relationship with the professional...**

Kirsten Horsburgh– I think people should be more empowered to try different treatments, as with for example someone going to GP for depression, there's lots of options in different areas. For example there's a shift people going into stimulants. People sometimes think there's no point as no treatments for stimulants.

**Brian Whittle – wanting to come to funding and resource allocation and additional costs that might not be accounted for?**

Justina Murray – they were concerned pressure to deliver this thing wouldn't be met by NHS services which then they'd expect third sector to pick up, but with no mention of finances - I think there would be lots of unfunded costs

Tracey McFall – no mention to back end of costs...

**Brian Whittle – has any work been done on positive impacts both personally and financially of a system that works well?**

Tracey McFall: lots of work we could do, but I think there will be some findings from PHS NM evaluation. What we don't have is a clear picture of where money is going for recovery systems of care. This year there is an opportunity to focus not just about treatment but recovery.

Those drug deaths would be higher if it weren't for the work that was happening in our communities, there needs to be some focus on this.

Kirsten Horsburgh – the last thing we want to do is pit different services against each other, we need ever treatment harm reduction, resi rehab, recovery, we need the whole – alcohol treatment, massively important but underfunded. Its not just about level of funding, but about length. Services aren't sustainable in short term funding

**Brian Whittle – my hope would be the bill, forcing the positive way in which we bring third sector into this. For me to deliver the bill would require all of the**

**services, force governments to properly fund, that's the only way this way will work**

Justina Murray – there's nothing in the bill that talks about that – it's all about NHS services, and the health professional and individual, nothing in the bill that commits to broader funding – our fear is that the bill would suck up broader funding and put it back into NHS which is not necessarily what people want. It would have reverse effect

**Brian Whittle - my point is the bill would reverse that**

Justina Murray the bill is all about statutory services – there's nothing in it that talks about that?

Tracey McFall – there are discretionary funders in Scotland, CORRA, Robertson trust, they need to be brought into mix –  
To do

Something around justice system in this, does this right follow me when put into prison

Kirsten Horsburgh – we are always going to be firefighting until we address root causes, poverty, deprivation, and take a longer-term view. When are we ever going to address the upstream work

**Sandesh Gulhane – how can we protect the community spaces that are doing great work?**

Kirsten Horsburgh – why is it that DA easy pickings, onus needs to be on local leaders to not discriminate – we know vulnerable people are least likely to complain. I'd like to look at how we address that locally in decision making procedures.

Justina Murray – I think its difficult as third sector CEO to say oh we should account for every penny. Its not always transparent where all the investment has gone. You talked about evidence based services that are closing – proving things work doesn't protect you. Community link workers are an unsung heroes, people who had already lost their jobs but were still on the conference it feels that no matter how we prove ROI it doesn't protect us when budgets are being cut.

**Convenor – does this bill address the issues that you've just vocalised**

Justina Murray – No.

Tracey McFall – Currently no.

Kirsten Horsburgh – Still don't think legislative approach is right.

## Panel 2

### **Elena Whitham – Will the provisions in the Bill ensure the rights of people who use substances are realised?**

Annemarie Ward: the organisation I work for is grounded in evidence and rooted in experience, and in hope and action – the rights people should have are not being experienced when they come forward for treatment, or, in the system. I'm here as someone who has walked the path of recovery, beside 1000s of people. The Bill is a matter of life and death, not abstract. From our advocacy I've learned the system is very obstructive. We know this because we have stood toe to toe with people when they're trying access services. We have fought tremendous bureaucracy. Its not cost, clinical judgement – it's a culture of gatekeeping.

Graeme Callendar – We support over 15000 people over various stages in their journey. We can get behind the intent of the bill, where we come from are the practicalities, we are not sure if the Bill as it is currently written – access to resi rehab and detox – most of our work is about getting people to these services in the first place. We are broadly supportive of the intent, but concerned around the practicalities.

Jan Mair: I would echo that exactly – we are in support of the intention of the bill, our org works with people that aren't getting into treatment, those who aren't ready, people need access to treatment, im not convinced this bill is the right way to do it. A slight worry for us that it might be a distraction. Many people were involved in the consultation of the charter of rights, the NC, which seems to do many of things without problems, in fact its broader, my worry is it might be a distraction from something that's already in train

Lee Ball – we work with people that aren't even at the door of treatment. Theres different reasons for that, people may have poor prior experiences etc. we do support the ability for someone to have their rights enshrined, and justify why treatment isn't provided. And that's a lot of responsibility on the system that is already stretched, which would need to be resourced.

### **Elena Whitham – to what extent the charter will conflict or compliment the charter – we don't have the Human Rights Bill which would underpin**

Annemarie Ward – the claim is that the bill is impractical is not a serious concern – those that are raising the concerns are commissioned by SG, they are funded by government, and embedded, this bill shifts power for them, that's not a distraction its democracy A charter isn't enforceable, it's a poster on a wall, it offers no redress, no accountability,

People are saying this bill is a distraction same people that haven't delivered for people.

None of our clients have heard of MAT standards, rehab isn't an option – a charter isn't enough, the bill is a real method of accountability. It's a distraction because it disrupts bureaucracy.

**Elena Whitham thinking about the collaborative and Charter of Rights, I share the concerns that its not enforceable as it might have been, taking that on board, do you think the bill complements or contradicts the charter?**

Graeme Callendar – I think the bill as presented – it feels a narrow definition on what is treatment. As a third sector who receives money from LA – we aren't responsible for prescribing. We come across challenges for people wanting reduce prescription on RR> we are supportive of intent. We wonder how it will be practically delivered. Weve got the charter and proposed legislation. I'm not clear whether this bill and charter, could fall down if it's not implemented. But with charter it does feel collaborative. With this bill its felt more challenging to engage with the key topics.

Jan Mair – I would agree with agree, I'd prefer the legal underpinning for the charter of rights what I like about the bill is the accountability, we want that accountability. Where we are working with people who aren't near treatment, they are a long way from it, this bill, because it focuses just on treatment, it doesn't give rights at earlier stage, what the charter does

Lee Ball – when you speak to staff and service users, they ask for accountability, we need to be careful of legislation tripping over each other. WE are concerned of omission of explicit HR they need to know before they come to treatment, need to considered before.

Annemarie Ward – let me respond to accusation that it offers narrow treatment – this is totally disingenuous., those pushing that line aren't neutral, they don't engage with bill, or inform their stakeholders or distribute our myths busting, they haven't engaged with it. They're confused but haven't spoken to us. Its manufactured. It defines treatment as it exists in NHS Scotland. The charter of rights, darling of services, it has no teeth and cant be enforced. It's a PR exercise.

This charter is not more collaborative, its written by those that don't collaborate with the bill. The charter is embraced because it asks nothing of the system.

**Brian Whittle – you discussed the bill not talking about pre-treatment. Would you agree if we get people to seek treatment and then not get it, is destructive – because the bill says if y ou access treatment, you have the right to get that, is that not important**

Lee Ball – it takes courage to access treatment. We are concerned about definition of treatment and when it begins. When will time be counted from that point?

**Emma Harper– advantages or disadvantages of requiring a diagnosis before entering into treatment?**

Jan Mair – we are concerned of the idea people needing a diagnosis – unnecessary barrier. A lot of people don't want or need a diagnosis, but need the treatment in its

broadest sense. There are many people who have serious issues with alcohol and cocaine, but they are not physically dependent, so the word and diagnosis. It would put people off, where often people need to come and talk about problems. Its more than just a health problem, it's a social problem, related to communities, initially it can be a barrier to support. We might focus energy on all of those with physical dependence away from those using in different pattern,

Graeme Callendar – very similar. It was a key thing, the diagnostic part. People come cos they need help, we don't wait for a diagnosis to happen before we support, often on same day. Occasions were you need a diagnosis. A lot of people that are at risk of overdose, they might need and should be no delay.

Other issues is upskilling of HP's, that they all need to become skilled in how to make a diagnosis. Lastly, a need to be confidential and addiction to be on medical records. A lot of people work. If the bill progresses it needs to be confidential

**Emma Harper – I am a nurse and have worked with people with substance use. Does the bill need to change then?**

Lee Ball addiction is a loaded term, its seldom a single issue, to give a diagnosis of that one thing without everything else is narrow. A diagnosis is a help or hindrance depending how its used. People have a right to privacy, being on medical issue is a risk. Id ask you to consider this term, its too narrow. Its often loaded, with stigma, negativity. Language defines our reality so we need to be careful.

**Emma Harper – protection of anonymity, this is where language of addiction is a problem...**

Lee Ball – it can increase, go up, down, it's a moveable issue, to define it as one moment in time, is narrow, we need to be careful to pigeonhole

Annemarie Ward – let's cut through noise, claiming its stigmatising is narrow. Every healthcare starts with diagnosis , they don't die because of a diagnosis addiction, they die because of lack of treatment. If HPs can't give a diagnosis, where are we. Don't use workforce failings to cover this up.

**Sandesh Gulhane – if we were to amend the language of addiction – we need to say you have something, what should the term be?**

Graeme Callendar ; treatment is there, for us its always been about access, we understand importance of clinical process, sometimes it's critical when other things are going on. A lot of people we speak to don't need a medical intervention, they need mutual aid, other support, it feels narrow to me-

**Sandesh Gulhane – it's a member's bill. My question was what wording you would use?**

Lee Ball – it's a person's right to want treatment – it's a difficult thing. We reduce deaths, without clinical work. I think if we move this forward, we should ask those in services, what word would you like

**David Torrence how confident are you that resi and detox services can meet increased demand?**

Jan Mair – I don't think we have enough capacity through different services. What's more important is we need a consistency of standards. Just because you are accessing resi services doesn't mean it's the same in one part than in other part of country. I'm not convinced we've got a capacity of a consistent standard throughout country

Graeme Callendar – I've seen people go through RR, for some it's not worked, i.e not right time or service. we do pre and post support / We are seeing demand skyrocket, we are seeing pinch point in systems. Every RR service is different, focus and selection, I suppose that's another thing we need to factor in. I don't think they have enough capacity

Lee Ball: Peoples caseloads are going up, stress and strain is going up, we are at capacity, there needs to be additional resources if this is going forward. We also don't want funding for one area at the cost of another. The person has the right to be informed and involved, and decide pathway as collaborative process

**David Torrence – how concerns are you that focus on RR could take away from community services**

Lee Ball – we are concerned, the evidence base for HR is huge, but what's also really important , some people want detox and rehab, and we welcome this, but it should never be at the expense of other things.

Its very difficult, especially when you are homeless, of thinking you can have a life away from drugs, its terrifying. So we need to support broad

Jan Mair – abstinence and harm reduction are not in conflict. Most people in abstinence have had a period of both. And those who have been in Resi rehab going through a decision of controlled drinking/drugs. I welcome the acknowledgement in the bill, but unless we spell out the harm reduction measures, my fear is we will privilege the abstinence based measures. We need them both named in the bill ,it's part of person centred care.

Lee Ball – I think the omission of harm reduction has the potentially to polarise the debate. Everyone has the right to choose their modality. We need to be careful we don't blame

Annemarie Ward – no one tells harm reduction services to watch their tone – when we talk about resi rehab, not to get carried away as if the subject is dangerous. Nothing in this system works for everyone, only RR and detox are treated as radioactive. The bill doesn't take focus away from other pays, gives a legal footing to every treatment.

I won't be softening my tone, civility cannot come at the expense of truth.

**Brian Whittle - Weve heard a lot about being able to coordinate treatment with other needs. Can the bill help with this?**

Graeme Callendar – instils a right to treatment but not anything else, not receiving mental health, counselling, perhaps it's about making amendments, I don't know how this bill will help sort other aspects of people's needs. For many peoples its housing, relationships, it's that they want to deal with that before addiction

Lee Ball – we are having an debate, treatment is a wider thing, its not just a clinical process not just in itself, it needs to be wider.

**Brian Whittle – how will the bill support a longer term recovery?**

Graeme Callendar – simply, it just needs to be in there and it needs to be explicit, if it's not set out, how will it be delivered. It might be a question of how that interacts with other policies.

Lee Ball – so much of what we consider is treatment is counted in the community, there is the potential for that, but needs to be counted.

**Brian Whittle – would you accept that by forcing treatment rights this will force change?**

Jan Mair – it has potential but it would need to be explicit, that follow on support, wraparound support. The post treatment, what is often involves is other parts of system, community housing, employment, it needs to explicit, otherwise money goes into one side and not in others.

Annemarie Ward – the idea money will be removed from one part of treatment into others – it wont happen, people will get the treatment they need. They're worried their branch of treatment will lose money. Surely we should get behind people getting help rather than protecting our own interests.

**Elena Whitham – if we get the totality of someone's journey right, we could then prevent a lot of the harm we see. I'm wondering if this right could realise that at an earlier stage. Could this bill realise that, or not?**

Jan Mair – yes, if this could be in the bill. I don't want to treatment in the bill out of the bill, but what we want as well is those upstream things, someone drinking hazardously, say if someone could get harm reduction much earlier on , it would perhaps mean harms are protected, upstream is important, that's why it feels that there's a lack of harm reduction spelled out here.

Lee Ball – quite often things that are not say are not done. There needs to be an explicit point about working upstream. That's where it all begins, it needs to be done at that point.

**Elena Whitham how do we ensure someone has the support they need upstream?**

Annemarie Ward - of course this bill won't support housing or rebuilt communities and broken benefits – but it will ensure that when they say they're ready it will guarantee any bill deemed appropriate – it doesn't undermine mat, close services, it protects them as a legally provided treatment. It's not about taking options away, it's about people getting to choose what recovery looks like.

Graeme Callendar – as its written it doesn't talk about early intervention and prevention. It speaks about narrow treatment, it doesn't say how it will do early intervention. If it goes forward it needs to be made explicit.

Lee Ball there needs a systemic focus.

**Gillian Mackay – can a I follow up on the potentially limited flexibility of treatment options, it may overly medicalise or standardise treatment pathways. How could it be amended**

Graeme Callendar - we were disappointed to see key bits of the work we do not mentioned. I know there is the catch all phrase at the end, but it's so vague. I think we need to be more specific on what treatments and what combinations are available, that's helpful, people need more than one thing

Lee Ball also about understanding role of community, it's not defined by a specific time, it goes on.

Jan Mair: what we need is a much wider definition of treatment, or a response to problematic drug and alcohol use, so that we are acknowledging the importance of working with people – they might not be ready to make changes but need support

Annemarie Ward – the claims that there is no prevention in the bill misunderstands the bill – it's a health rights bill , focusing on access to treatment because its broken. The problem is when they need help the door is locked, it doesn't cancel prevention, it complements it. Its not flawed because it doesn't try to fix everything. I don't know why people keep referring to housing etc, its outside of the scope if this bill, I'm concerned its deliberate conflation...

**Gillian Mackay – people have said the requirement for in person treatment will place barriers – would the panel support flexibility in the bill to reduce those barriers**

Lee Ball – I worry people would be excluded from this method of treatment. I think we do absolutely need to be as creative as possible and involve people, the staff, families, I agree with that.

Graeme Callendar – needs to be provisions of bill for online, telehealth, our services work in rural areas and in person would be difficult

Annemarie Ward – this isn't true, it doesn't require in person requirement, a qualified healthcare professional must make the assessment, it gives a right treatment not how services must engage

**Sandesh Gulhane – a narrow members bill should not look on the entire journey. Its focusing on people at the ned who say they need medical intervention . Would it help those seeking treatment?**

Graeme Callendar – in your narrow definition, yes. All we can do as service providers is share our experiences. We are advocates for the people we support, everything we have said is that all aspects of treatment are considered, that there are no unintended consequences. We don't want unintended consequences, that's all.

Lee Ball – we believe there is there potential for the bill to do as you suggest, what I do have direct experience of , people will struggle to advocate for themselves, it's one thing to give someone a right, but another for them to be able to use it.

Annemarie Ward – calling it too narrow is saying it just does one job too well. Some people don't like that. It gives a people a right. That's not narrow, that's targeted. We've had strategies that say they deliver everything and do nothing. If the scope of the bill makes people uncomfortable is it finally gives accountability and that's what's being resisted here.

**Sandesh Gulhane – there's discussion about how the bill would create a power imbalance but also that people are not getting the treatment they need. Why do you think the bill would create further power imbalances.**

Lee Ball – the omission of harm reduction, explicitly could fuel reduction harm reduction. Stigma already exists, the idea that this bill would just

Graeme Callendar – people will tell us about the negative experiences they have, mostly within wider services, and the focus of the bill on NHS health services, the concerns come from that you might have right, but those attitudes and treatment might not change.

**Sandesh Gulhane – do you think there is a top down bad attitude that comes from health professionals?**

Lee Ball - yes, we have experienced this.

Graeme Callendar – it varies where you go – there is so much pressure and strain, how could it not be...but yes I've seen some.

Lee Ball there is potential in the bill for them to call it out, but who is going to empower them to challenge.

Annemarie Ward – some people say it would assert the power dynamics – and I say, exactly, it should. Right now they can say no, without any consequences. If someone says a person needs treatment, they cant block it, due to budget, or opinion, or gatekeeping.

Jan Mair: I'd like to pick up on Lee's point – if this Bill has a narrow definition of the options of what are available, that will steer people into what they think they can ask for, and we need advocacy to ensure people can get that broader package

When we talk about Health professional, this could be someone who doesn't have much experience in substance use and does not know what is available. We could use the principles from the self-directed support act. This build in collaboration between health professional and person seeking support, if we could have something like that, it would help;

**Paul Sweeney – I want to turn to issues of timescales and treatment availability within 3 weeks. There have been some queries on this timescale. Do they think the requirement allows sufficient flexibility for preparatory steps etc, or would that fall within the 3 weeks?**

Annemarie Ward – the fact people are quibbling over 3 weeks maximum just shows that there is no timescale at all – people can wait a long time and there's no accountability. It says you can't be left beyond that. If its delayed beyond three weeks they get a route to challenge. It's a legal safeguard not a clinical prescription. The MAT standards same day prescribing, who is getting that, our clients haven't heard of it, never mind accessing it. Lets not pretend we are meeting tighter deadlines already.

**Paul Sweeney – is there a way to actually define the three week period adequately, i.e. the need to do preparatory work, can we define that, if people are in that period, that it includes this period?**

Annemarie Ward – Absolutely, if we can't offer a treatment plan in 3 weeks, what are we doing. Its been resisted because it holds people accountable for delays. Some people never get treatment at all.

**Paul Sweeney could the drafting be tightened a bit?**

Graeme Callendar – the 3 week target has been in for as long as I've been in the sector – there are fundamental challenge in how that is being delivered. I think it is the bare minimum, and I think that's maybe not what was explained fully in the Bill, sometimes it can be delivered in same day. I think its important to be reflected in Bill. Sometimes there are waiting lists, unless we have a huge increase of capacity, I don't know how we get round that. The most important thing is that people see someone, and treatment begins, irrespective of what that is. Its good there is a timescale, but its been a well known timescale for a long time.

Jan Mair: a 3 week wait for RR , its appropriate and we welcome that, but for some, its needed immediately, we wouldn't want the three weeks to become a barrier, and wondered if this could become more nuanced and making it clearer for different types of treatment. I.e. could we have a legal requirement in this Bill for MAT to be at same day? That's what we are looking for.

Lee Ball – we need to ensure that same day treatment isn't deprioritised as the result of another timescale coming in. we also need to consider what constitutes treatment

– it always starts from the get to, defined by the relationship you develop when you walk in the door, the relationship with worker. We need preparatory work, some need to go straight to detox, it needs to clear what defines treatment, that needs to be clearly spelled out.

### **Paul Sweeney – Would that signal the demand and standards needed?**

Jan Mair: Need to avoid issues with treatment target

Annemarie Ward: three week maximum not barrier. People are being left for years with no progress. It is a safety net not a waiting period. Deadline not a delay...

Lee Ball: three week time limit if we don't resource correctly it will put pressure on frontline staff. It needs to be resourced

### **Paul Sweeney: Is the content of the Bill suitably flexible?**

Graeme Callendar: change in types of substance use, more poly substance use. Make sure that people can be fully supported even if not alcohol or opiates.

Lee Ball: not always a medical route to support, need psychosocial support to be explicit in Bill

Jan Mair: echo that. Careful distinction of treatment needs as means different things to different people.

Lee Ball: stabilisation understood in different ways, Bill policy memo states it is with aim to reduce use, this is not always what people want or understand it to be

Annemarie Ward: happy for definition to be made in the Bill

### **Paul Sweeney: financial memo: are costs appropriate?**

Graeme Callendar: welcome consideration of financial support, not clear if it is accurate, Need to make sure money is enough.

Lee Ball: is we don't pay now we will pay later elsewhere. Also need to take account of the work that third sector do

Annemarie Ward: people are dying. Bill is not demanding new treatments. Just establishing rights. It will force the money to follow the need. Scrutiny is not done for other things that are being funded like MAT Standards and third sector orgs.

**Claire Haughey (Convenor): the requirement for in person meeting is in section 2.1(d) in the Bill. Sure member in charge will reflect in that when gives own evidence.**

# DRUGS POLICY

**[Redacted-out of scope information]**

**13 May:** Third evidence session on Right to Recovery Bill held with third sector. Annemarie Ward (FAVOR) was a witness. AMW co-drafted the policy of the Bill.

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## **RIGHT TO RECOVERY BILL**

**We welcome the introduction of the Right to Addiction Recovery Bill and have engaged with the lead committee.**

- We want to now carefully consider the evidence gathered through the Stage One process, and look forward to the opportunity for the Cabinet Secretary for Health and Social Care to give evidence to the committee on 20 May.
- We support the stated outcomes of the Bill - indeed our £250m National Mission works to get people into the treatment and recovery that is right for them, while also supporting them to address other social and economic needs.
- We are committed to following an evidence-based approach, will carefully consider the evidence provided to the committee by experts, including people with lived and living experience.

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# DRUGS POLICY

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