Diagram

Description automatically generated

**Detailed Analysis: Contradictions and Misrepresentations in Committee Evidence on the Right to Recovery Bill - Health, Social Care and Sport Committee Tuesday 25 March 2025 Session 6**

**Prepared by:**  
Annemarie Ward  
Chief Executive, FAVOR UK  
April 8th 2025

### **Purpose**

This document delivers a comprehensive analysis of testimony from the Health, Social Care, and Sport Committee’s Stage 1 evidence session on the **Right to Addiction Recovery (Scotland) Bill**. Each section highlights contradictions between witness statements and the international evidence base or the factual contents of the Bill. Myth-based arguments are exposed using the FAVOR UK Mythbusting document.

## Index

1. Purpose of Report

2. Detailed Examination of Witness Testimony and Contradictions

- 2.1 Dr Sue Galea-Singer (NHS Fife)

- 2.2 Eddie Follan (COSLA)

- 2.3 Dr Flora Ogilvie (NHS Lothian)

- 2.4 Gillian Robertson (Aberdeenshire HSCP)

- 2.5 Liam Wells (East Ayrshire ADP)

- 2.6 Kelda Gaffney (Glasgow ADP)

- 2.7 Pamela Dudek (Dundee ADP) – Additional Themes

3. Cross-Cutting Themes Identified in Testimony

4. Conclusion: Implications for Policy Debate and Evidence Integrity

5. Next Steps for Advocacy and Parliamentary Engagement

6. Analysis of MSP Contributions and Evident Biases

- 6.1 Supportive or Constructively Critical

- 6.2 Ambiguous/Neutral Engagement

- 6.3 Sympathetic to Anti-Bill Narratives

7. Testimony Supporting the Bill

- 7.1 Health and Human Rights Experts

- 7.2 Addiction Delivery Partners

- 7.3 Parliamentary Endorsements

8. Reinforcement from FAVOR UK Mythbusting Report

9. Final Recommendations to MSPs

### **Detailed Examination of Contradictions by Witness**

#### **2.1. Dr Sue Galea-Singer (NHS Fife)**

* Claimed that addiction treatment in Scotland begins within 24 hours, undermining the Bill’s necessity.
  + **Contradiction:** This claim ignores national variability. Lived experience accounts and Public Health Scotland data show considerable waiting times.
* Argued that rights to a second opinion and collaborative care already exist.
  + **Contradiction:** Rights in practice are not enforceable or consistently applied across health boards.
* Dismissed the Bill’s collaborative approach as unnecessary.
  + **Contradiction:** WHO guidelines promote enforceable rights to treatment and second opinions as good practice.
* Warned about confusion between MAT 24-hour goals and the Bill’s three-week access.
  + **Myth:** This is a false dichotomy. The Bill sets an upper limit—not a delay—and supports existing rapid-access models.

#### **2.2. Eddie Follan (COSLA)**

* Claimed the Bill was overly medicalised and misaligned with MAT standards.
  + **Contradiction:** The Bill explicitly allows harm reduction, psychosocial, and residential options.
* Argued that social determinants should be the focus.
  + **Contradiction:** WHO and UNODC agree that addressing medical treatment access is essential in parallel with social reform.
* Asserted that treatment rights would strain underfunded services.
  + **Myth:** International examples (Portugal, Switzerland) show that legislated rights drive service investment.

#### **2.3. Dr Flora Ogilvie (NHS Lothian)**

* Claimed the Bill might increase stigma by singling out addiction.
  + **Contradiction:** Rights-based framing has been shown to **reduce** stigma by establishing parity with other health conditions.
* Suggested existing rights frameworks make the Bill redundant.
  + **Myth:** No binding right currently guarantees timely access to addiction treatment in Scotland.

#### **2.4. Gillian Robertson (Aberdeenshire HSCP)**

* Warned that the Bill would jeopardise multidisciplinary practice.
  + **Contradiction:** Legal rights in countries like Canada and Portugal enhanced cross-disciplinary integration.
* Said treatment determination under the Bill was too restrictive.
  + **Myth:** The Bill allows prescribing professionals from multiple roles and supports patient-driven care.
* Objected to non-NHS prescribers triggering statutory timelines.
  + **Contradiction:** Collaborative prescribing models are international best practice and already used across the NHS.

#### **2.5. Liam Wells (East Ayrshire ADP)**

* Argued that diagnosis requirements would exclude people.
  + **Contradiction:** Portugal’s legal system integrates early-stage, non-diagnostic interventions under a treatment rights umbrella.
* Claimed trauma-informed care is absent from the Bill.
  + **Contradiction:** Trauma-informed language and collaborative principles are embedded; implementation detail is secondary legislation.
* Downplayed legal advocacy as unnecessary.
  + **Myth:** Advocacy is a cornerstone of WHO-aligned, rights-based care. The Bill enhances—not replaces—existing advocacy efforts.

#### **2. 6. Kelda Gaffney (Glasgow ADP)**

* Denied seeing evidence that people are denied treatment.
  + **Contradiction:** This contradicts Public Health Scotland reports and lived experience testimony.
* Framed diagnosis as stigmatising and exclusionary.
  + **Myth:** Diagnosis is not required for all treatments. The Bill allows voluntary engagement at all stages.
* Argued the Bill could unravel trauma-informed and MAT standard progress.
  + **Contradiction:** Legal frameworks in countries like Ireland show rights legislation strengthens standards and access.
* Dismissed funding flexibility from legal duties.
  + **Contradiction:** International experience shows legal mandates support increased funding via ring-fencing.

### **2.7. Pamela Dudek (Dundee ADP) – Additional Contradictions and Myths**

#### **1. Undermining the Need for Legal Guarantees**

* **Claim:** Expressed uncertainty over whether the Bill would provide “leverage in the system” or if it would “help or hinder” service delivery.
* **Contradiction:** This dismisses international evidence (e.g. Portugal, Canada) showing that statutory rights improve access, integration, and outcomes. Countries that legislate access to care show measurable improvements in service accountability and user outcomes​.

#### **2. System-Capacity Mistrust**

* **Claim:** Argued that same-day access (MAT Standard) was challenging in rural areas like Highland and Argyll, casting doubt on whether the Bill could work nationwide.
* **Contradiction:** Countries with vast rural populations (Norway, Australia) have implemented legal rights frameworks that flexibly accommodate geography via mobile units and community-based clinics. The existence of barriers is not a reason to deny rights—it’s a reason to plan effectively​.

#### **3. Mischaracterising Access and Gatekeeping**

* **Claim:** Suggested that the Bill could “limit access” by focusing only on medicalised entry points.
* **Myth:** This echoes the myth that diagnosis and clinical determination are exclusionary. In reality, the Bill allows a range of professionals to assess and respond. It ensures **structured pathways**, not restriction​.

#### **4. Preference for Non-Legal Alternatives**

* **Claim:** Advocated for community-based charters of rights as a preferable alternative to legislation.
* **Contradiction:** Charters are unenforceable. UNODC and WHO recommend statutory protections to guarantee access for vulnerable populations. Soft policy frameworks cannot ensure parity with other health conditions​.

#### **5. Overstatement of Harm in Using “Medical Language”**

* **Claim:** Warned that the Bill’s use of “diagnosis” and “treatment” language might stigmatise people and set back community trust.
* **Myth:** This mirrors the myth that medicalisation equals marginalisation. International guidance affirms that framing addiction as a treatable health condition reduces stigma by reinforcing parity of esteem with other illnesses​.

### **3. Cross-Cutting Themes**

* **Minimisation of Systemic Failures:** Several participants claimed current systems are adequate or improving, despite rising drug deaths and public dissatisfaction.
* **Medicalisation Misconception:** Most criticism frames the Bill as exclusively medical. However, it promotes **choice**, including psychosocial and harm reduction paths.
* **Conflation of Complexity with Inaction:** Many argue the system is too complex for legal clarity, ignoring international evidence that legal frameworks enhance clarity and access.

### **4. Conclusion**

The witnesses’ collective narrative casts doubt on the Right to Recovery Bill using arguments that contradict international health standards and the documented lived experience of people in Scotland. These misrepresentations must be directly countered to enable a fair and evidence-informed debate.

### **5. Next Steps**

* Expand public awareness of the misinformation presented.
* Ensure MSPs are briefed with international evidence and myth-busting content.
* Monitor future evidence sessions and issue public corrections where needed.

### **6. MSP Contributions and Evident Biases During Committee Scrutiny**

As part of the Stage 1 scrutiny of the **Right to Addiction Recovery (Scotland) Bill**, Members of the Scottish Parliament (MSPs) on the **Health, Social Care and Sport Committee** engaged with witnesses through questions, clarifications, and commentary. While MSPs are expected to adopt a neutral and evidence-seeking posture, a review of the official transcript reveals that several members demonstrated **clear patterns of bias**, either **in favour of or against the Bill**, through their language, framing, and lines of inquiry.

This section categorises each MSP based on their **direct questioning**, **supplementary comments**, and **overall stance** inferred from their participation. These patterns help to contextualise the political dynamics surrounding the Bill and highlight where **institutional narratives may have influenced scrutiny**.

Below is a validated summary of each MSP's engagement, indicating where support, scepticism, or neutrality was apparent.

* **Direct questions that reflect clear support or opposition** to the Right to Recovery (Scotland) Bill
* **Supplementary comments revealing implicit bias**
* **Any procedural or reflective comments about the Bill, service delivery, or underlying philosophy**

Here is a **summary of MSP biases and stances**, now fully validated against the official report:

### ✅ **Supportive or Constructively Critical**

**6.1. Dr Sandesh Gulhane MSP (Conservative)**

* Chair of the medical advisory group on the Bill.
* Argued that similar rights exist in the Patient Rights Act.
* Challenged witnesses who claimed the Bill would override clinical judgement.
* Asked probing questions about cost barriers and professional discretion.
* Consistently corrected myths presented by witnesses.
* **Bias:** Strong supporter, rational and rights-focused​.

**Brian Whittle MSP (Conservative)**

* Asserted that **systemic failure** in addiction services justifies legislative reform.
* Challenged inconsistencies in claims about workforce burden and service availability.
* Saw the Bill as an opportunity to **expose and address structural failure**.
* **Bias:** Supportive of legislative action; clearly evidence-driven​.

### 🟡 **Ambiguous/Neutral**

**6.2. Paul Sweeney MSP (Labour)**

* Focused primarily on philosophical and moral considerations rather than specific Bill content.
* Expressed empathy but **no strong position** on the policy mechanics.
* **Bias:** Neutral or unclear​.

**Joe FitzPatrick MSP (SNP)**

* Only made thank-you remarks—**no policy-based input**.
* **Bias:** Undetermined​.

**Carol Mochan MSP (Labour)**

* No contributions recorded in the transcript on substance of the Bill.
* **Bias:** Undetermined.

**Jackie Dunbar MSP (SNP, substitute)**

* No substantive questions recorded.
* **Bias:** Undetermined.

### ❌ **Sympathetic to Bureaucratic/Anti-Bill Narratives**

**6.3. Elena Whitham MSP (SNP)**

* Repeated concerns about diagnosis, stigma, and rigid language in the Bill.
* Posed questions that echoed panellists’ negative framing, particularly around access and rurality.
* Suggested that community-based rights charters might be more appropriate than statutory law.
* **Bias:** Leaning against Bill; deferential to witness fears​.

**Emma Harper MSP (SNP)**

* Framed the Bill as potentially **in conflict with MAT standards**.
* Repeated concerns about people in rural settings being coerced into treatment or fearing child removal.
* **Bias:** Opposed or heavily sceptical; reinforced stigma-based concerns rather than countering them​.

**David Torrance MSP (SNP)**

* Repeated witnesses’ concerns about diagnosis and medicalisation.
* Posed questions that positioned **multi-disciplinary teams as threatened** by the Bill.
* **Bias:** Sympathetic to ADP critiques; possibly opposed​.

This briefing outlines all supportive statements made during the Health, Social Care and Sport Committee Stage 1 evidence session on the **Right to Addiction Recovery (Scotland) Bill**. It is intended to assist Members of the Scottish Parliament (MSPs) in understanding the **breadth of support** expressed by professionals, advocacy leaders, and fellow parliamentarians.

### **7. Endorsements from Health and Rights Professionals**

#### **7.1 Dr Tara Shivaji (Public Health Scotland)**

* Described the Bill’s **vision and ambition** as valuable.
* Stated that a **legal right to treatment could improve outcomes**, provided it is implemented effectively.

#### **Eleanor Deeming (Scottish Human Rights Commission)**

* Confirmed the Bill aligns with key human rights legislation:
  + **European Convention on Human Rights (Article 2 – Right to Life)**
  + **UN Covenant on Economic, Social and Cultural Rights (Right to Health)**
* Emphasised that legislating access to treatment would likely **improve Scotland’s human rights standing**.

#### **7.2 Pamela Dudek (Chair, Dundee ADP)**

* Highlighted the Bill’s strengths in **trauma-informed language** and its **person-centred approach**.
* Commended the intention behind the Bill, stating it is **inclusive and well-intentioned**.

#### **Kelda Gaffney (Glasgow City ADP)**

* Recognised the Bill’s incorporation of:
  + **Trauma-informed ethos**
  + **Independent advocacy**
  + **Family-inclusive practices**
* Affirmed the Bill’s support for **harm reduction alongside recovery**, stating: “Recovery is not and cannot be linear … Harm reduction keeps people alive.”

#### **Liam Wells (East Ayrshire ADP)**

* Supported the idea that a legislative model could:
  + **Reduce system churn**
  + **Improve recovery outcomes**
  + **Strengthen the case for resource investment**
* Accepted the **financial and social benefits** of fewer returns to treatment and reduced criminal justice burden.

### **7.3. Strong Parliamentary Support**

#### **Dr Sandesh Gulhane MSP (Scottish Conservatives)**

* Argued that patients already have rights under the **Patient Rights (Scotland) Act**, and this Bill simply extends that to addiction.
* Consistently challenged myths presented by witnesses:
  + Reaffirmed the Bill’s **protection of clinical discretion**.
  + Corrected misstatements suggesting the Bill imposes a singular treatment model.
* Called for the Bill to be seen as a **rights-based extension of the NHS framework**.

#### **Brian Whittle MSP (Scottish Conservatives)**

* Asserted that **systemic failure in addiction services necessitates legislation**.
* Suggested the Bill could act as a lever to **expose and correct failures**.
* Emphasised that legal rights would **ensure consistency and accountability**.

### **8. Reinforcement from FAVOR UK Mythbusting Report**

* The Bill supports **all treatment options**, including:
  + **Harm reduction**
  + **Detoxification**
  + **Residential rehabilitation**
  + **Psychosocial and trauma-informed care**
* Enshrining a legal right to treatment would:
  + Reduce stigma by **normalising addiction treatment as healthcare**
  + Provide enforceable rights to challenge **treatment denials or delays**
  + Complement, not override, **existing MAT standards and strategies**
  + Strengthen access to **independent advocacy and multidisciplinary support**

### **C9. Conclusion**

Despite vocal opposition from certain institutional stakeholders, the Right to Recovery Bill received **significant support** during evidence sessions—from public health officials, human rights experts, ADP leaders, and parliamentarians alike.

The Bill reflects **international best practice**, aligns with **human rights obligations**, and offers a much-needed framework to ensure that **every person in Scotland can access addiction treatment as a legal right**.

MSPs are encouraged to:

* Publicly acknowledge the supportive testimony in favour of the Bill.
* Reinforce that the Bill allows **full clinical discretion and treatment flexibility**.
* Champion the Bill as a step toward **ending Scotland’s tragic inequality in treatment access**.