OFFICIAL REPORT
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DRAFT

Health, Social Care and Sport Committee

Tuesday 13 May 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 13 May 2025

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
14th Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Lee Ball (Salvation Army)
Graeme Callander (WithYou)
Kirsten Horsburgh (Scottish Drugs Forum)
Jan Mayor (Turning Point Scotland)
Tracey McFall (Scottish Recovery Consortium)
Justina Murray (Scottish Families Affected by Alcohol and Drugs)
Annemarie Ward (Faces & Voices of Recovery UK)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 13 May 2025

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 14th meeting in 2025 of the Health, Social Care and Sport Committee. I have received no apologies.

Agenda item 1 is a decision on taking business in private. Do members agree to take item 4 in private?

Members *indicated agreement.*

Right to Addiction Recovery (Scotland) Bill: Stage 1

09:15

The Convener: The next item on our agenda is the continuation of our evidence taking on the Right to Addiction Recovery (Scotland) Bill.

Today, the committee will hear from two panels of witnesses. Our first panel comprises representatives of a number of third sector organisations, and I welcome to the meeting Kirsten Horsburgh, chief executive officer, Scottish Drugs Forum; Tracey McFall, chief executive, Scottish Recovery Consortium; and Justina Murray, CEO, Scottish Families Affected by Alcohol and Drugs. A fourth witness, Laura Mahon from Alcohol Focus Scotland, is unfortunately no longer able to join us this morning.

Again, I welcome you all to the meeting. We will move straight to questions.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Good morning, and thank you for coming in this morning.

I want to explore the right to recovery as set out in the bill and what it means to be a rights holder and a duty bearer. To what extent will the bill's provisions ensure that the rights of people who use substances are realised in the way that we would all like to see?

Kirsten Horsburgh (Scottish Drugs Forum): Thank you for the invitation to the meeting. First, I want to set out the context of where we are coming from with our response. We absolutely welcome the national conversation that the bill has created on the problems with the treatment service and the light that it has shone on issues around access, choice and the quality of services.

However, although we agree with that conversation being had, we do not agree with the matter being dealt with through a legislative process. The issues at the core of treatment service problems are to do with access to immediate treatment, the quality of that treatment and the disempowerment felt by people who use substances when they are accessing treatment. Those are not legal issues; they are issues of culture, capacity and resourcing.

A legislative process would not guarantee the improvement of the quality of services; it certainly would not help enhance the access that people are looking for; and it would not guarantee a person-centred therapeutic approach. The bureaucracy, the confusion and legislating for clinical decision making are also concerns, and we are concerned, too, that it would not provide any meaningful change. We need to fully invest in implementing the standards that are already there and the recommendations that have been made—time and time again—on improving the accessibility, acceptability and equity of services across the country and to fully embed lived and living-experience perspectives in service design and delivery.

Tracey McFall (Scottish Recovery Consortium): As far as these discussions and our input into the bill are concerned, the Scottish Recovery Commission’s perspective is that we want to be constructive, but as you—and we—know in relation to legislation in Scotland, and as Kirsten Horsburgh has said, the fact that it is in law that people have rights does not mean that people will be able to access those rights. We know as much in relation to housing legislation and, indeed, a range of bills right now.

As Kirsten also pointed out, the fundamental issues in Scotland are access to and choice and quality of treatment. In principle, we all want people to access their rights in relation to treatment. From the SRC perspective, if the bill is to go through, a range of changes will be needed to address the power imbalance; to align with current standards, using a human rights-based approach; and to ensure that people with lived and living experience are included in the process. Yes, we all want people to access their rights in relation to treatment, but, as I have said, the fact that those rights are in legislation does not mean that they will come to fruition in Scotland. There are many things that we need to talk about in relation to that.

Justina Murray (Scottish Families Affected by Alcohol and Drugs): I want to make a more general point about human rights, which are universal and for everyone. We all have human rights. I cannot give you your rights and you cannot give me my rights, but what we can do is recognise and uphold them. My point is similar to some that have been made already. We do not support the legislation, because it includes a lot of gatekeeping of rights or conditional rights, which, in our view, makes it fundamentally flawed.

Elena Whitham: I want to explore how the bill could enhance, or come into conflict with, the charter of rights that has been worked on for quite some time. That charter was to have been underpinned by a Scottish human rights bill that has now been delayed, and I am hugely concerned that we will now enter a vacuum in which people are unable to make an effective challenge to realise their rights. Could the bill, as drafted, complement that, or might the two conflict with each other?

Tracey McFall: For the SRC, and for the people whom we have spoken to, this is not only about the charter of rights; there is also the national care service charter. A range of things would have to work in synergy with the bill.

However, although there is a range of conversations to be had about the charter of rights, the national care service charter of rights and this bill, the fact is that individuals, families and communities in the middle are trying to navigate a really complex system to access what they need to keep them alive. We must keep coming back to that. The more complex we make the system, the harder it will be for families and communities to navigate. Right now, the bill has no synergy with the charter of rights or, more broadly, with the national care service charter of rights.

I hope that that makes sense.

Justina Murray: We think that the charter of rights is a really helpful document. It sits as part of a suite of rights-based documents, along with “Rights, Respect and Recovery”, the medication assisted treatment standards and the patient charter, and I will speak about carers’ rights later.

We think that the charter is helpful, but we also know that family members and loved ones need a lot of support to understand and access their rights. We have done a lot of work on that through our “My Family, My Rights” programme. Just telling families, “You’ve got rights—isn’t that fantastic?” does not change the world for them, but providing them with the knowledge, skills, confidence and connections to access those rights has been a game changer.

Kirsten Horsburgh: When, as part of our response, we consulted people with living experience of substance use across the country, one key comment that they made was that they are only just getting their heads around the MAT standards and the charter of rights. They cannot see how the legislative process would enhance or support them, and actually, they see it as conflicting with some of what is in the MAT standards. The bill as introduced completely misses the real-life experiences of people who are trying to access services.

Elena Whitham: How can a family or an individual challenge decisions if they are not getting access to the support that they believe that they require? That, to me, is the nub of the issue: if they do not have a right in legislation, what is the remedy? Do we lack a remedy at the moment?

Justina Murray: The bill is silent on that and does not talk about what someone would do to challenge their rights, beyond seeking legal redress. Families tell us that no one has the money to do that, let alone the knowledge, headspace or time, so that is not an appropriate route for redress.

Advocacy services do need to be strengthened, but they can support people through the existing complaints processes, from stages 1, 2 and 3 all the way up to the ombudsman. We know that that sometimes succeeds in making families feel that they have been heard and that the issues they have raised have been listened to.

It is not a perfect system. However, the bill does not really solve that issue—it just adds another layer of legislation. As we have already reflected on, Scotland is full of legislation that is not being effectively implemented.

Tracey McFall: Justina Murray is correct. Although there has been investment in independent advocacy organisations with a specific role and remit to support those who want to challenge the system and make complaints in relation to access to alcohol and drug support, it has not been enough. As Justina has said, in order to access your rights, you need to know them. There is a massive gap in relation to individuals, families and communities fundamentally understanding their rights in Scotland.

Emma Harper (South Scotland) (SNP): Good morning, and thank you for being here.

The bill requires a relevant healthcare professional to diagnose individuals with a drug or alcohol-related problem and then to provide a treatment determination. What are your thoughts regarding the requirement for somebody to receive a diagnosis before they can enter into treatment?

Kirsten Horsburgh: Gatekeeping, which Justina Murray has mentioned, is a key part of that. Such a requirement will allow for a system in which there is gatekeeping, given that someone will need a diagnosis before they are able to access any specific treatment.

The whole process creates something adversarial rather than collaborative. We do not want this to be a battle, do we? We do not want a situation in which people are having to challenge treatment decisions. We need to get to the root cause of why people are not being offered the treatments and support that they want and require when they present.

There is a lot of work to be done, and there are a whole range of things that we could do to improve the treatment services, so that we do not even reach that point. The need for independent advocacy is a great point, but it is not mentioned in the bill. There is a range of other workplace and workforce development that would be beneficial, too, but I will save that for later.

Tracey McFall: The SRC engaged with people across the country on the bill, and a key theme that emerged was the stigma of having a diagnosis of addiction. There were implications arising from such a diagnosis being on people's medical records, including for jobs and access to training and education.

When people are in crisis and need to access treatment, there is an intervention point at which you can start to build a relationship with them. The difficulty—and this was talked about in a previous committee meeting—is that the time that it takes to make the diagnosis might delay treatment. That is a significant issue that is not addressed in the bill, and which needs to be explored further.

The big thing that came out most strongly from the people to whom we spoke was the stigma attached to a diagnosis. Not everybody recognises the term "addiction" and they do not themselves as being in that space. The attachment of stigma is a fundamental issue.

Emma Harper: Some people might not want to seek that diagnosis, then, or the stigma might prevent them from coming forward to access care or treatment because, although they know in themselves that they have a problem with alcohol or drugs, they do not want to hear it. Do we need to find some way of getting people into treatment without a diagnosis?

Justina Murray: Yes. As a nation, Scotland has done so much work on understanding the difference between alcohol and drug use, and alcohol and drug-related harm. We want people to recognise that they can get support if they are concerned about their own drinking or drug use, or if family members are concerned about it, because of the level of harm involved.

The returning focus on clinical diagnosis is so narrow. That has been well covered in previous evidence sessions, especially in relation to alcohol; a tiny minority of the population might be clinically diagnosed as being dependent on alcohol, but 25 per cent of the population drink at levels that risk their health. There are people dying from alcohol use or causing themselves harm all the time who would not be diagnosed as being clinically dependent on it. It seems to be an unnecessarily narrow focus that strengthens the already existing power imbalance between health professionals and people seeking support.

09:30

Gillian Mackay (Central Scotland) (Green): Good morning to the witnesses. Does the bill adequately promote collaborative working among health, addiction and broader support services to ensure the holistic approach that it seeks to achieve?

Justina Murray: My quick answer is no. The bill does not reflect the importance of multidisciplinary teams or collaborative working, and it is pretty silent on the role of others such as the third sector. It does not touch on the other issues someone with harmful substance use might experience, such as mental health issues, relationship issues or issues with housing or finance. Where is their right to support with those concerns? The bill has an overly minimal focus on a clinical diagnosis of addiction, without there being any responsibility to respond to all the other needs that people would have.

Tracey McFall: We know that problematic substance issues and alcohol and drug use are complex and that medical treatment is a very small part of everything else that needs to be wrapped around the individuals, communities and families that are facing those issues. In Scotland, the evidence base is really clear on that. The United Kingdom guidance on drug misuse and dependence is clear that the clinician’s role is to support and assist joint decision making in relation to treatment. I agree that the bill does not provide for the services that Gillian Mackay asked about. Joint collaborative decision making will be absolutely critical. For the bill to move towards a medical treatment model is a retrograde step.

Kirsten Horsburgh: Sometimes, treatment is secondary to what people really want to address in the first place. Often, people will attend a service when they are looking for support with housing or with benefits. When the service has been able to support them with those things, it builds their trust and they might consider making other potential positive changes in their lives, such as accessing treatment. Our services are back to front in the way that we engage. We should be encouraging people to attend service appointments for a variety of reasons. Prescribing treatment or engagement with other treatment services are secondary components.

Gillian Mackay: Notwithstanding what the witnesses have already said about what the bill does and does not do, is there a way to amend it in order to reflect some of what has just been said? Could the bill enhance some of the services that we already have, or do we need to put more effort into enhancing and promoting them?

Tracey McFall: If the bill was passed in its current form, the SRC would be looking to address the imbalance of power in relation to joint decision making. To go back to Kirsten Horsburgh’s opening remarks, we still have to some work to do in Scotland. If quality accessible treatment options were available for people in Scotland, we would not need the bill. I believe that, although amendments could be made to the bill, the fundamental issue in Scotland is that we need to work on the treatment systems that we have in order to make them more accessible to individuals, families and communities.

Kirsten Horsburgh: For the avoidance of doubt, we are clear that we do not feel that a legislative process is the right way forward. I would feel disingenuous if I were to suggest amendments to a bill that we would not support.

Justina Murray: Our view is the same. We set this out in our formal response to the consultation, so it is not a great reveal for me to say that we do not support the bill in any form. We are all on the same page about there being issues with the current system. We have already mentioned a number of things that are in place to begin making improvements, but that journey is nowhere near finished. In our view, the bill diverts attention and resource from the changes that need to be made.

The Convener: I have a follow-up question. Justina, you talked about resources. As an organisation, does SFAD feel that the resources that could be put in, were the bill enacted, would be better placed bolstering services and addressing some of the issues that you raise—advocacy and access to services such as housing and benefits, for example? Would that be more beneficial in the long run?

Justina Murray: Yes. As you will know, the financial memorandum quotes estimates of £28.5 million to £38 million for the treatment changes alone. I am not sure whether that money has been identified, but I would have many ideas for how it could be spent to improve the system.

We need to look at a fundamental redesign of where resources are placed in the existing system. Almost all of our resource is locked into national health service-led treatment services, which are not what people ask for. We talk all the time about listening to lived experience and being person centred, but people do not want to engage with NHS services, and, to be honest, the staff do not particularly want to work for those services either.

I would like to see a fundamental service redesign that builds much more of a whole system around the third sector and includes statutory services, families and communities. We need to put money where people want to engage, not where it has traditionally been invested.

Brian Whittle (South Scotland) (Con): Good morning. Thank you very much for your candid views on the topic.

You have talked about the issues with the bill and the need to put money where it is most needed. I have been in the Parliament for nearly a decade and this topic has been at the forefront of the Parliament during that time, but the changes that have been made have all been negative. Do you not see that the bill could force the Parliament to consider how we look at addiction, how we treat addiction and how we fund addiction services? The bill could force the Parliament to change. It could focus the Parliament's attention on the issue. That attention has been missing for all the time that I have been here.

Tracey McFall: It might force Parliament to change and to have that conversation, but I go back to my original point. Just because there is a legislative framework does not mean that people will get access to treatment as and when they require it.

I know that this is a member's bill and it is quite narrow, but, to me, that is a fundamental flaw with it. Addiction complexities and the impact that they have on individuals, families and communities are not narrow but very broad.

For me, there is an issue around how we currently fund addiction services. You said that you have had many discussions in Parliament but that nothing is working. If you look at the work of recovery communities across Scotland, you will see that the approach is working, but the difficulty is that most of the money goes into treatment. Every week, thousands of volunteers support thousands of individuals with thousands of hours, so a huge amount of positive work is happening to save people's lives, but our focus is on treatment. We need to move some of the money across the system, and we need to support and value recovery communities' lived experience and everything else that is needed around treatment.

Brian Whittle: I very much agree with that. I also very much agree that some of the biggest impact happening in our communities around third sector organisations is unseen. Many will not cross the lines of a statutory service, and the reality of what has happened over the past decade is that third sector organisations that have an impact on the front line are being starved of investment.

We have to do something different, which is why I ask whether the bill focuses attention on that.

Tracey McFall: I am so sorry, but the issue is around how we commission human rights-based services at a local level. There is a critical role there for health and social care partnerships, based on local need and on evidence. The issue is around how we commission services locally rather than whether we need a legislative framework; it could be addressed without legislation.

Kirsten Horsburgh: There is another major issue with data and reporting. The emphasis on continual data collection takes away from the ability to deliver quality services. There is so much focus on collecting all of the data that focus is taken away from service development and improvement. Rather than using our data for performance management and reporting, we should be using it for service improvement. A lot of that comes from fully embracing and involving people who use substances in service design and delivery and from getting true, raw feedback about what is happening locally and what improvements are needed.

I disagree that nothing has improved. Scotland's drugs policy direction and intent is welcome. There are definite positives. The major problem is the lack of urgency and the need to fully embrace the issue across the country. More things in more areas is what is required, and that comes with more resource.

Justina Murray: I return to Brian Whittle's point about the frustration or disappointment of sitting in Parliament and not seeing the changes that we all want to see. We also feel that deeply. Following on from what Kirsten said, we are tripping over progressive legislation, policies, strategies and documents around alcohol and drugs, and not only relative to England; Scotland stands in its own right. However, what is written down is not felt by families and communities on the ground. That does not mean that we need more legislation. We keep tripping over and layering on more paperwork, and writing down more of the things that we want to do. We need to put a laser focus on what is happening with implementation on the ground. A lot of that comes down to where the resources are, as we have touched on, but also the culture in our public services. I am sure that we will come on to those themes.

Kirsten Horsburgh: Scotland has no shortage of inquiries, evidence-gathering sessions and recommendations that have been made year after year after year. We absolutely share those frustrations with things not being actioned in the way that we would like them to be.

Joe FitzPatrick (Dundee City West) (SNP): Good morning. It is good to see you all. One area on which we all agree—whether you support the bill or not—is that to be successful in this area and other areas of health we need to be person centred. You have all touched on that to some extent, but the committee is keen to hear your thoughts on whether the procedures in the bill help or hinder the move to a person-centred approach. As well as anything else that you want to say, could you tell us whether you think that the bill helps with the move to a person-centred approach? If not this bill, what will help us to get to the point of ensuring that care is person centred? Tracey McFall, you talked about the imbalance of power in the system, so do you want to go first?

Tracey McFall: I do not think that the bill in its current form covers that, to be honest. It is not only about a person-centred approach, but about a trauma-informed approach. It is about joint decision making, choice, control and access to services. I do not have much more to add apart from saying that, ultimately, the bill does not touch on trauma-informed practice. Work is being done by NHS Education for Scotland, and there is a range of different workstreams going on around the MAT standards, covering access, choice and support, including access to rights-based training and access to independent advocacy. In its current form, the bill hinders that, and its focus on joint decision making is narrow.

Justina Murray: At the heart of any person-centred care, there is a relationship of trust that is built up between the person providing support and the person seeking support. I think that the bill misappropriates the language around rights and a focus on the individual, because it only cements the power imbalance that is already there.

There are already very good person-centred documents to support NHS patients. There is the patients charter, obviously, and there is a campaign called "It's OK to Ask". We are encouraging patients all the time to recognise the rights that they have as NHS patients. The bill does not add anything to what is already there.

09:45

The other thing that it is important to flag up regarding the person-centred approach is that it takes time to build up positive working relationships. It seems from the bill that there is an event of diagnosis, and then this other thing happens. Work with people who are concerned about their alcohol and drug use is a process that should go on over a period of time. It is not a one-off meeting, at which something is written down and enacted. It should be a much more fluid, on-going relationship.

Kirsten Horsburgh: People who use substances tell us time and again that the key thing when they are accessing a service—what makes or breaks it for them—is the relationship with their worker. It might be an all-singing, all-dancing service, or it could be one with very little resource, but it is down to the key relationships, where people feel like they are being heard and that their views are being listened to and acted upon.

Our concern is that legislation such as the bill threatens that therapeutic relationship by creating bureaucratic processes, such as having written information about treatment decisions and formal second opinions. It also creates an adversarial process rather than a collaborative one.

Joe FitzPatrick: That is really good: I think you that have probably answered the second part of the question that I was going to move on to. If I were to ask anything more, I would be moving on to the next member's questions, so I will leave it there.

David Torrance (Kirkcaldy) (SNP): Good morning, everyone. I put on record that I am a trustee of the Fife Alcohol Support Service.

Does the bill make adequate provision to ensure that individuals seeking treatment have access to advocacy and support throughout the process?

Tracey McFall: No.

David Torrance: I knew that that answer was coming.

Kirsten Horsburgh: All of us have touched on this point. Advocacy is a key aspect that is definitely missing. It is really important in the sector, and it has been developing a lot over the past few years—I refer to the greater emphasis on people's access to advocacy, particularly with the national mission funding. Obviously, what is available is still not enough, but that is an important aspect and it is completely missing from what has been described.

Justina Murray: In an ideal world, we would not need advocacy, would we? Services would be person centred, trauma informed and all the things that we want. However, we know from our work on the "My Family My Rights" course, which is based on a self-advocacy model, that families use warlike language when they talk about engaging with treatment services and with various other public services. They talk about "going in armed with information" and "battling with services". That violent language suggests that there is not a level playing field whereby everybody is respectful and people's needs are being met.

We provide families with learning, information and useful models and templates, such as the FAIR—facts, analysis, identification and review—model. It does not take a huge amount to help people to access and understand their rights, but we need to do something; it is not going to happen automatically.

Kirsten Horsburgh: Reflecting on what Justina Murray has just said, we have similar conversations with people who use drugs, although there is more of a risk ethos there. We know that treatment is a protective factor, but people often comment to us that they might "risk" going back and accessing treatment again. They see engaging with a treatment service as a risky process, which is obviously the complete opposite of what we are trying to achieve for them.

Tracey McFall: The charter of rights has started to draw out the importance of independent advocacy, so there is a massive opportunity in relation to the charter in this space.

David Torrance: Does the bill effectively address the needs of family members and carers who are supporting individuals with alcohol or drug problems?

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

I like to play a little game with myself, just to see how family friendly different documents are—it is word search, basically. The bill as introduced mentions "treatment" 57 times, "patient" 37 times, "health professional" 16 times, "recovery" 14 times, and "rehabilitation" five times; it mentions "family", "carer" and "relative" zero times. It does not mention "advocate" or "advocacy" either. In that context, you can see that it flies in the face of all the other positive written commitments that have been made around families and rights with respect to recovery. I am sure that you know about the national whole-family approach framework, as well as other documents such as the Promise and the charter of rights, which is for people who are affected by substance use, including families. Families were deeply involved in that process. I probably have nothing more to say on it, but it is ridiculous.

Tracey McFall: I will not add a lot, because I think that Justina has said it all. I will just say that there is a broader policy context in relation to the issue. Public Health Scotland has done a lot of work with regard to the evaluation of the national mission and the role of families, and Audit Scotland and the people's panel have published reports. There is a lot of evidence around how families feel disconnected and disengaged, not only in relation to the bill but also, more broadly, in relation to policy.

Kirsten Horsburgh: I agree with the comments that others have made.

David Torrance: I have no further questions, convener.

The Convener: Thank you. I call Paul Sweeney.

Paul Sweeney (Glasgow) (Lab): Thank you, all, for coming today. I will turn to the quality of services, service standards and reporting mechanisms. What impact could the implementation of the bill have more broadly on the quality of services and treatment that are provided to people with alcohol and/or drug problems? I am happy to take responses in any order.

Kirsten Horsburgh: At the risk of repeating myself, we do not believe that a legislative process would improve the quality of services, so I will comment on the improvements to treatment that we think need to be made. There is a raft of things that could be done, such as enabling better choice and making different options available for people.

A large part of the issue is about the support for the workforce. The workforce is underresourced, undersupported and undervalued, and people are often running with exhausting case loads. When some members of staff have 90 people in their case load, they are not able to provide the quality of care that they would like to provide and are not able to spend quality time with people to address their needs.

The way in which we deliver and design our service needs to be fully led and supported by people who use substances and those with lived experience. We also need to look at different models of service provision, because we have been quite fixed in the way that we have been delivering things. Over the past five years of the national mission, the opportunity to fully address the structural issues around how we deliver our services has been missed. That needs to be addressed.

Stigma needs to be addressed at all levels. Although we absolutely need the views of people with lived and living experience, we must also be mindful that some people's experience does not necessarily or automatically challenge stigma. We must be cautious in relation to the views that we amplify and how we hear them, to ensure that we are not inadvertently stigmatising people who use substances, as they face enough shame and stigma as it is.

Tracey McFall: In relation to the workforce development aspect that Kirsten Horsburgh raised and the quality of service that is provided by the paid workforce, I add that it is important to remember that we have an unpaid workforce—tens of thousands of volunteers—who are doing that work free of charge, although it is true that they are gaining relevant experience around assertiveness, confidence building, education, recovery pathways and so on.

In response to your question, the legislation will not improve the quality of services. Doing that would involve commissioning, using the data, looking at what people need locally and recommissioning local services in a human rights-based way.

Justina Murray: When we spoke about the bill with family members and family support workers from our charity and partner charities, one concern that arose was that there is a possibility that the pressure to come up with a treatment determination from the quite limited list and provide something in a very tight timeframe would actually reduce the quality and choice of services, rather than open up a conversation about what people need over time.

Particular concerns were raised about what choices are available in remote rural and island communities or for some population groups, such as women with children. They felt that the bill was narrowing everything down and that NHS boards would be under a legal duty to provide something, so they might just provide anything to tick the box of having met the bill's requirements rather than provide a quality option.

Paul Sweeney: That helpfully moves me on to my next question, which is about the unintended consequences of the reporting mechanisms in the bill as it is currently drafted. You just alluded to some, but could you perhaps expand on the point about potentially unintended consequences?

Justina Murray: Yes. There are a lot of unintended consequences. As we have reflected, we all have concerns about the state of treatment, care and support services, but that does not mean that the bill will make things right. I probably do not have much to add to what I have already said, but families were quite cynical about whether a full range of options would be offered.

We support families—from different kinds of social groupings across urban, rural and island areas—in 32 different local authority areas. They do not all have such options available for their loved ones on their doorstep. Therefore, what would NHS boards do? Would they have arrangements with neighbouring boards? How would that work when the provision of most support is actually limited in any case? The bill is ill thought through when it comes to reflecting what is available.

Paul Sweeney: Do any other witnesses have any comments to make on the adequacy of the bill's reporting mechanisms and the potential for unintended consequences?

Tracey McFall: From an SRC perspective, we have a number of data systems in Scotland that do not connect or join up, and they do not let us see the cradle-to-grave picture of the journey that someone goes through.

For SRC, an unintended consequence of the bill is how much more data we will be gathering as a result and what that means. Currently, our third sector services and data systems do not connect with the NHS, and our NHS systems in prison do not connect with local communities. We are gathering a lot of data in Scotland, but is it the right data and what is it telling us right now? An unintended consequence is that we might actually end up with more bureaucratic, complex data systems, which will take us away from front-line delivery.

Public Health Scotland has been really clear on that in some of its evaluations. Front-line staff are saying, "We don't want to gather more data; we want to work alongside people to support them in their community." The failure to join up data in order to see the big picture is a massive unintended consequence of the bill.

Paul Sweeney: In its written submission, the Scottish Drugs Forum mentioned the risk of gaming the system. Kirsten Horsburgh, could you perhaps elaborate on what your written submission said about that potential unintended consequence?

Kirsten Horsburgh: We have seen that happen as a result of many policies and processes over the years—it is not an issue that is only to do with this bill. I was working as a mental health nurse and in a drug treatment service when the health improvement, efficiency and governance, access and treatment targets, which set out that people had to be in treatment within four weeks, were originally introduced. What I saw was that, in order to manage the capacity, people were ticking the box to say that folk were in treatment within that period because they were getting motivational and preparatory work, which nobody would really consider to be treatment. That is the sort of thing that happens when services cannot meet capacity and demand. We have seen that with the MAT standards: we have all this pressure to be seen to be performing well and doing local reporting, but that has overtaken the need to see what the raw issues really are in communities.

We have done a lot of peer research work with some of the alcohol and drug partnership areas to gather information about the MAT standards, to see whether they are being implemented in the way that was intended. We get the reality of the situation from the areas that have the peer research approach. Things are far from perfect. However, until areas are empowered to be honest about what is not going well for them locally and to be able to work on that, and while services are still in the position of having to report and be seen to do well, we are never going to address the quality of those services.

10:00

When you walk through an airport, there are those little machines that let you say whether you have had a good service that day. Imagine if we were to implement a system so that every time you access a service you are able to give immediate feedback on how you feel that the service has treated you that day or on the experience that you have had. Those are the things that we need to focus on—people's true experiences of what those services are like. Without that focus, the services will never improve.

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

Paul Sweeney: Thank you.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising NHS general practitioner.

Kirsten Horsburgh, you spoke of data. The figure that really matters is the 1,172 drug deaths in 2023, at 27.7 deaths per 100,000 people. That is three times higher than the next nearest country, which is Ireland. The other figure that matters is the 1,277 alcohol deaths in 2023. We can all agree that those levels are disgracefully high.

Justina Murray, you spoke of families talking about going into battle "armed with information" and how this bill could be a retrograde step. Would it not be important that the families who are armed with information could go into the battle that you speak of—which is what is happening right now—with a right in law to get treated?

Justina Murray: There is no mention in the bill of any rights for families. Families would have no right whatsoever to be involved in any of this process. Not having that right would be in contravention of the Carers (Scotland) Act 2016, which gave carers the right to be involved in decisions that affect them. As I said in my answer to the previous question, to exclude families from this entire process would be contrary to every other bit of carers legislation and much of the substance use legislation—

Sandesh Gulhane: That could be put into the bill through amendments at the next stage. If that were to be an amendment to the bill, would it not—to go back to my question—be important for the families, who you are saying go into battle, to have that right?

Justina Murray: The bill would not add anything to what is already there. We are already working with families so that they can understand their rights as carers. For example, they are already going into meetings with all the information on the patients charter and the MAT standards. The bill would not add anything to that picture. In other ways, it would undermine much of the progress that has been made on promoting person-centred care and trauma-informed care.

Sandesh Gulhane: Forgive me, but, from the evidence that I have been hearing, it does not seem as though that is the case right now.

Justina Murray: The change that we want to see is for public services to recognise their role as duty-bearers. For example, I am not sure how many people would say, "I have the right to health and the right to life," when, just now, they even have to negotiate to get a GP appointment. This relates to the cultural shift that we need to see in services, which I mentioned at the start. There is nothing in the bill that would achieve the change whereby services recognise their role in upholding and responding to people's existing human rights.

Sandesh Gulhane: If we created a bill that said that, by law, you would have to be able to get a GP appointment within a week, would that not completely change the conversations that would occur with GP receptions?

Kirsten Horsburgh: Do you mind if I jump in to talk about some real scenarios that have been brought to us by people who are using substances?

We meet around 150 people across the country every week. They share their concerns and we can feed those back to alcohol and drug partnerships. What we have found in our consultation about the bill and what it would mean for them is that it completely misses the reality of people's lives.

They tell us what happens when they attend a treatment service, when they are often quite vulnerable and already feel pretty disempowered, and request a treatment but have that declined by the practitioner, healthcare professional or clinician, who gives a reason for that. The person might seek a second opinion, but even that is unrealistic. People tell us that they probably would not do that because they are already in a disempowered position of just wanting some help and are likely just to accept whatever is offered.

If someone decides to go on and ask for a second opinion, that involves waiting, and there is no timescale for how long they might have to wait. Then, if they get that second opinion, they go through the exact same process with another healthcare professional and can again be told, "No. You want that, but we suggest this." The onus to seek a legal challenge to that is all on that person, but it is completely unrealistic for people in that position to feel empowered to do that. This is all about disempowerment.

Sandesh Gulhane: Are people empowered now?

Kirsten Horsburgh: No, because of the way that our systems operate. The disempowerment continues, and there is no feeling among the people that we engage with that the bill would improve their situation. In fact, it would probably create more bureaucratic hurdles and threaten the therapeutic relationship that is important to them.

Sandesh Gulhane: Alcohol Focus Scotland made a comment that, as we do not have one of its representatives here, I will ask you about—if you cannot answer, that is fair enough. It said that

> “there is no clear way for individuals to hold public authorities accountable”.

How do people currently hold public authorities accountable and do people know who is accountable?

Justina Murray: I have already spoken about the implementation gap and there is also an accountability gap. Most people who have an issue with a service want to resolve that there and then, either with the worker they are dealing with or with a manager. They do not want to go through years of complaints processes at stages 1, 2 and 3, let alone take someone to court. All of that is beyond most people’s resources.

We are trying to emphasise the need for change in interactions within services. A service should begin by recognising that people come in with rights and asking what can be done to meet their needs in a person-centred and trauma-informed way. All of us know that that is not happening now and have been saying so, but the bill does nothing to change that.

Other things are already in place or planned and some things need to happen. For example, we need investment in advocacy and promotion of the charter of rights. Those things must be driven forward so that we get the change that we want to see, but the bill would just add another layer that would not resolve the existing issues in the system.

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

Kirsten Horsburgh: They are at increased risk of death throughout that whole process. The more delays and processes there are and the more that someone feels disempowered, the more likely an accidental drug death becomes.

Brian Whittle: I want to touch on one point following Sandesh Gulhane’s question, because I do not think that what was said about requesting a treatment is quite correct. Surely, when you request a treatment, the medical professional will suggest the most beneficial treatment for you, even though it might not be the treatment that you want. Am I getting that wrong? The way that the suggestion was framed was that someone would request a treatment and that was the treatment that they should get. Surely what is important is the medical professional’s opinion, as well as the discussion with the patient. Am I getting that right?

Justina Murray: Someone comes into a service seeking support. There might be one presenting need, but, through a good relationship with the worker, all the other things that also need support would be uncovered.

There are times when somebody might request a particular treatment. For example, they might ask about residential rehab or, if they are on methadone and have heard about Buvidal, they might want to explore that. There are times when people have heard about particular interventions and they want to explore them. However, under the patients charter, they already have rights to have options given to them, to ask for a second opinion and to have somebody at the appointment with them, so the bill does not introduce anything new on that interaction.

Kirsten Horsburgh: The sad reality is that many people have been in and out of services for years. Often, they have tried a number of different types of treatments, so they have built up a good knowledge of what works best for them at different points in their lives.

A huge thing that is lacking in the bill is harm reduction. The feedback from people we consulted is that the bill has a heavy abstinence focus. The reality is that people need different things at different points in their lives. Sometimes people seek abstinence, and sometimes they might seek prescription treatments, but people generally know what is going to work best for them in their lives.

Of course, it is valuable to have the clinician advising and giving information about different types of treatment. Certainly, there might be new treatments that people have been unaware of, such as the long-acting buprenorphine. Clinicians will give advice, but people are generally set on what they would like to try and, if we deny them that, they are more likely to disengage. That is something to be considered.

Brian Whittle: From listening to what you are saying, what seems to be lacking is a consistent relationship with a carer, healthcare professional or whatever. My worry is that there is a danger there. You are almost saying that, even if a medical professional thinks that the treatment that someone wants is not in the best interests of their health, they should have the right to try it.

Kirsten Horsburgh: Yes, I think that people should be more empowered to choose treatments in the same way that somebody who suffers side effects from a prescribed antidepressant can go to their GP and ask for a different one. The options are endless for some other medical conditions, but we are limited in what we are able to offer people with substance use issues; the options are already restricted.

Another thing for Scotland to consider is that we have seen a massive shift towards people using way more stimulants than ever before. There are no medical treatments available to support people who are using stimulants. A lot of people who are using cocaine as their primary drug, as well as opiates, do not see the point in going to treatment services to address their opiate use, because they know that their stimulant use is the thing that is most out of control. There are not enough options for people.

Brian Whittle: I will go back to the line of questioning that I was supposed to be on.

I will start on funding and resource allocation with a basic question about additional costs that are not accounted for in the financial memorandum that might arise from the bill's implementation. Do you see that being an issue?

Justina Murray: In the conversation that we had with our family support workers, they were concerned that NHS services would not be able to meet the pressure to deliver a thing, and NHS services would then expect third sector services to pick up the slack. However, the financial memorandum does not mention any additional funding for third sector services, and there is no mention, either, of funding for advocacy, as we have already discussed. I am sure that a lot of uncosted costs would come along with the proposed legislation, as always happens.

10:15

Tracey McFall: There is no mention of the funding that is required at the back end of the system around recovery, recovery capital, recovery communities, lived experience and recovery organisations, which are a fundamental part of keeping people alive in Scotland. There is no mention of, or cost attached to, those things, which are currently underfunded.

Brian Whittle: My personal passion is for the prevention element. With the way in which the system works at the moment, there is no funding for third sector organisations, other than by going through statutory services, such as those that are part of the ADP programme. Those are the ones that pass on the funding to third sector organisations.

Has any work been done on the positive impact not just on the lives of people who are caught in addiction, but on society as a result of the reduction in the finances that would require to be spent? Is enough work being done to understand the positive impact, both personally and financially, of a system that works in the way that you want it to work?

Tracey McFall: We could probably look at a range of different pieces of research in relation to social return on investment. As part of the national mission, Public Health Scotland has been commissioned to evaluate where the money goes, and I think that there will be some findings from that over the next few months.

I am glad that you raised that point. The SRC is doing work on the issue, because we do not have a clear picture of where the money is going in relation to recovery and recovery-orientated systems of care. I have mentioned that a lot, but it is so important.

Through the national mission, the Corra Foundation has funded a number of grass-roots recovery organisations, but we know that that funding will end post-2026—it will end next March. Currently, we do not know what things will look like post-2026. This year, we have an opportunity to start to focus our energy not only on treatment, but on everything else that we need in order to support people's lives and to reduce drug deaths in Scotland.

To go back to Sandesh Gulhane's point about the drug death stats, they are absolutely horrendous, as are those for alcohol-related deaths. Having spoken to hundreds of people across the country over a number of years, I think that the numbers of drug deaths and alcohol-related deaths would be higher if it was not for the work that is currently being done in and by communities. That needs to be recognised and valued. There needs to be some focus on that part of the system, because I have no doubt that the numbers of drug deaths and alcohol deaths would be higher if it was not for the work that is being done in our communities.

Kirsten Horsburgh: It is important to emphasise the point that Tracey McFall has just made about the funding not being only for treatment. The last thing that we want to do is to pit different services or forms of care provision against one another. The reality is that we need everything: we need recovery communities, we need residential rehab, we need treatment and we need harm reduction. We need all of that.

There has been some discussion about the lack of investment in alcohol-related support, which is massively important and massively underresourced, but none of that stuff should be at the expense of the funding that is currently in place for dealing with substance use. We simply do not have enough resource for that as it is.

When it comes to funding, the issue is not just about the level of funding; it is about the length of funding, too. That is a key issue, and it goes back to the previous point about relationships between people and different workers. Services are not sustainable when they have only one year's funding and they are constantly in a cycle of short-term funding.

Brian Whittle: That is another one of my bugbears, but I do not want to go down that rabbit hole.

I hope that, if the bill was passed—albeit in an amended fashion—it would have a positive impact by enhancing health services and forcing us to bring in the third sector in a positive way. Delivering the bill would require all the services that you have set out. Do you not think that the bill has the potential to force Governments to properly fund and invest in the whole system? That is the only way that this could work. It is scary to say that, bad as our drug deaths are, the situation could be a lot worse for all the volunteers and third sector organisations in our areas that we all know about. Is it not the case that we need to force the issue?

Justina Murray: Nothing in the bill talks about that. It is all about NHS services and the relationship—or, rather, the interaction or transaction—between the health professional and the individual. Nothing in the bill commits to funding for other parts of the system. Our concern is almost the opposite of what you have set out, which is that the bill, if it is enacted, would suck up funding that is currently in the wider system and put it back into NHS-led services. As I have said already, those are not necessarily the services that people want to engage with or where people want to work. In my view, if the bill is enacted, it would have almost the reverse effect to the one that you have suggested.

Brian Whittle: My point is that that is what is happening just now. All the funding comes through statutory services before it gets to the third sector, and it is not getting passed on. We need to reverse that.

Justina Murray: I do not see how the bill would do that, however it is written. There is nothing in it that talks about the whole system, multidisciplinary support or the third sector. It is all about statutory services.

Tracey McFall: There is a broader point. I understand how the structures and systems work, and that the money comes from health and social care partnerships and is then allocated to ADPs and commissioning. However, a number of discretionary funders in Scotland, such as the Corra Foundation and the Robertson Trust, fund a range of services across country. They need to be brought into the mix as part of our consideration of the total investment across Scotland and how we change our treatment system. Yes, more services would come through the statutory route. However, a range of services across the country are being funded by a huge amount of money that does not come through the statutory route, and we need to make sure that we can broaden that out.

There is also a point about the justice system. If someone received access to treatment as a result of the bill and was then put into prison, there is a question about whether their right to treatment would follow them through the justice system and after their release. I do not think that any committee has touched on that important question. I added in that caveat very sneakily—sorry.

Kirsten Horsburgh: I will make a broader point about the wider resourcing and focus. We will always be firefighting the issues until we properly address the root causes upstream, such as poverty, deprivation, trauma and lack of opportunity. We need to look at having a process that lasts longer than a Government's term of office; we need to look at having a 15 or 20-year strategy across all the portfolios that have been mentioned. Otherwise, we will always be in this position. Of course, we will always need some resource for emergencies and firefighting, but, my God, when are we ever going to look at the broader picture and really address the upstream work?

Brian Whittle: On that note, I shall leave it there.

The Convener: Sandesh Gulhane has a supplementary question.

Sandesh Gulhane: Tracey, I am glad that you know how the funding works, because I struggle with it. The system is very opaque. I do not think that we are able to accurately audit the way in which the money is distributed.

We have spoken about the third sector and communities. In my region of Glasgow, funding for award-winning services is being cut. NHS Grampian has been escalated to level 4 of the NHS national performance framework, partly because of the financial situation there. Further cuts will occur. One of the easiest places to make those cuts seems to be within drug and alcohol services in the community. How can we protect the community services that do amazing work, especially the people who know individuals? They know when they are starting or stopping their substance misuse and what is going on with them, and they are able to intervene.

Kirsten Horsburgh: Why is it that drug and alcohol services are easy pickings when cuts are made? Who in a leadership position is not considering the range of areas across their remit? We rely not only on national but local decision makers to stop stigmatising and discriminating against people who use substances. Decisions to make cuts to drug and alcohol services at the local level should not be easy.

We can do the work at our end to empower people to know their rights, but we know that people in vulnerable and marginalised positions are the least likely to complain—they are the least likely to go through complaints processes and services. Although they might have some independent advocacy to support them, there is still disempowerment. I would like to look at how we address decision-making processes in local areas so that decisions to make such cuts are not an easy option.

Sandesh Gulhane: That is what my question was about.

Justina Murray: It is difficult for a third sector CEO to say, “We need to evidence the impact of absolutely everything, to account for every penny that we have spent and to ensure that all of that is published.” Where all the investment in public services has gone is not always transparent, and we are finding that with the national drugs mission. As Tracey McFall said, Public Health Scotland is doing work to look at cost benefit analysis.

You mentioned the fact that evidence-based services are closing. Proving that things work does not protect us. Last week, I had the privilege of chairing the Scottish community link worker network conference. In relation to any declaration of interests, I was simply asked to do that, and I was happy to oblige. Those in the community link workforce are the unsung heroes of the health and social care system, as I am sure that members know. There were people there on that day who had already lost their jobs, but they still wanted to be present at the conference. Almost everyone in the room was on a year-to-year arrangement, which is very nerve-wracking for them.

No matter what the third sector does to prove its worth and to prove the return on investment, that does not protect us at all. When push comes to shove and budgets are being cut, we are the first victims.

Tracey McFall: In the national meetings that I attend, it is interesting to hear how the work that drug and alcohol services cuts across everything that we talk about: child protection, adult protection, community planning and mental health. If we took a fundamental look at how we fund that, we would realise the impact on a range of different areas across the country. We know about the number of cases in Scotland in which there are drug and alcohol issues in families, and the additional costs that that incurs for social work, health, child protection and the children’s hearings system.

If we looked at the issue in a different way, we would realise that drug and alcohol harm cuts across every element of our community, and I think that there would be a different outcome.

Kirsten Horsburgh: On Justina’s point about demonstrating the impact, what is happening in Canada and the States is really concerning. It does not matter if we show the phenomenal impact of some of the services that we provide, because when we are up against moralising and ideology, that sometimes has a bigger impact. It is scary to see some of the cuts to services in Canada and the States, based on who is in the Administration, and the impact that those cuts are having on communities. The rate of deaths is rising because of that approach.

Tracey McFall: Is there a way that we could stop the siloed approach to how funding comes into the system? Money goes into justice and mental health services, and a lot of people in the justice system have issues with problematic substance misuse or mental health issues. We need to look at the issue in a different way, because although there is a lot of money in the system, it is siloed.

The “Hard Edges Scotland” report showed that thousands of people in Scotland are being bounced around five or six different systems—justice, mental health, addiction, domestic violence and homelessness. They are all going to different services. If we could find a way of getting the money from the national level to the local level and could bring some of that money together, we could bring about a change in how that is done in Scotland. We need you guys, as MSPs, to start having that discussion. The challenge goes back to you, I would say. I will work with you, if you like.

The Convener: You covered a number of areas in response to Sandesh Gulhane’s question, and you have raised a number of important issues. Does the bill in any way address the issues that you have vocalised?

Justina Murray: I think that I have made it quite clear that I do not think that the bill adds anything at all.

Tracey McFall: Currently, it does not.

Kirsten Horsburgh: We are still not convinced that going down a legislative path is the right approach.

The Convener: Thank you for your attendance today.

I briefly suspend the meeting to allow for a changeover of witnesses.

10:30

Meeting suspended.

10:42

On resuming—

The Convener: Welcome back to the Health, Social Care and Sport Committee as we continue scrutiny of the Right to Addiction Recovery (Scotland) Bill at stage 1. The committee will take oral evidence from a second panel of witnesses, comprising representatives of third sector organisations.

I welcome to the committee Lee Ball, director of addictions, Salvation Army; Graeme Callander, public and policy lead, WithYou; Jan Mayor, alcohol and other drugs innovation and practice lead, Turning Point Scotland; and, Annemarie Ward, CEO, Faces & Voices of Recovery UK, who joins us online.

We move straight to questions from Elena Whitham.

Elena Whitham: I thank the witnesses for joining us. I set out some questions about rights to the previous panel, which I will put to you, too.

It is important, given what we have heard and what we know, that we realise that, a lot of the time, people are not able to access the treatment that they think will work for them in a timely fashion. Do you believe that the extent of the provisions in the bill will ensure that the rights of people who use substances are realised? I will start with Annemarie Ward.

Annemarie Ward (Faces & Voices of Recovery UK): Hi there. Thank you for the opportunity to speak to you today.

As you know, the organisation that I work for is rooted in lived experience and is absolutely grounded in evidence. It is also built from grief, hope and action in the past few years—as I am sure you are aware of. We have seen clearly that the rights that people are supposed to have are not being experienced by them in any way when they first come forward for treatment. They can also be in the system for 20, 30, or, in some cases, even 40 years—and, in all that time, their rights are not being met.

I am here today not as a theorist or a policy bureaucrat, but as someone who has walked the path of recovery and who has stood beside thousands of people in Scotland who have been trying to do the same thing. Many of those people are no longer with us.

10:45

The Right to Addiction Recovery (Scotland) Bill is not abstract to me. It is not an academic exercise. For many people, it is a matter of life and death. I have learned from our advocacy work over the past three years that the system is not just overwhelmed; in many cases, it is obstructive. We know that because we have stood toe to toe with people when they have tried to access the treatment that they know will help them.

Our advocacy staff team has the equivalent of one and a half members, and it has supported 123 clients and more than 40 families over 25 local authority areas in Scotland. We have fought through tremendous bureaucracy to secure those people’s right to the treatment that they have asked for. Only in 22 of those 123 cases were we able to secure the residential rehabilitation that they were asking for, despite the other two thirds of those 123 people asking us for it.

We have prevented homelessness, helped people to resolve their benefit chaos and challenged illegal and discriminatory decisions across the sector. So, if you asked me whether people’s rights are being adhered to, I would unequivocally say no.

What is preventing people from getting that help? It is not cost, clinical judgement or capacity. It is culture. It is a culture of gatekeeping, unaccountable panels, risk-averse funders and quangos that are more interested in optics than in outcomes.

Elena Whitham: Thank you for that, Annemarie. I will open up to the rest of the panel. Following on from that line of thinking about people who are not always able to realise their rights, which comes down to the issues that were narrated by Annemarie, do you think that the provisions in the bill will ensure that people are able to realise their rights?

Graeme Callander (WithYou): Thank you for the opportunity to share our feedback and give evidence on the bill.

WithYou in Scotland is a national drug and alcohol charity. We support more than 15,000 people a year at various stages of their treatment and recovery journeys.

When we looked at the bill, we could get behind the intent to try to make things better for people. The angle that we come from is about the practicalities: we see people before they even get to treatment, and we know that there are barriers to treatment. We are not sure whether the bill as written will be the answer to that problem.

It is not the intent or the rationale behind the bill that we have any objection to—we want to make sure that its aims happen. I have been in this sector for 20 years—in operations, on the front line and, more recently, in policy—so I know how difficult it is for people to navigate it. However, I am not sure about the focus of the bill, which is on access to residential treatment and community detoxes. Those things are really important; most of our job is about trying to get people into those things in the first place, but we cannot see whether the bill would be able to address that issue. Maybe with more consultation or adaptation, it could be.

We are broadly supportive of the intent behind and the rationale of the bill, but we are concerned about some of the practical implications of it.

Jan Mayor (Turning Point Scotland): I echo that exactly. We are completely in support of the intention behind the bill. Like Graeme's organisation, our organisation works with many people who are not even getting in to treatment yet and are not ready to do so. We do a lot of assertive outreach and work with overdose response teams and drop-in harm reduction clinics. Yes, people need access to treatment, but I am not convinced that the bill is the right way to do it. I am absolutely behind the intent of it, but I am not sure that it is the right way to do it.

One slight worry for our organisation is that the bill might be a distraction. Many of the people who use our services across Scotland were involved in the consultations with the national collaborative for the charter of rights, which has come a long way and seems to do many of the same things as the bill, but without some of the problems. The charter of rights seems broader. My worry about the bill is that it might be a distraction from something that we are already a long way down the line with and that has had a lot of consultation.

Elena Whitham: What is the Salvation Army's perspective?

Lee Ball (Salvation Army): Thank you for the opportunity to talk about the bill today. Like Graeme Callander and Jan Mayor, we work with a lot of people who have not even reached the treatment door. Over the past five years, we have worked with almost 3,000 people who have arrived at Salvation Army services in Scotland but who cannot or will not access treatment for their drug and alcohol problems. There are several reasons behind that. Some treatments are not designed to be easily accessible. A lot of clients who come to us have poor prior experiences of treatment or of healthcare systems and are reluctant to engage.

We support the idea of people's rights being enshrined, and we welcome the proposed right to a second opinion and the need for healthcare professionals to justify a denial of the support that an individual would prefer. That said, all of that would place a huge amount of responsibility on the system, so it needs to be understood that the system, and workers on the front line, are currently very stretched, which means that supporting a person to enact their rights must be resourced.

Elena Whitham: Jan Mayor has already touched on something that answers my second question. To what extent would the bill complement, or even conflict with, the charter of rights for people who are affected by substance use? I am concerned that the Scottish human rights bill that was meant to underpin the charter of rights is not on the horizon. Annemarie, I see your hand going up. I am interested in hearing how you think the bill might complement or conflict with the charter of rights.

Annemarie Ward: With respect, any claim that the bill is impractical or is a distraction is just wrong and deeply cynical. That is not a good-faith concern; it is a strategic deflection coming from organisations that are more worried about control and optics than about outcomes. It is no coincidence that those objections are being raised by the organisations that are currently commissioned by the Scottish Government to provide treatment. The first two speakers today came from the status quo providers. They are funded by Government and are entirely embedded in the existing hierarchy of control, so—of course—they object, because the bill threatens to shift power from them to the person seeking help. That is not a distraction; that is democracy.

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

Most of our clients have been silenced by multidisciplinary teams and are not even allowed to attend meetings about their own future. They have been given care plans that they have never seen and have been stuck on methadone for decades with no review, no reduction and no route out.

I will be absolutely blunt. The people who are saying that the bill is a distraction are the same people who have failed, year after year, to deliver access, transparency or choice. They are not neutral observers, so to say that they are is ridiculous. They are institutionally and financially invested in avoiding scrutiny.

Our advocacy service has worked with 120 clients, but not one of them had ever heard of the so-called MAT standards, not a single one had ever been shown a care plan until we stepped in, and many were explicitly told that rehab was not an option. We succeeded in getting them the treatment that they needed only by relentlessly challenging the system. We were told that a charter would be enough.

The bill is not a distraction—it is a real mechanism of accountability. The bill would change the Scottish treatment landscape—that is why they are saying that it is a distraction and is not practical. The question is not whether the bill is too ambitious, but how long we will keep prioritising the comfort of institutions over the lives of the people they are supposed to serve. The bill does not disrupt recovery—it disrupts bureaucracy, which is precisely what Scotland needs.

Elena Whitham: Thanks Annemarie. I open up the question on the work of the national collaborative and the charter of rights to the rest of the witnesses. I share the concerns that the charter might not be enforceable in the way that it was seen that it would be down the line with the human rights bill. Taking that on board, do you feel that the charter of rights could complement the bill, or is there conflict because, as it stands, people are unable to realise their rights in every instance?

Graeme Callander: I repeat that it feels to us that the bill as it is presented gives a very narrow definition of what is classified as treatment in Scotland. As a third sector provider, we receive our money directly from local authorities to deliver recovery services on their behalf, and we are not responsible for prescribing. We come up against the same challenges as many of our clients do with regard to reducing harm and accessing residential rehab. We advocate on a lot of those issues.

Coming back to the bill, we have always said that we are supportive of the intent of instilling the right to recovery in legislation; our concern is about how that will be delivered practically. At the moment, the charter of rights is coming and we have this proposed legislation, but the system is still difficult to navigate. Without proper consultation, collaboration and joint working, and without proper implementation, the bill or the charter of rights could fall on deaf ears.

The process around the charter of rights has felt a lot more collaborative—it seems that the sector has come together to talk about some of those things—whereas it has been a lot more challenging to engage in some of the key aspects of the bill. That is our observation as a third sector provider. In short, my view is that there is still a lot of work to do with the bill, although the charter could complement it.

Elena Whitham: Jan Mayor or Lee Ball, do you have any thoughts to add before I hand back to the convener?

Jan Mayor: I agree with Graeme Callander, really. I would much prefer to see that legal underpinning for the charter of rights. What I like about the bill is the accountability. We want that accountability—and not only for ourselves, because, as Graeme said, we also work with people who have come out of residential rehab to support them back into their communities.

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

Lee Ball: You mentioned accountability. I was in services in Scotland yesterday and noted that, when you speak directly to them, one of the things that the staff and the service users who are in receipt of services ask for is accountability, because they do not feel that that is currently there.

We must be concerned about almost tripping over different pieces of legislation that are competing with each other. We need to always ensure that we come back to the fact that there is an unheard voice that, quite often, does not even appear in treatment—it is the need for people to have the ability to hold services to account for their treatment pathway before it even begins—

Jan Mayor: Yes.

Lee Ball: —and to know what options are actually available to them.

Although we support many things in the bill, one of the things that we are concerned about is its omission of explicit harm reduction interventions. Before they walk through the door, people need to know that that is possible, that they have power or control over that as well and that they can hold services to account.

Elena Whitham: Thank you. I think that accountability and implementation will be big topics this morning.

The Convener: Annemarie, I believe that you want to come back in. I ask that you be brief, because we need to move to other questions.

11:00

Annemarie Ward: I will respond directly to the accusation that the bill offers a narrow definition of treatment or is somehow confusing people because it exists alongside the charter of rights. Again, that is a completely disingenuous critique, and we should be honest about where it is coming from. The organisations that are pushing that line are not neutral players; they are the very institutions that have refused to engage with the bill's creators, refused to inform their own stakeholders and refuse to distribute the "Myth busting the bill" document that has been publicly available since 2022.

In three-and-a-half years, those organisations have not made one bit of effort to engage with the bill. They say that the charter was much more collaborative, but they have not engaged with even one briefing session that has been offered. Those people are claiming to be confused, but that is because they have not spoken to us or engaged with us.

If there is confusion, it has been carefully manufactured by omission, not by the bill. Let us be absolutely clear: the bill defines treatment exactly as it exists today, in law, under the National Health Service (Scotland) Act 1978. It covers all recognised forms of treatment: detox, rehab, MAT, psychosocial interventions, harm reduction, day programmes and peer-led services. If a treatment is legally available on the NHS, it is included.

What the bill does not do, and has never claimed to do, is write poetry about recovery. It is not meant to be a feel-good declaration—it is legislation, not a campaign badge. It creates an enforceable right to access what is already supposed to be available. By contrast, the charter of rights—the darling of the very services that have failed to deliver results—is non-binding; it has no teeth, and it cannot be challenged in the court. It is, at best, a public service announcement, and, at worst, it is a public relations exercise to distract from the fact that services still deny treatment, refuse rehab referrals and ignore lived experience unless it is conveniently pre-approved.

Let us talk about the idea that the charter is more collaborative. It is not—it has simply been written by those people who have refused to collaborate with the drafters of the bill. There is no high-minded unity here, just politics, exclusion and turf protection.

Let us be honest—the charter has been embraced because it asks nothing of the system. It requires no structural change, no reallocation of power and no uncomfortable scrutiny. That is why it is so collaborative: it costs nothing and it changes nothing.

The bill is not confusing—it is confronting, and it challenges a system that has become too comfortable with managed decline. The people who are saying otherwise are not confused; they are just being challenged for the first time ever. Let us not pretend that the issue is clarity—it is about control.

The Convener: I will bring in Mr Whittle.

Brian Whittle: Good morning. I have a quick question. It has been said that the bill does not talk about the pre-treatment work that is important in trying to get people towards treatment. Would you agree, however, that if we get those people to make the hard and brave decision to seek treatment and then they do not get it, that is incredibly destructive to that person?

The bill is explicit that, if someone asks for treatment, they have the right to get it. Is that not important? I worry about people who may seek treatment and then not get it and about where that leaves them. It would leave them in a much worse place.

Lee Ball: It takes huge courage for someone to actively seek treatment, and to have that need not met at that moment can be devastating; that person will tend to appear somewhere else in the system at some point because of the decision that has been made.

We are really concerned about the definition of "treatment" in the bill and when it begins. We have witnessed people actively seeking treatment but being held on a waiting list, with that being quantified as the beginning of treatment in and of itself.

We need to be clear about what "treatment" means. It might be taken to mean getting on to a waiting list for rehab or a methadone programme, but those things can be devastating in and of themselves. We need to be clear about what it means and when it truly begins, and the point from which the numbers will be counted.

The Convener: I call Emma Harper.

Emma Harper: I asked the previous witnesses about the requirement for a diagnosis of an addiction. I am interested to hear your thoughts on the advantages or disadvantages of the bill's approach to requiring a diagnosis ahead of entering into all the different types of treatment that could be offered.

Jan Mayor: There are a couple of issues for me in that. We are concerned about the idea that people need a diagnosis. It is an unnecessary barrier. An awful lot of people do not want a diagnosis and do not need it, but they need treatment in its broadest sense. I am particularly worried about the term “diagnosis of addiction”, because many people across Scotland have serious problems with their use of alcohol or cocaine, but they are not physically dependent.

I am not even sure that a diagnosis of addiction exists; I think that substance use disorder is the technical diagnosis. The requirement for there to be a diagnosis would put people off seeking support. People often need to come and talk about their problems and they do not want such a diagnosis hanging over them.

I am not saying that people’s drug and alcohol use is not a health problem, because it is a health problem and a medical problem, but it is more than that. For many people, it is a social problem and it is related to community issues. At the initial stage, a diagnosis can be a barrier to getting support. There is a risk that, because of the use of the word “addiction”, we will focus all our energies on people who are physically dependent and miss all the people who are at risk of serious harms or dying from their drug use or their alcohol use, but who are using in a pattern that means that they are not physically dependent.

Graeme Callander: Our view is similar. When we looked at the bill as it was introduced, we spoke to more than 30 people within the organisations. Half of our staff have lived experience, and we spoke to a number of our clients in front-line services as well as clinical staff. The part about diagnosis was one of the key things that they picked up.

People come to our services because they need help. They are not saying that cocaine or this or that is their main problem; it could be a number of different things. We do not wait for a diagnosis to be given before we start to support them, which is, a lot of the time, on the same day as they present in our services.

However, there are occasions when you need a diagnosis. People’s lives are complicated and significant health harms go along with drug use. A lot of the people who are most at risk of overdose are the ones who might require a diagnosis, and there should be no delay in that.

The other issue is the medical professionals element. We would need reassurance about how we would upskill all medical professionals to undertake diagnosis, if that is the route that we take. Not every health professional is at the same level. Before we came in, we were chatting about how we are sometimes in a bit of a bubble, and it is easy to assume that everyone knows the things that you know, and so on. However, someone who works in a GP surgery will have to juggle a million different topics, so we need to be able to upskill medical professionals if we decide that diagnosis is the way to go.

The final point that I want to raise came directly from our clients and is about the need to be confidential and the potential of a diagnosis of addiction to be on someone’s medical records. A lot of the people who we support are in work and might be worried about disclosing things that are tied to what is going on in their personal lives. Our clients raised concerns about that. As the bill progresses, if it does progress, that is one aspect that needs to be carefully considered. People have the right to remain anonymous.

Emma Harper: Before Lee Ball comes in, I need to remind everyone that I am a nurse and I have worked in recovery rooms and operating theatres with people who were harmed by drugs and alcohol.

While you are responding, Lee, can you say whether the language in the bill needs to change? What language would you suggest?

Lee Ball: The term “addiction” is often quite loaded. When we talk about a diagnosis of addiction, that is seldom the only issue; addiction is a symptom of many other things. Therefore, it is quite narrow to give a diagnosis based on just that one thing while not incorporating all the other biopsychosocial issues. A diagnosis is a help or a hindrance; it depends on how it is used. That is a really important point.

On Graeme Callander’s point, we agree that people have the right to privacy. The idea that a diagnosis of addiction could go on to medical records is another issue to consider.

However, the one thing that I ask to be considered in the bill, should it go forward, is the narrow term “addiction”. Addiction is a symptom of many other things and is too narrow a word to be used in this context—that issue will probably come up regarding funding and other matters. For some people, “addiction” is a loaded term; it can come with stigma and an awful lot of negativity. Language defines the reality that we live in, so we need to be careful about the way in which we talk about substance use and the way in which we talk about people who are using substances as a coping strategy.

Emma Harper: To be clear, the protection of somebody’s anonymity is one thing that we need to be careful about with regard to the language around addiction. That is something that could be amended in the bill as it progresses.

Lee Ball: Absolutely. It is important to remember that these things ebb and flow. We work with many people for whom addiction is a symptom of their situation at that point in time. It can increase, it can go down and it can move back; it is a constantly movable issue for an awful lot of people. Therefore, to have a diagnosis for one point in time is to take a really narrow approach. We need to be careful about pigeonholing the diagnosis in that one area.

Emma Harper: Thank you.

Annemarie Ward: Let us cut through the noise here, guys. The claim that a diagnosis is stigmatising or a barrier is absolute nonsense. Every area of healthcare starts with a clinical assessment, and addiction should be no different. People do not die because they get a diagnosis; they die because they are denied treatment.

Now, we are hearing that staff are not skilled enough to assess need. That is not a flaw in the bill; that is an indictment of the system. The same staff already prescribe methadone, assess risk and make daily decisions. If they cannot confirm that someone needs help, then what exactly are we funding?

This is not about ability; it is about accountability. This bill would make services legally answerable. That is why it is being resisted. If training is needed, let us provide that, but do not use workforce feelings as a reason to deny people rights. The truth is simple: diagnosis saves lives. The bill would ensure that people can act on a diagnosis. Let us stop making excuses, please.

The Convener: Can we make sure that our language is courteous throughout the proceedings? Thank you.

Sandesh Gulhane: I declare an interest as a practising NHS GP.

On the point about addiction being used as a diagnosis, it was clear from our evidence session with the Royal College of Psychiatrists that the word "addiction" is perhaps not the right word to use. I am sure that Douglas Ross, who is the member in charge of the bill, will be looking into that.

If we were to amend the bill—because we need to say that the patient has something, although that does not necessarily have to be a diagnosis—what should be the way to access the right to treatment? Is it simply that the patient would like to receive treatment? What exactly would you suggest?

Graeme Callander: For us, it has always been about access. Treatment exists. As an organisation, we have a full clinical offer in England—though not in Scotland—so we understand the importance of clinical processes. In certain circumstances, diagnosis is absolutely critical because there will be other things that are going on, such as underlying mental health and physical health problems. We completely recognise that.

However, the reality is that people cannot get access to the system. It is not always about treatment. All that services such as ours do is try to find ways to navigate the system to try to get people to where they need to be. A lot of people that we engage with do not need a medical intervention; they just need some mutual aid and support or some practical stuff in relation to their housing, for example. As I read the bill as introduced, the disappointing thing for me was that it felt narrow—I cannot deny that. It did not reflect the experiences that we have had as an organisation.

Sandesh Gulhane: Forgive me, but, being a member's bill, it needs to be narrow. It is not a Government bill. If it were to be a Government bill, that point would be fair enough. However, this bill needs to have a narrow scope.

My question was: what wording would you use instead of a diagnosis of addiction? What wording would you like there to be for people who want to access treatment?

11:15

Lee Ball: For me, it is about the person's right to want treatment, and it is really difficult to give that a word or a title. I do not envy your job of coming up with a word for that, because there are so many words that have so many different meanings to so many different people.

I take the point that the solution is not always about clinical support, because some fantastic work is done in communities. Look at the Salvation Army's work in Scotland: we have reduced overdose deaths by 43 per cent. None of that was done by clinical services; it was done by love, compassion and relationships. It was all done in-house and managed by front-line staff.

If we are to progress the bill, we should be asking the people who are in receipt of services what words they would like to be used.

David Torrance: Good morning. How confident are the witnesses that residential and detoxification services have the capacity to meet the increased demand that the bill's implementation would result in?

Jan Mayor: For me, one aspect is that we do not have enough capacity across all the different types of service. Perhaps more importantly, we need consistent standards. Accessing residential services does not mean that people get the same thing in different parts of the country. Addressing that might be beyond the bill's scope, but, to answer your question about whether we have the capacity at the moment, I am not convinced that we have consistent enough standards across the different parts of Scotland.

Graeme Callander: Over the 20 years that I have been in the sector, I have seen many people successfully go through residential rehab. However, I have also seen large numbers of people for whom rehab has not worked for a variety of reasons, such as no support being provided before or afterwards, or it not being quite the right time or service for them.

It is clear that there is not enough capacity, because we run several pre and post-residential rehab support services, and demand is skyrocketing. That is a real positive, because people are saying, "I want to change." Our pre-stage support was initially designed to last for six weeks; now, we are looking at anywhere up to 18 weeks before we can access a suitable residential placement. We are definitely seeing some pinch points in the system, because the capacity is not there.

Also, every residential service is different—the selection criteria and focus are different—which is another bit that we need to factor in to how we promote better and quicker access to residential services. Our rehab service in South Ayrshire is very focused on the outdoors and has an environmental focus, whereas other services have a completely different focus and entry criteria. The bottom line is that the system does not have enough capacity.

Lee Ball: We do not feel that the system has enough capacity. At the Salvation Army in Scotland, the number of people we work with and who come into our services has increased by 70 per cent over the past five years. An experience of homelessness is quite often a co-occuring issue with addiction. Over the past five years, we have had roughly 3,000 people who could not access treatment because the services were full. At the moment, if you ask any worker, they will say that their case loads are going up. The stress and strain on the system are continuing to increase. We are at capacity and additional resources are needed if we are to increase support.

In our evidence, one area that we said we were concerned about is that we must not increase one area of support—for example, residential detox and rehab—at the expense of another, because we need a whole range of treatment options for people. We believe passionately in person-centred healthcare and approaches, so the person has the right to be really informed and involved. That must be done in collaboration with medical professionals who are skilled enough to be able to give support, but deciding the treatment pathway is a collaborative process.

David Torrance: How concerned are the witnesses that the bill's focus on residential treatment could inadvertently deprioritise things such as community-based treatments and harm reduction strategies?

Lee Ball: We have concerns—we say openly in our submission that there are concerns if one treatment approach is prioritised over another.

The evidence base for harm reduction as a treatment option, certainly for the people with whom we work, who are experiencing homelessness, is absolutely huge. We could sit here all day and recite the evidence base over and over.

What is also important, however, is what happens within services. Only yesterday, I was speaking directly to people in receipt of services, and some of them said that detox is the option that they want. They want to go into rehab, and they just do not feel that that is available.

We welcome the bill's emphasis on rehab and detox, but we also say that that should never be at the expense of all the other treatment options that are available to somebody.

It is difficult for someone, certainly when they are experiencing homelessness, to think that they can have a life without the coping strategies on which they have relied for years to help to get them through. For some people, the thought of taking those away is absolutely terrifying, so we would always advocate for a whole range of treatment options.

Jan Mayor: I would absolutely echo that. Abstinence and harm reduction are not in conflict. Most people who get to abstinence—most of those I have seen go through residential rehab successfully—have had a period of time in which they have accessed harm reduction services as part of that journey.

With regard to person-centred care, people have a right to go both ways. I have seen people go through and come out of residential care, and then decide that they want to go down the pathway of controlled drinking and successfully achieve that. People should have the right to navigate their own route through harm reduction and abstinence; both are important.

I really welcome the bits of the bill that talk about the range of treatments and what is missing. There is a risk that arises if we do not name the harm reduction services. There is a line in the bill that refers to "any other" approaches, but my fear is that, unless we spell out the harm reduction approaches, we will put more emphasis on the abstinence-based approaches and people will not have a route into them through harm reduction services such as drug checking and needle exchange. We also have drop-in harm reduction cafes that are really good at holding people until they are ready to make a choice to go into treatment.

We need both approaches, and we need them both named in the bill. The treatment options are all part of the same pathway, and part of person-centred care is about people being able to navigate which route is right for them at a certain point in their journey.

Lee Ball: To add to that, the omission of harm reduction from the bill has the potential to polarise the debate even more, because it is almost about putting people into different camps—it is either this or that. I completely agree that harm reduction and abstinence are not in opposition; they are expressions of treatment, and everybody has the right to treatment and to choose their mode of treatment.

There is a concern that if we choose one pathway over another, we are almost blaming the person if that pathway is not successful for them. We should learn the lessons from housing. If we put all the emphasis on the housing first approach and it does not work for the person, it is as if they are the problem, not the system. We need to be really careful, in framing that aspect of the bill, that we do not blame the person.

David Torrance: Annemarie, do you want to come in?

Annemarie Ward: Thank you—I am cognisant that I have been told to watch my tone. That is usually code for "You're making us uncomfortable" in the Scottish Parliament. With respect, if my tone rattles anybody, I would suggest that it is not the volume that is the issue; it is the truth behind it—

The Convener: Ms Ward. Ms Ward—

Annemarie Ward: Let us be honest: no one ever tells—

The Convener: Ms Ward, if I can interrupt you for just one minute.

We conduct our proceedings here courteously, so I was reminding everyone to do so. I would do that whether it was a witness or a member of the committee.

Annemarie Ward: Okay, but let us be honest—nobody ever tells harm reduction services to watch their tone, and no one ever questions whether MAT works for everyone, yet the moment that we talk about detox or residential rehab, suddenly the tone in the room gets cautious and the qualifiers come out, and we are told not to get too carried away, as if even raising the subject is dangerous.

You say that detox and rehab do not work for everybody. Of course they do not, but nothing in this system works for everybody, and yet, somehow, it is only abstinence-based or time-limited treatments that are treated like they are radioactive options. That is not clinical reasoning—that is ideological discomfort.

This is not about pitting rehab against other services—it is about making all options genuinely available. The bill does not take focus away from other pathways; it simply gives a legal footing to the full spectrum of care, including the options that have been quietly erased or endlessly delayed.

You do not protect the system by silencing voices that are too forthright; you fix it by listening to them, especially when they are backed by thousands of families who have buried loved ones while waiting for the right help. So, no, I will not be softening my tone, because when lives are at stake, civility cannot come at the cost or the expense of truth.

David Torrance: I have no further questions, convener.

Brian Whittle: We have heard a lot of evidence on the issue of co-ordinating drug treatments with housing, trauma treatment and social care. Do you think that the bill will help to promote that co-ordination by focusing our attention on how we cross those portfolios?

Graeme Callander: From what I have read of the bill, it seems to me that it instils a right to receive treatment, but it does not instil a right to housing or anything else. The main challenge that we and the clients we support face is around access to mental health services, physical health services or counselling services.

From what I understand of the bill—this is where the whole process is about making amendments and trying to make it better, and it is okay to do that—I do not see how it will help with those wider social issues. It might sort out the narrow definition of treatment, but it might not sort out the other aspects of someone's life.

Brian Whittle: The bill is designed to make sure that those who seek treatment get treatment.

Graeme Callander: If that is how it happens, it is great that someone will have that right to treatment, but what I am saying is that—you alluded to this earlier—for many of the people whom we support, it is more important to deal with issues such as housing, relationships, employment, money and poverty before we even get to talking about their addiction. That is the reality that we see in our services.

Brian Whittle: Does anybody want to add to that?

Lee Ball: We are having the debate, which is a good thing in that we are talking about treatment and are able to wear the fact that treatment is much wider than a clinical process or a necessary social intervention—it is a range of different things at different times.

There is the potential for the bill to do what you say, but we cannot just define treatment as the clinical process in and of itself. The definition needs to be wider and the bill needs to acknowledge that.

Brian Whittle: I will just throw in another question. How can the bill put emphasis on supporting a longer-term recovery beyond that initial treatment?

Graeme Callander: It simply needs to be in there and be explicit. In my experience of being involved in services, if something is not set out, how will it be delivered? That might be more of a question about how the bill interacts with existing policies and frameworks, but it certainly does not make that explicit. It offers the treatment to begin with, but it does not necessarily set out what happens over a longer period.

Lee Ball: I had the opportunity to listen to the earlier evidence session this morning. There is a need to acknowledge that much of what we would normally consider to be treatment is done within the community by people who are not even counted as services; it is done by community groups and advocacy groups. There is real potential for that longer-term support, but we have to include it.

Brian Whittle: I agree—100 per cent—that a lot of the most effective treatment is being done by volunteers and third sector organisations in our communities. We are all aware of them in our communities. Would you accept that, by almost forcing the Government to offer treatment when it is asked for, that will, in and of itself, mean that all those services will have to be properly financed and supported?

The very services that we need are the ones that are being drained at the moment, so we need to finance them. Does the bill have the potential to pull them back into the mix?

Jan Mayor: I guess that the bill has that potential, but that follow-on and wraparound support, as Graeme Callander said, would need to be made explicit in the bill. Post-residential rehab and community treatment often involves other parts of the system, such as those to do with employment, housing and community engagement. We need to spell that out if it is going to happen, otherwise the risk is that the money goes into one bit of the system but people come out without that support.

Brian Whittle: Annemarie, do you have anything to add to that?

11:30

Annemarie Ward: The idea keeps being suggested that somehow money is gonnae be removed from one part of treatment and put into another, but that is no gonnae happen. If the bill is enacted, people will get the treatment that they are seeking. There is simply terrible fear here from people that their particular branch of treatment is gonnae lose funding. If we are supposed to be serving the people who are asking for help, surely we should all get behind that rather than trying to protect our own organisations or our own interests.

Elena Whitham: I have a wee supplementary question. Let us look at the totality of somebody’s journey in, through and out of services. If we get this right as far upstream as we possibly can, we can prevent a lot of the harm that we see happening to individuals, such as losing custody of their children, interacting with the criminal justice system, facing homelessness and being unable to secure employment. Could the right to treatment realise that for an individual at an earlier stage?

Jan Mayor: Yes, if the bill was more explicit. Let me reinforce the point that I do not want to take residential rehabilitation and the prescription of the treatments that are listed out of the bill. I want them in there. We have lots of people who are desperate to access those services, and we want them.

We also want those upstream things. For example, if somebody who might be drinking a bit problematically and hazardously but is not yet dependent had the right to a brief intervention much earlier, and we were doing that harm reduction work much earlier, we might prevent them from needing a place in residential rehab, which might mean that that place was available for other people. It might also mean that they do not lose their children or that they are protected from physical harm.

The upstream work is really important, and it feels to me as though harm reduction is not spelled out in the bill. It should sit alongside the other treatments. We are not asking for one or the other. Lee Ball has already said that we need to get away from the idea that it is one thing or the other; it is the whole thing.

Lee Ball: One of the things that worries me is the bill not being explicit. Quite often, things that are not said are not done. Everybody around the table would probably agree that we need to eradicate and tackle homelessness, but the evidence in the report “Homelessness in Scotland: 2021/22”, was that a household in Scotland became homeless every 19 minutes, and 32 children became homeless every day. There therefore needs to be an explicit commitment to tackling the problem at source as far upstream as we possibly can.

I have never worked with anybody who woke up one day and decided to start using substances as a way of coping. It does not start on the day that they start to use—it started 20, 30 or 40 years earlier. If we do not go back to that point, and if we are not explicit about going back to that point, we will continue to see a stream of people coming into services that are overwhelmed; the staff and the service users are overwhelmed, too. Upstream work is where it all begins; the work needs to be done at that point.

Elena Whitham: I guess that my question was really about how we ensure that somebody is able, and has the right, to access what will work for them at the earliest opportunity to prevent some of this from happening down the line. I know that Graeme Callander wants to come in, and I do not know whether Annemarie Ward has anything to say.

Annemarie Ward: I am glad to hear that kind of honesty, so thank you for that, Elena. It lets us deal with what is really going on. Of course, on its own, the bill will not sort out housing, it will not fix the broken benefits system and it will not rebuild communities that have been devastated by addiction. But the bill will ensure that, when someone finally reaches the point at which they say, “I’m ready—I need help,” they are not told, “Come back when you’re worse,” or, “We don’t offer that here.” It will guarantee a legal right to treatment—not just rehab or detox, but any treatment that is deemed appropriate. That is what the bill says.

That includes all the harm reduction interventions, so the bill does not remove harm reduction or undermine MAT. It does not close services—it protects them by making them part of a legally recognised treatment pathway that an individual has the right to access.

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

Let us be honest: someone cannot stabilise their housing if they are using daily, and they cannot get back to work if they are trapped in a system that only medicates rather than motivates. They cannae rebuild their life if they are dead.

The bill does not claim to solve everything, but for the people we serve—the people who have been left behind, written off or pushed through so many revolving doors for years and years—it provides the one thing that they have never been given: a legal right to be helped when they are ready.

Yes, we need to fix the rest, but we should stop using the absence of everything as an excuse to do nothing. If we cannot pass a bill that simply gives people the right to the help that they are asking for, what exactly are we doing in the Parliament?

Elena Whitham: Graeme, I will bring you in briefly—I know that we have loads of questions from other members.

Graeme Callander: Sure. The bill as it is currently drafted does not explicitly mention early intervention and prevention—it just does not. It speaks about the narrow definition of “treatment”. We support the intent of the right to treatment, but the bill does not explicitly say how early intervention work is going to be done. It does not guide the system or tell us that.

If the bill is to go forward, that aspect needs—as others have said—to be explicitly mentioned. The bill provides a narrow definition of what we understand to be “treatment”. At that point, for many people, it is almost too late, is it not? They are at a point at which things are so bad that they need a medical intervention. We would much prefer that they see people much earlier than that. Unfortunately, the bill as it is currently drafted does not really capture that.

Lee Ball: There needs to be a systemic focus. If we are looking at the point when the person is presenting at the door because they want treatment, we are misunderstanding the fact that they probably need treatment much earlier than that. The support services around poverty, housing, health and homelessness—all those different things—also need to be addressed.

The Convener: I call Gillian Mackay. [*Interruption*.]

Gillian Mackay: Sorry, convener—I was waiting for my microphone to come on.

Good morning. I want to follow up, in particular, on what Graeme Callander, who is in the room, just said about the potentially limited flexibility in treatment options. We heard from a few stakeholders that, while there is a person-centred approach in the bill, it may inadvertently create standardised or overly medicalised treatment pathways. In your opinion, how could the bill be amended to ensure that treatment remains genuinely personalised, especially for people who may need a longer-term psychosocial approach or who may require support before they are available or able to take up some of those clinical interventions?

Graeme Callander: When we read the bill, we understood the balancing act that had to be undertaken to try to capture everything without simply having a huge list of different interventions. However, we were really disappointed to see that key bits of the work that we do are not specifically mentioned in the bill.

That goes back to my earlier point that if an option is not written down, it might not be offered. I know that there is the catch-all phrase at the end that refers to anything else that may reasonably be expected to be offered. To me, however, that is so vague. We have that kind of open-ended system at the moment. We need to be a bit more specific about what different types of treatments are available, and in what combinations, because the bill does not necessarily speak about things such as detox plus rehab. That would be really helpful, too, because, in our experience, people tend to need more than one thing.

Lee Ball: It is also about understanding the role of the community in the treatment pathway. Treatment does not begin and end at certain points, and it is not defined by a period of time; it tends to go on much longer. It is about not only understanding early intervention, but recognising the post-treatment support that is done in the community. There are so many community groups. If I think about the community churches that the Salvation Army runs, some of the best drug and alcohol work that I have ever seen has been done in those services, and they do not even know that they are doing it. It is not recognised or accounted for, and it is certainly not funded.

Jan Mayor: I agree that we need a much wider definition of treatment, or perhaps the word is response to problematic alcohol and other drug use, so that we acknowledge the importance of working with people when, at that moment, they are maybe not ready to make changes but still need support.

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

Of course prevention is vital, but you do not prevent deaths by denying people treatment when they ask for it. The problem is not that people do not know that drugs are dangerous, but rather that, when they realise that they need help, the door is locked or, at worst, disnae exist. The bill does not cancel prevention. It complements it by making sure that, when prevention fails, there is a legal right to treatment.

There is a misunderstanding or a deliberate conflation—I am not sure which—from people giving evidence to the committee who do not understand that the bill is not flawed because it does not try to fix everything at once. It is not a manifesto. It is a legal safeguard in relation to one piece of the system that desperately needs structure and accountability. That is what the bill is trying to fight for.

There is no better prevention than watching somebody get well. No poster, toolkit or campaign is more powerful than seeing somebody escape addiction and reclaim their lives. I do not know why people keep referring to different aspects that are outside the scope of the bill, including even things such as housing, for example. I am very concerned that it is deliberate conflation.

Gillian Mackay: Several organisations have warned that the bill's requirement for in-person appointments could exclude some vulnerable individuals or those who have barriers to being able to attend appointments for whatever reason, including those with mental health issues, who may find attending appointments difficult. Would the panel support changes to the bill, to allow for greater flexibility and greater use of telehealth and outreach models, for example, to reduce those barriers and make recovery within the bill more accessible and inclusive?

Lee Ball: Part of the evidence that we submitted stated just that. We work with a population for whom, as a result of a number of issues, a rigid system that requires in-person attendance at a specific point at a specific time is really difficult. Those issues often include long histories of significant trauma, addiction, poor mental health and feeling excluded from the services that appear to be inviting them in through the door, because of cognitive issues or harm caused over the years.

I am worried that our client group would be extremely excluded from a model that is so rigid. In relation to flexibility, not only do we need to think more creatively about accessible sources—whether that be online or more telehealth interventions—but we also need to rely on the workforce that we have. Yesterday, I visited a service where a lot of the staff felt that they are not included in the treatment pathway to support the individual. Those are the people who live directly with people in services, and they should be included, to a degree, to support the individual to get to appointments. They are quite often an excluded and unheard group.

We absolutely need to be as creative as possible, but we also need to involve the wider circle. We talk a lot about the involvement of families within the treatment pathway, which we completely support. For a lot of the people who live in our buildings, the staff in that building are their family, and they are completely excluded. I therefore completely agree with the suggestion in Gillian Mackay's question.

Graeme Callander: The vast majority of our services at WithYou are in rural and semi-rural locations. When Gillian Mackay was asking her question, I thought instantly about our Argyll and Bute service, which is Highlands and Islands. A requirement for someone to get from Islay, for example, to the mainland would mean mammoth logistical planning. The bill needs to provide for online and telehealth care. It has to be flexible to cater for those needs.

The issue goes wider than just this bill and is why we need to consider how we deliver and implement anything in our rural services, because of the geographical challenges that exist.

Jan Mayor: I agree.

11:45

Annemarie Ward: Again, this simply is not true. The Right to Addiction Recovery (Scotland) Bill does not require in-person appointments as a condition of access to treatment. This is another example of misinformation that has been circulating, mostly unchallenged.

The reality is that the bill says that a qualified healthcare professional must assess whether a person would benefit from treatment. It does not specify how that assessment is delivered, whether in person, online, over the phone, or via multidisciplinary input. That is a matter for clinical judgment and service design, not legislation.

The bill gives people a right to treatment, not a prescribed format for how services must engage. The idea that the bill somehow mandates face-to-face appointments and therefore excludes and delays people is completely false. It is a distortion of the bill's intent and content. It is simply not true. Let us not invent barriers where they do not exist.

Sandesh Gulhane: Before I move on to my topic, I want to talk about early intervention and the points that were discussed. Along the line of a patient's journey for whatever problem they might have—whether that be addiction to alcohol or drugs, or a medical issue such as a chest infection—there are multiple touch points with services. When you have a member's bill, which is a very narrow-scoped bill, it should not look at the entire patient journey. It needs to be very focused on something, and this bill is very focused on trying to improve things for those people who are at the end of the journey and who are saying, "I need help. I need some medical intervention."

That is not to reduce the rights of people to have early intervention; it is absolutely vital that that happens. Cuts are occurring in my area of Glasgow that are stopping that early intervention from happening, but that has nothing to do with the bill. If we look specifically at this narrow bill, which is about the person who has said, "I want medical help," will it help them?

Graeme Callander: Based on Sandesh Gulhane's comments and definition, yes, it absolutely would help them. If someone requires medical intervention and that is enshrined in law, yes, it would help them.

All that we can do is share our experience of people with lived experience, and our experience as service providers. We are not trying to block things because we do not like the bill or whatever. We are trying to help scrutinise it.

Deep down, we are advocates for the people that we support and the people that live in our communities, and we want things to be better, not worse.

Anything that we have said is about making sure that all aspects of addiction and treatment pathways are considered. It does not mean that it is an either/or. All that we are doing is making sure that there are no unintended consequences. At the moment, we see people being denied entry into residential rehab and denied treatment.

Everything that we have said is not about saying that the bill needs to include all these other things. It is simply about saying that we need to consider what the impact could be, because we do not want unintended consequences. That is always where our organisation has come from.

Lee Ball: From the perspective of the Salvation Army, we believe that there is the potential for the bill to do exactly as Sandesh Gulhane explained. However, because the bill is so narrow and does not have the capacity to take on all those additional early intervention markers that we may well see, we have to understand that those early intervention incidents will have an impact on the person's ability to represent themselves and to fight for their rights in the bill.

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

Sandesh Gulhane: Annemarie, do you wish to respond before I move on to further questions?

Annemarie Ward: Yes. Thank you, Sandesh.

Calling the bill too narrow is just another way of saying that it does one job well—and some people do not like that. The bill disnae try to do everything; it does not rewrite every part of the addiction system. It does one crucial thing: it gives people a legal right to access treatment when they need it—not a leaflet, an appointment, a pilot or a postcode lottery, but a right. That is not narrow; that is targeted, effective legislation. We have had endless strategies that try to do everything but deliver nothing. What we do not have is a single enforceable guarantee that says, "If I ask for help, you have to respond." If the bill's focused scope makes some people uncomfortable, perhaps that is because it finally brings accountability. That is what is really being resisted here.

Sandesh Gulhane: Thank you.

I want to move on to treatment determinations. In the evidence provided by the Salvation Army and WithYou, there was discussion about the attitudes of healthcare professionals and how the bill would create a power imbalance. There was also discussion about the fact that people are being denied access to treatments from professionals right now. How can we improve the situation right now for people who want help while there seems to be that power imbalance? Why do you think that the bill would create further power imbalance?

Lee Ball: For us, it relates to the attitudes around substance use in and of itself. A lot of the power imbalance and the issues around why people cannot access the treatment that they need or want right now can be explained by the fact that there is so much stigma around addiction that people already have ideas about the right course of action before they come into the setting. In order to do things ethically and openly—so that the determinant of treatment is an equal process—we need to eradicate some of that attitude first. We need to do some work there, and that work needs to be done up front.

I have walked directly into healthcare services with some of the people I work with who are experiencing homelessness, and some people put gloves on before they even open their mouth and talk to the person. The level of stigma that the people in our services receive is palpable and obvious. If we think that the whole process is going to involve equity and equality, we need to work on the stigma around addiction first, before doing anything else.

One thing that we have commented on in relation to the bill is the fact that the explicit omission of harm reduction could potentially fuel the stigma that already exists around the right course of treatment for an individual. That is where we would come from.

Graeme Callander: From WithYou's perspective, numerous clients regularly tell us—even outwith the consultation process—about some really negative experiences that they have had. That is mostly outwith the drug and alcohol sector, however: it tends to be in the wider health settings. Noting that the bill focuses on the medical/professional aspects, our clients were concerned to know how it would improve things—and their experiences were already negative. People might have a right, but that will not necessarily challenge the behaviours or the cultures that remain, or the attitude towards alcohol and drug use in Scotland. That is where the concerns came from.

Regardless of what happens next, we need to be able to support medical professionals if the bill is to progress. At the moment, there are too many examples of people facing bad experiences.

Sandesh Gulhane: Can I clarify something? Do you think that we have a top-down, bad attitude towards drugs and alcohol at the moment?

Lee Ball: Do we think—

Sandesh Gulhane: That there is a top-down, bad attitude that is coming through to our health professionals?

Lee Ball: I cannot say that in each and every case, but I have experienced it at first hand, yes.

Graeme Callander: I think that it varies everywhere you go. There are some brilliant professionals who have an active interest and are compassionate and caring, but I also recognise that the health system is under great stress and strain, and it is almost impossible for them to remain so. How can people keep up that level of care at all times, given the amount of work that they are doing? Like Lee Ball, I have been in numerous appointments with clients in which the attitude has been shocking—as in, "Why are you here? This is your fault." That is all too common.

Lee Ball: In the bill, there is the potential for our clients to be able to call that out.

However, the term "early intervention" can be applied so broadly. What work will be done with the clients to enable them to understand their rights when they go into the room? Who will empower them to be able to argue for those rights so that the determination of treatment is made in a collaborative way? We need to think about that, because a lot of the clients with whom we work, when we ask them about their experiences of healthcare, have some fantastic examples and some absolutely atrocious ones, too.

Annemarie Ward: Let us not dance around the issue. Some professionals are saying that the bill would change the power dynamic between service users and providers. To that, I say, "Exactly—it should," because right now the power sits entirely with the systems, not the people, with unaccountable panels, opaque decisions and service providers who can say no without any explanation and without any consequence.

The bill would simply level the playing field. It would mean that if a healthcare professional agrees that someone needs treatment, that need can no longer be blocked by a budget, an opinion or bureaucracy. That is not undermining professionalism—that is backing it up with legal weight. In fact, it is a vote of confidence in professionals that their clinical judgment and their compassion should matter more than a finance panel, a gate-keeping service manager or a postcode lottery. Yes, the power dynamic will shift—it will shift towards the person who is asking for help. If that makes the system uncomfortable, it is long overdue.

Jan Mayor: I have a couple of points. First, I will pick up on Lee Ball's point. If the bill has a very narrow definition of the range of options that is available to respond, that will steer what people feel that they can ask for, and we would need the advocacy in place in order to provide a broader, collaborative care package.

The use of the phrase "healthcare practitioner" has already been picked up on. In some rural areas in particular, a healthcare practitioner may be a GP who does not have particular experience in this field and does not know what is available. In our submission on the bill, we offered a way forward on that: an approach that could be based on the principles in the Social Care (Self-directed Support) (Scotland) Act 2013, which would build in collaboration between the person who is seeking services and the healthcare practitioner to enable that person to plot their own course. If we could have something like that, I think that it would improve the bill.

Sandesh Gulhane: Thank you.

Paul Sweeney: I thank the witnesses for attending today.

I turn to the issue of timescales in the bill. Section 3(1) states that

> "treatment described in section 1(3) is to be made available to the patient as soon as reasonably practicable and in any event no later than 3 weeks after the determination is made."

Some written submissions from stakeholders have queried the three-week timescale after the treatment determination. Some have raised issues around appropriate preparatory work with those who would be attending treatment to ensure that they are stabilised, assessed and so on.

Do the witnesses think that the bill's requirement that treatment be made available within three weeks allows sufficient flexibility for necessary preparatory steps, such as assessment and stabilisation, to be undertaken? Would that fall within the intent of the bill's idea of access to treatment being triggered at that point? I am keen for that provision to be clarified. Perhaps Annemarie Ward can start.

12:00

Annemarie Ward: The fact that people are now quibbling over a three-week maximum timescale just shows that we have reached the point where there is no timescale at all. Right now, someone can wait three months, six months or indefinitely for treatment, and no one is being held accountable. That is not a system that is functioning. The bill does not say that treatment must take three weeks; it says that you cannot be left in limbo beyond that with no action, no plan and no urgency. If it can be done sooner, which it absolutely should be in many cases, that is great, but if treatment is delayed beyond three weeks, people will have a route to challenge that. Let us remember that three weeks will be a legal safeguard, not a clinical prescription. It is the first time that we will have drawn a line in the sand to say that there is a limit to how long you can leave someone suffering.

By the way, on the MAT standards same-day prescribing, how many people are actually getting that? None of our 123 advocacy clients had even heard of the MAT standards, never mind being able to access a prescription the same day, so let us not pretend that we are meeting tighter deadlines already. If the system objects to a three-week maximum timescale, maybe that is not because it is too short; maybe it is because it is the first time that anyone has ever been told that time matters.

Paul Sweeney: The bill's policy memorandum says:

> "The Bill also establishes a timescale to begin treatment of, at most, three weeks after being prescribed it but earlier if practicable. This is in recognition that time delays in receiving treatment impacts on the treatment having a positive effect, as someone can become more unwell in the period between diagnosis and treatment, potentially becoming seriously ill and in a state of trauma. In addition, delays in treatment can lead to scenarios where a person cannot take up the treatment after a period of time passes, for example if they have deteriorated in condition or lost faith that treatment will be provided that will help them."

I note that the Salvation Army, WithYou and Turning Point have raised concerns about the need for preparatory work to be undertaken before individuals can begin abstinence-focused recovery treatment. Therefore, with regard to how the bill is drafted, is there a way to define that clearly, so that the time in which people enter into the process of preparation would count in relation to that three-week period? Could that be considered?

Annemarie Ward: Yes, absolutely. Again, we are talking about people who are in crisis—people whose lives are at risk. If we cannae guarantee that they will be offered a treatment plan within three weeks, what are we actually doing here? The three-week timescale is not an aspiration—it is the bare minimum—and the only reason that it is being resisted is because it finally holds services accountable for delays that they have been getting away wi for years. Right now, people can and do wait months. In fact, we worked with somebody who had been asking for residential rehab for more than five years—some people never actually get treatment at all, and nobody answers for that. If the system finds a three-week maximum to be too ambitious, it is openly admitting that it has no intention of changing.

We are no asking for same-day miracles; we are asking for a legally enforceable deadline—a line that says that, beyond this point, someone needs to explain why help has not been given. Let us not forget that the MAT standards promised same-day prescribing, but, when we did the work, we found that none of the 123 people we were supporting had ever even heard of those standards, never mind received the care that was supposed to be provided through them. Let us stop pretending that services are delivering tighter targets already—they are no. This three-week timescale matters because it is the first time that anyone has said, “Enough. No more endless waiting, no more silent failures.” Is that too much to ask? If it is, we are no longer talking about capacity—we are talking about collapse.

Paul Sweeney: I want to turn to the witnesses in the room to pick up that point. In written correspondence, there has been mention of the fact that, for example, some people might require

> “at least 6 weeks of psychosocial interventions and practical organisation.”

Given what has been said, could the drafting be tightened?

Graeme Callander: There has been a three-week target for as long as I have worked in the sector—it is a national waiting time—and, as a third sector provider, we have always strived hard to meet that target. There are fundamental challenges in relation to how the target is being met or not met. It is good to see the three-week timescale included in the bill. It is a bare minimum—I agree; some treatment can start straight away. Perhaps that bit was not fully explained.

The fact that treatment can start on the same day, the next day or the next week should perhaps be reflected in the bill, if it could be. Sometimes, however, there are waiting lists for residential rehab and, unless we have a huge increase in capacity, I do not know how we get around that. In previous guises of waiting times, it was said that “the clock was ticking” as soon as people got their referral, and we need to be careful that that does not happen again.

The most important thing is that people actually see someone and that their treatment begins—whether that is support, assessment, one-to-one, group work, or whatever. That is more important. It is good that there is a timescale, but let us acknowledge, too, that it has been a well-kent timescale in the sector for a long time.

Jan Mayor: From our point of view, a three-week wait for residential rehabilitation is appropriate, and we would really welcome that. However, as Graeme has already said, many other treatments are needed more instantly. Access to somewhere such as our crisis service often needs to be within 24 hours.

What we would not want, therefore, is for that three-week target to become a barrier, as has happened with other waiting list targets. We just wonder whether that could be made more subtle in the bill and whether there could be a more nuanced approach to waiting times. Three weeks is the absolute minimum standard, but it is about making it even clearer that it is for a particular type of treatment. For another type of treatment such as MAT, the legal requirement for it to be accessible within one day could be added to the bill. That is what we are looking for.

Paul Sweeney: That is helpful.

Lee Ball: One thing that we would hate to see happen is for the critical, admirable goal of that one-day entry point for MAT standards to be threatened or deprioritised as a result of another timescale coming in. We do not want one to be sacrificed for the other.

To go back to a point that I made earlier about what constitutes treatment, looking at it in the broader sense, treatment always starts on day one, because it is defined by the relationship that you develop when you walk through the door—I think that we put that point in our submission. It always starts right from the get-go, and that relationship is really important. We must understand that some people need preparatory work for stabilisation while others require the opportunity to go straight to detox. We need that whole range of options in what is defined as "treatment", and that needs to clearly be spelled out.

Paul Sweeney: That is helpful. On the point that was made earlier about resource and capacity, surely creating that clear demand signal would indicate where there is a gap. It might be helpful to have those expected target times against each type of treatment and pathway, so that there would at least be a clear signal of where we are not meeting those standards. Would it be helpful for that to be defined in the bill?

Jan Mayor: Yes, with the caution that we would not want to create unintended consequences, which often happens with those waiting times. However, yes, there is absolutely a case for that. As Graeme has already said, people are waiting far too long at the moment, for instance for residential rehab.

Paul Sweeney: Annemarie, would you like to come back in?

Annemarie Ward: Yes—thanks very much. With respect, claiming that a three-week maximum wait could become a barrier is completely backwards. The real barrier right now is that people are being left for months, sometimes years, without any timeline or urgency, and with no right to challenge the delay. The bill does not stop people getting treatment sooner; it ensures that they are not forgotten.

The three-week cap is a safety net, not a waiting period. It says that you must not leave someone hanging beyond that point without action or accountability. It is a deadline, not a delay. If anyone is genuinely worried that services will suddenly slow down and say, "We'll wait until day 21," I say to them that that would be a failure of leadership, not legislation. If a system treats a legal minimum as a target, that tells you everything that you need to know and everything about why the bill is needed.

Let us be honest, people already face huge barriers, but they are not created by timescales—they are created by inertia, gatekeeping and unaccountable systems. The bill challenges that, which is why it is being resisted. No, the three-week limit does not build barriers—it builds boundaries for a system that has had none for too long.

Lee Ball: Paul, can I come in on that?

Paul Sweeney: Yes.

Lee Ball: The three-week time limit could, all of a sudden, become an unobtainable target because we do not resource the services that we are talking about to be able to deliver on it. I am really concerned that that target will increase pressure on front-line staff, who are already feeling isolated and guilty and that they cannot make a difference in the work that they are trying to manage. If we are going to put in the bill that aspirational idea that people can get into treatment in three weeks, it will require to be resourced.

Paul Sweeney: If I am correct in my understanding, the issue is that some treatments can, and should be expected to, begin on the same day, and one should not expect it to become the norm that the process is dragged out to three weeks.

In the case of residential rehab and access, however, it would definitely be expected that the pathway, involving an initial psychosocial assessment and preparation, would start to get under way within that three-week period as an absolute maximum.

I think that I am clear on that—is that right? The three-week deadline is more to do with the residential pathway than, say, the MAT standard approach beginning on day 1, and the latter should not be considered as something that it is fine to kick into the long grass over a three-week period.

I see that the witnesses are nodding. That is fine—perhaps we can adjust the language in the bill in some helpful ways to clarify those differences in approach.

Let us turn to the definition of "treatment". The explanatory notes to the bill currently state that the bill

> "sets out a non-exclusive list of treatments that may be provided"

and that

> "Subsection (6) provides that the Scottish Ministers may add to that non-exclusive list by regulations."

Are witnesses content that the bill's definition of "treatment" provides suitable flexibility to accommodate evolving best practices in drug and alcohol recovery and to respond to changes in substance use over time?

Perhaps we can start with one of the witnesses in the room, if anyone has a view on that.

Graeme Callander: In recent times, there has been a real change in the types of substances that we see on the streets. We are seeing an increase in illicit benzodiazepines and synthetic opioids, which is of real concern. However, one of the key issues is polysubstance use. We want to ensure that the bill's intent from the get-go is to include those people who are currently not necessarily always being fully supported because they use non-opiate drugs or they are not drinking alcohol.

The definition needs to capture those groups of people, as we need to ensure that people are not excluded unintentionally. That exclusion is not an intentional act, but we know how the system operates just now, so we need to ensure that the bill improves on what we have.

Lee Ball: There is not always a clinical intervention that can support every use of every drug, so the need for psychosocial and community-based support has to be made explicit in the bill. As drug use evolves, changes and morphs, we are seeing an awful lot more people not being able to fit into current critical interventions, so the need for community psychosocial support is of paramount importance. We cannot miss people, and that polydrug use is what is killing people.

Jan Mayor: I would echo that. I also think that, even with the list of treatments in the bill, we need careful definition of treatments, because they often mean different things to different people.

One example is stabilisation services, which are mentioned as such in the bill. It is really welcome to see them in there, and that is important, but we need to define what we mean by that and make sure that we all mean the same thing. If someone has a right to ask for a treatment, we need to know what it is. There may need to be some way of defining that in a bit more detail; I do not know.

Lee Ball: In looking at the bill, we picked up on that exact point about stabilisation services, as "stabilisation" is one of those terms that could potentially be really loaded. It is about literally that: stabilising the person. In the glossary at the back of the bill, however, "stabilisation" is defined as stabilising with a view to reduce consumption. That has an explicit motive within it.

However, it should be up to the person to say, collaboratively, "This is what stabilisation means to me." For some people, the approach that gives them the best quality of life is to optimal dose and leave them there for a period of time to be able to stabilise all the peripheral issues that go along with addiction. We cannot say that stabilisation has a motive, which is to reduce.

Paul Sweeney: To be clear, are you content that there is sufficient flexibility in the provisions in section 1(5) and (6) as currently drafted to enable Scottish ministers to include the nuances to which you refer, or do you want those provisions to be amended to include specific mention of community-based support?

Lee Ball: We think that it has to be explicitly mentioned.

Paul Sweeney: Right, okay—that is helpful.

Annemarie Ward, I wonder whether you have any views on the provisions in section 1(5) and (6) in that regard?

Annemarie Ward: I am happy for that to be amended as well, but it is interesting that we are quibbling over the definition of "treatment". Really? "Treatment" is already defined in law, in clinical practice and in the NHS (Scotland) Act 1978. The bill does not invent a new meaning. Instead, it uses what is already recognised in health legislation: detox, rehab, MAT, psychosocial support, harm reduction, peer services and anything that helps someone to reduce or recover from dependency. That is not vague; it is standard practice.

12:15

It is telling that no-one seemed confused about what treatment was when they were denying it. It is only now, when people might actually get a legal right to access treatment, that we are pretending that the term is ambiguous. We do not ask for a line-by-line definition of treatment in cancer care legislation or mental health rights, because we trust clinicians to apply their judgment based on need. The same should apply here. Let us not insult the intelligence of the Parliament or the public by pretending that the bill is unclear. The only thing that is unclear is why some are so desperate to keep access to treatment vague, unchallenged and out of reach.

Paul Sweeney: Does the financial memorandum take appropriate account of potential costs if treatment options, as defined in the bill, were to be expanded? Does anyone in the room have a view on that?

Graeme Callander: It was welcome to see that there was at least some consideration given to increasing the resource to support the implementation of the bill. What is less clear is how much money would be required. Is there currently enough resource in the system to do what we are doing, never mind potentially increasing capacity and demand for services? We need to understand whether whatever money is put forward to support the bill would be enough to do what is being asked. It was welcome to see that consideration, but it was not clear to me whether there would be enough resource to support all the different parts of the bill.

Lee Ball: If we do not pay for this now, we will pay for it elsewhere and a bit later on. The need to properly financially resource the whole process is absolutely vital. However, we also need to take into account the money that is being spent by third sector organisations, which we do not see. They do a lot of the community relationship work that also feeds into preparing somebody for treatment.

Annemarie Ward: The financial memorandum is bothering people, but what bothers me is that thousands of people are dying. Frankly, we have lost sight of the real crisis. The bill does not demand new treatments and it would not require the building of new facilities from scratch. It simply creates a legal right to access the treatment that is already available—the same treatments that the NHS and the third sector are supposed to be offering now. The idea that the bill would somehow bankrupt the system is a myth. If anything, it would force the money to follow the need—not the ideology, not the postcode, and not whichever quango shouts the loudest.

We should be asking ourselves this: where was all this concern about financial memorandums when tens of millions were handed out to quangos with no measurable outcomes? Where is the scrutiny of the funding for the MAT programmes that have seen no reduction in drug deaths? The bill would cost a fraction of what Scotland already wastes on failure. People are worried that implementing rights might cost more than maintaining decline but maybe that is a price worth paying, because the alternative is what we have now: an expensive system that lets people die with no legal recourse.

Yes, the financial memorandum matters, but let us not pretend that it is a reason to stall this process. Justice costs something, and recovery is worth it. Doing nothing has already cost many families much more.

Paul Sweeney: Thank you very much.

The Convener: My colleague Gillian Mackay asked Mr Ball a question about in-person meetings for a treatment determination. Section 2(1)(d) of the bill says:

> “the treatment determination is made following a meeting in person between the relevant health professional and the patient”.

Given that the member who in charge of the bill is currently in the room and will have heard the concerns that were raised by the witnesses about that particular issue, I am sure that he will reflect on that and perhaps be able to speak to the committee about that particular subsection of the bill when he is in front of us in a couple of weeks’ time.

I thank the witnesses for their attendance and for their evidence. The committee will meet again next Tuesday, when we will further consider the Right to Addiction Recovery (Scotland) Bill.

12:19

Meeting continued in private until 12:47.

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