Before the Bill

Reading a right to recovery before it is lodged: the record, the design and the money

Introduction

Context Matters Consultancy exists to make context core to every discussion. We are also about intelligence: looking at trends, and at what I call the crumbs, the small signs that appear in and across the sector before anything is announced. That intelligence suggests a new attempt at a Right to Recovery bill is coming, and in September and October 2026 the question returned to the Scottish Parliament (Scottish Parliament, 2026a; 2026c). This piece is not commentary after the event. It is written before it, so that whatever is proposed can be read against a record already in place.

Context Matters Consultancy is not against a legislative solution. But any solution must be built on transparency, and on the understanding that dismantling existing service provision, whether deliberately or as a consequence, is not a solution. As this article shows, even the most well-meaning solution can have unexpected outcomes, and some of those outcomes have yet to be noted in similar programmes abroad. One thing is clear: gatekeeping risks further deaths and further costs. The choice is whether we acknowledge that or not.

Scotland records alcohol and drug deaths in detail, and that intelligence is what has allowed Scotland to build the system it has. We also have to account for the legal differences between what the Scottish Parliament can do and what is reserved to the United Kingdom Parliament, as I have discussed in recent articles.

However much we might want to, we cannot remove the need for scaffolding. A person has to feel safe and secure before they are psychologically ready to move through the process. The model should inform the service, and serve the person.

Standpoint

I have been a nurse since 1987. Between 1987 and 2013 I worked in the National Health Service in Scotland, across psychiatric, addiction, forensic and public health services, and I have not worked clinically since. As an addictions nurse, I supported people through admission to residential rehabilitation, and I saw what it gave some of them. Later, as an Education and Prevention Specialist, part of the team for blood-borne virus work in a health board, I saw where most journeys actually began: at a needle exchange, with an outreach worker, through a peer educator, often without a name being given. Those first contacts were the rungs everything else stood on.

That is the ground I read this from. A right to treatment is written for the person who reaches the door. Much of my working life was spent with the people who could not yet reach it, and with the services that kept them alive until they could. A right worth having has to hold both.

Once a bill is in front of Parliament, its supporters defend it and its critics attack it, and the design is argued over rather than examined. The time to examine it is before anyone has ground to hold.

Why read a bill before it exists

A member's bill in the Scottish Parliament does not appear without warning. A draft proposal is lodged first, with either a consultation of at least 12 weeks or a statement of reasons arguing that the case has already been made. If a committee accepts a statement of reasons, there is no public consultation at all. The final proposal then needs the support of 18 other members, from at least half of the parties represented on the Parliamentary Bureau (Scottish Parliament, n.d.).

The Right to Addiction Recovery (Scotland) Bill fell at Stage 1 in October 2025. A reworked bill could rely on its consultation and the Stage 1 evidence, leaving only a month in which a committee decides whether a new consultation is needed. This piece is written for the time before that month begins.

The seeds are on the public record. Before the 2026 election, the Scottish Conservatives committed to reintroducing the bill (Scottish Conservative and Unionist Party, 2026). In September 2026, a Reform UK member asked why "a right to rehabilitation enshrined in law for everyone" was not in the programme for government, the leader of the Scottish Conservatives called the 2025 Bill "our bill", and Reform UK's business manager listed bringing it back among the approaches to drug deaths (Scottish Parliament, 2026a; 2026b).

On 29/10/2026, the seeds reached a vote. In a Scottish Government debate on alcohol and drug deaths, the Parliament agreed a Reform UK amendment that "the right to recovery must be considered as part of the efforts to address substance abuse", by 36 votes to 18. Reform UK, Scottish Labour and Scottish Liberal Democrat members voted for it, and most Scottish National Party and Green members abstained. A Scottish Conservative amendment calling for "a legal right to timely and clinically appropriate treatment, backed by funded detoxification, residential rehabilitation, community recovery and aftercare" was supported by Reform UK and Scottish Liberal Democrat members, while Scottish Labour members abstained, and it was not agreed (Scottish Parliament, 2026c; 2026d). One Liberal Democrat member said his party had "cautiously supported a right to rehab, but it is not a silver bullet" (Scottish Parliament, 2026c). The members who voted to consider a right were not the same as those who voted for a legal one. Interest across parties is not support for a particular design, and no published text yet sets out what a new bill would contain.

What the record already shows

The 2025 Bill would have given a right to treatment to anyone diagnosed with a drug or alcohol addiction by a doctor, or a nurse or pharmacist independent prescriber. Treatment determined with the person would start within three weeks. Where none was considered appropriate, the person would receive a written statement and could seek a second determination. Ministers would report each year on determinations, treatments started, people not treated and waiting times (Scottish Parliament Information Centre, 2025a).

The Bill fell at Stage 1 on 09/10/2025, by 63 votes to 52 (Scottish Parliament, 2025a). The majority of the lead committee found that people without a diagnosis could not exercise the right, that the Financial Memorandum significantly underestimated the costs, and that a three-week deadline could compromise treatment quality, limit choice and increase relapse risk. It also warned of litigation and of a precedent for other conditions (Scottish Parliament, 2025b).

On 24/09/2026, the Scottish Government restated its position. It would focus on access to residential rehabilitation and wider treatment "through investment, service improvement and a rights-based approach, rather than by creating a new statutory right to a specific form of treatment" (Scottish Parliament, 2026a).

Meanwhile the harm has moved. In Public Health Scotland's October 2026 report, cocaine was the most commonly reported drug across treatment and toxicology data, and powder cocaine was the main drug in 34 per cent of specialist treatment assessments. Nitazenes were found in 8 per cent of deaths positive for a controlled drug, and treatment starts were 10 per cent lower than in the same period of 2025 (Public Health Scotland, 2026b). Residential rehabilitation met its target of 1,000 publicly funded placements a year, but in 2025 only 30 per cent of people able to refer agreed that it was easily accessible (Public Health Scotland, 2026a). People who want residential rehabilitation and cannot reach it are being failed, and the case for better access is real. What Gets Counted Gets Funded sets out this record in full (Context Matters Consultancy, 2026a).

Much of what a right would promise already exists in policy. Since 2011, a national standard has said that 90 per cent of people referred for help with drug or alcohol use should wait no more than three weeks for specialist treatment. In the quarter to June 2026, 93.6 per cent of referrals to community services met it (Public Health Scotland, 2026c). Waits for residential rehabilitation, where the case for the 2025 Bill was made, are not reported separately. The standard is a target, not a right, and the Scottish Government has questioned whether an absolute right to provision within three weeks would require services always in excess of need (Scottish Government, 2025a).

Rights are also already written down. The Charter of Rights for People Affected by Substance Use sets out what people can expect from services, and the strategic plan for 2026 to 2035 commits to embedding it in the national service specification, funding and quality assurance (Scottish Government, 2026b). The question is therefore not whether people have rights. It is whether those rights are enforced, and whether the places exist to meet them.

Reading the build-up

A bill that has fallen does not return as it left. Before it is lodged again, the conversation around it changes shape. None of this is improper. It is how campaigns work, and it is why the design matters more than the campaign. These are the movements to watch for, and the question each should prompt.

- **A funding story arrives before the bill.** Totals, levies and allocations appear, answering the cost finding before anyone asks. The question: is this money raised, or money estimated?
- **The gate is renamed.** Diagnosis becomes assessment, or need. The question: who assesses, against what threshold, and who never reaches an assessment at all?
- **The language widens.** Harm reduction is named alongside recovery. The question: is it in the design of the right, or only in the description of it?
- **Ownership is spread.** The appeal goes to every party and to none. The question: when the right is not met, who will answer for it?
- **The case becomes personal.** Stories of people failed by the system come to the front, and they cannot be argued with. The question: would this design have changed what happened to them?

Some of these movements are already visible. Within five weeks, the right has been described as a right to rehabilitation, to timely and clinically appropriate treatment, and to recovery (Scottish Parliament, 2026a; 2026c). Each name implies a different design. One amendment asked for a count of people “assessed for rehabilitation who are not subsequently admitted” (Scottish Parliament, 2026c). That would count people turned away at the gate, which is welcome, but not the people who never reach an assessment at all.

Each movement can be sincere and still change nothing in the design. Reading the build-up is not reading intentions. It is noticing where the questions have moved, so they can be asked of the right thing.

The design, read through the Seven Signals

The Seven Signals are the patterns Context Matters Consultancy uses to read how harm gathers in people and in services (Context Matters Consultancy, 2026b). Four can be read in the design of the 2025 Bill. Each reading is a proposition of the model, not a research finding, and applies to the design, not to the people who support it.

Enclosure: the gate

In this model, Enclosure is a fence that builds as a crisis builds: it keeps some people in, and it keeps help out. A right attached to a diagnosis is a fence of this kind. The people the 2026 record points to are the people most likely to be outside it: people who use stimulants or several drugs at once, people not in contact with services, and people whose harm is not recorded as dependence. Renaming the gate does not remove it. An assessment is still a gate. For a person at the Survival stage, a named diagnosis can itself be the risk, and declining it can be the safest decision they make (Context Matters Consultancy, 2026c). Scotland's current system has gates of its own. On 29/10/2026, the Cabinet Secretary for Health and Care said that residential rehabilitation is "not for everyone" and that "people need to be ready for it" (Scottish Parliament, 2026c). Readiness is a threshold too, and the same question applies: who never reaches it?

Ritualized Relief: what the right would count

In this model, Ritualized Relief is a sequence that releases pressure while the thing beneath it does not move. The 2025 Bill would have reported determinations, treatments started, people not treated and waiting times. Each measures the right being performed. None measures what changed for the person. A right measured this way can be met in full, year after year, and still leave the harm where it was. The relief would be real. It would come from the report.

Deniable Attribution Architecture: who answers

In this model, Deniable Attribution Architecture is the set of mechanisms by which an institution covers itself, so that when something fails, the attribution lands somewhere other than where the decision was made. Under the 2025 Bill, Ministers would have held the duty, but its visible working would have sat at the individual determination: the written statement, the second determination, the three-week deadline. When a deadline is missed in a service without the places to meet it, the person who must explain is the clinician in the room. The decision that left the places unfunded was made elsewhere. Reporting by named patient adds a second effect: a service that keeps contact anonymous shows activity but not patients, and so appears to need less (Context Matters Consultancy, 2026c).

Prophetic Legitimation: a case every outcome confirms

In this model, Prophetic Legitimation is a self-fulfilling prophecy that justifies present action and is made true by it (Merton, 1948). Its mark is that every outcome confirms it. When deaths rise, the rise proves the right is needed. When deaths fall, the fall is too small to count, and the right is still needed. A case that no figure could weaken is not tested by the figures. It is protected from them. The question for any reworked proposal is simple: what result would show that the right was not working?

The same mark appears in the politics. For any party in opposition, a returning bill is a position every outcome confirms: if it passes, the party delivered a right; if it falls, the vote becomes evidence against those who blocked it. For any government, the reverse holds. Neither outcome is decided by whether the design works for the people it is meant to serve. That is why the tests in this piece sit outside the vote.

Alberta: a model ahead of its evidence

The nearest comparison abroad is Alberta. Its recovery model, set out in May 2026, defines recovery as remaining free of substances and has expanded publicly funded treatment to more than 10,000 spaces. Once compassionate intervention is implemented, family members, health professionals or police could request a treatment order for an adult. The overview does not name harm reduction (Government of Alberta, 2026). A model that defines recovery for the person asks the person to fit the model. In the Scottish Parliament on 29/10/2026, the Minister said there is "no one linear route

to recovery", and the Cabinet Secretary for Health and Care that "we cannot pigeonhole people and their needs into neat treatment boxes" (Scottish Parliament, 2026c).

Supervised consumption in Alberta has closed alongside the model: in Red Deer on 31/03/2025, and in Calgary and Lethbridge on 30/06/2026 (Global News, 2026). A study of the Red Deer closure, cited by the province, found no significant change in emergency department visits, ambulance responses or deaths over 26 weeks, but a rise in hospital admissions. Commentary notes that it could only have detected very large differences, and that people without a provincial health number were excluded (CATIE, 2026; Context Matters Consultancy, 2026d).

None of this shows that Alberta's model has failed. It shows a model adopted, and praised, before evidence on its consequences could exist, and that the people a gate is most likely to harm are the people a study of this kind is least likely to count.

The money

The 2025 Financial Memorandum estimated costs of £29.0 million to £38.5 million in the first year, and £28.6 million to £38.2 million a year after that (Scottish Parliament Information Centre, 2025b). The Scottish Government noted that it might not account for non-clinical costs or costs falling on other services (Scottish Government, 2025a), and the committee majority found it a significant underestimate (Scottish Parliament, 2025b).

What exists. Of the additional £250 million for the National Mission on drug deaths, £100 million was set aside in 2021 to expand residential rehabilitation over five years (Scottish Government, n.d.). What follows will be shaped by the Scottish Budget for 2027-28, due on 03/12/2026 (Scottish Government, 2026a).

What is estimated. A levy on large retailers that sell alcohol has been estimated to raise about £57 million a year, in research commissioned by a public health charity, and a similar supplement ran from 2012 to 2015, raising £95 million (Holyrood, 2024). Until a new decision is made, the levy is an estimate, and setting it against a Financial Memorandum the committee found too low proves little.

What is not collected. Minimum unit pricing raises the price of the cheapest alcohol, but the extra revenue goes to retailers, not to the Government. The Scottish Government's own estimate put that extra revenue at about £17.9 million a year for a 65p minimum, part of it subject to taxes reserved to the United Kingdom Parliament (Scottish Government, 2025b). On 29/10/2026, a Scottish Labour amendment called for the Scottish Government to "recoup the profits from minimum unit pricing from large retailers to fund frontline rehabilitation services", a sum its mover put in the region of £65 million. The Cabinet Secretary for Health and Care replied that the Government "does not receive revenue from minimum unit pricing", and the amendment was not agreed (Scottish Parliament, 2026c; 2026d). The two figures rest on different bases, and neither is money that has been raised.

Who holds which lever. Health funding, non-domestic rates and minimum unit pricing are devolved. Alcohol duty, Value Added Tax, Corporation Tax and the law on controlled drugs are reserved. A funding case that does not say which lever it relies on cannot be costed, because it does not say who would pay.

In this model, the diagnostic economy reaches the money as well as the gate. An annual estimate multiplied across the years produces a large total of money never raised, and an allocation fixed before need is costed decides in advance what will be counted, and so what will be funded. The test is whether the money exists, who holds it, and what it would buy.

Six tests for any right to recovery

Drawn from the committee's findings, the Government's stated position and the 2026 record, these are the questions any reworked proposal can be read against:

- **Who does the gate leave out, whether it is called diagnosis, assessment or need?**
- **Does the right follow the harm as it is now, including stimulants, polydrug use and people not in contact with services?**
- **Is it costed against the services it would draw on, from money that has actually been raised?**
- **Does it measure what changed for people, or count determinations, starts and waits?**
- **When the deadline is missed, who answers: the clinician, the health board or the Minister?**
- **Does it protect the routes that reach people without asking for a diagnosis, including harm reduction and outreach?**

The same tests can be asked of the system Scotland has now.

What to watch for, and when

This piece is dated, and so are the signs it expects. Each can be checked as it happens.

- **03/12/2026, the draft Scottish Budget 2027-28.** What follows the National Mission, and whether funding for alcohol and drug services, including harm reduction, is protected.
- **The Business Bulletin.** Whether a draft proposal for a right to recovery is lodged, and whether it comes with a consultation or a statement of reasons.
- **The words at the gate.** Whether a new proposal speaks of diagnosis, assessment or need, and who would make that decision.
- **The words on the money.** Whether its funding is stated as money raised or money estimated, and which lever it relies on.
- **January 2027, Public Health Scotland's next quarterly report.** Whether treatment starts keep falling and stimulant harm keeps rising.
- **Alberta's monthly figures.** Mortality and emergency data in the months after the June 2026 closures.

When a proposal is published, Context Matters Consultancy will read it against the six tests in this piece, and publish that reading.

What the record does not show

The record does not show that a right to treatment is wrong in principle, or that residential rehabilitation does not work. It does not show what any reworked bill will contain, because none has been published. It does not show the intentions of anyone who supports one. This piece reads a design and a public record. Where the design changes, the reading should change with it.

The standard

A right in law is the strongest promise a parliament can make. It deserves the strongest evidence a debate can offer. From here, Context Matters Consultancy will read every proposal for a right to recovery against the same record. Every figure will be checked against its source, its year and its definition. Every total will be traced to what was raised, not what was imagined. Every design will be read for who it counts and who it leaves at the gate.

This applies to everyone who enters the debate, Context Matters Consultancy included. Our sources are listed below, and any error of fact will be corrected and the correction noted. People who need

treatment are owed that much. A proposal that cannot meet this standard is not ready to become law, however strongly it is felt.

Method and independence

This analysis uses public sources only: Scottish Parliament records, research briefings and the Official Report, Scottish Government publications and freedom of information releases, Public Health Scotland reports, and Government of Alberta material and commentary. Statements labelled “in this model” are the propositions of Context Matters Consultancy, not research findings. No organisation or individual is the subject of this piece; political parties are named only where their own published statements or recorded votes are cited. Context Matters Consultancy is independent: this work is not commissioned, and it receives no external funding. It is paid for from the author’s own professional income. The author also runs EiE Training, which provides professional development courses, and works as a subject matter expert for an online health and social care training provider. EiE Training’s income does not cover its costs, and most Context Matters Consultancy material is free. Neither practice has any role in this piece, and nothing in this debate profits the author.

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