OFFICIAL REPORT
AITHISG OIFIGEIL

Criminal Justice Committee, Health, Social Care and Sport Committee, and Social Justice and Social Security Committee (Joint Meeting)

Wednesday 22 March 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 22 March 2023

CONTENTS

CRIMINAL JUSTICE COMMITTEE
9th Meeting 2023, Session 6

CONVENER

*Natalie Don (Renfrewshire North and West) (SNP) (Social Justice and Social Security Committee)
*Gillian Martin (Aberdeenshire East) (SNP) (Health, Social Care and Sport Committee)
*Audrey Nicoll (Aberdeen South and North Kincardine) (SNP) (Criminal Justice Committee)

DEPUTY CONVENER

*Russell Findlay (West Scotland) (Con) (Criminal Justice Committee)
*Paul O'Kane (West Scotland) (Lab) (Health, Social Care and Sport Committee)
Emma Roddick (Highlands and Islands) (SNP) (Social Justice and Social Security Committee)

COMMITTEE MEMBERS

Jeremy Balfour (Lothian) (Con) (Social Justice and Social Security Committee)
Miles Briggs (Lothian) (Con) (Social Justice and Social Security Committee)
Stephanie Callaghan (Uddingston and Bellshill) (SNP) (Health, Social Care and Sport Committee)
Foysol Choudhury (Lothian) (Lab) (Social Justice and Social Security Committee)
Katy Clark (West Scotland) (Lab) (Criminal Justice Committee)
James Dornan (Glasgow Cathcart) (SNP) (Social Justice and Social Security Committee)
Pam Duncan-Glancy (Glasgow) (Lab) (Social Justice and Social Security Committee)
Jamie Greene (West Scotland) (Con) (Criminal Justice Committee)
Sandesh Gulhane (Glasgow) (Con) (Health, Social Care and Sport Committee)
Emma Harper (South Scotland) (SNP) (Health, Social Care and Sport Committee)
Fulton MacGregor (Coatbridge and Chryston) (SNP) (Criminal Justice Committee)
*Gillian Mackay (Central Scotland) (Green) (Health, Social Care and Sport Committee)
Rona Mackay (Strathkelvin and Bearsden) (SNP) (Criminal Justice Committee)
Paul McLennan (East Lothian) (SNP) (Social Justice and Social Security Committee)
*Pauline McNeill (Glasgow) (Lab) (Criminal Justice Committee)
Alex Rowley (Mid Scotland and Fife) (Lab)
Collette Stevenson (East Kilbride) (SNP) (Criminal Justice Committee)
Paul Sweeney (Glasgow) (Lab) (Health, Social Care and Sport Committee)
David Torrance (Kirkcaldy) (SNP) (Health, Social Care and Sport Committee)
Evelyn Tweed (Stirling) (SNP) (Health, Social Care and Sport Committee)
Tess White (North East Scotland) (Con) (Health, Social Care and Sport Committee)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Angela Constance (Minister for Drugs Policy)
Orlando Heijmer-Mason (Scottish Government)
Kirsten Horsburgh (Scottish Drugs Forum)
Justina Murray (Scottish Families Affected by Alcohol and Drugs)
Liz Nolan (Aberlour Child Care Trust)
Karen Reynolds (Renfrewshire Alcohol and Drug Partnership)

CLERK TO THE COMMITTEE

Alex Bruce (Health, Social Care and Sport Committee)
Stephen Imrie (Criminal Justice Committee)
Claire Menzies (Social Justice and Social Security Committee)

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Criminal Justice Committee

Wednesday 22 March 2023

[The Convener opened the meeting at 10:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the first joint meeting in 2023 of the members of the Criminal Justice Committee, the Health, Social Care and Sport Committee and the Social Justice and Social Security Committee. We will be considering the progress that has been made in implementing the recommendations of the Scottish Drug Deaths Taskforce report.

We are joined by a selection of members from each of the committees, but we have also received apologies from the following members who usually like to join us: Miles Briggs, Foysol Choudhury and Sue Webber. Pauline McNeill is attending the meeting, too; she is joining us online.

Agenda item 1 is a decision on taking business in private. Do members agree to take item 3 in private?

Members *indicated agreement.*

Reducing Drug Deaths in Scotland and Tackling Problem Drug Use

10:01

The Convener: Item 2 is an evidence-taking session on reducing drug deaths in Scotland and tackling problem drug use. I welcome to the meeting our first panel of witnesses: Kirsten Horsburgh, director of operations, Scottish Drugs Forum; Karen Reynolds, service manager, Renfrewshire alcohol and drug recovery service; Liz Nolan, deputy director operations, Aberlour Child Care Trust; and Justina Murray, chief executive officer, Scottish Families Affected by Alcohol and Drugs.

I thank the witnesses for coming in this morning. It would really help to go round everyone in the order in which I have introduced them and for you to provide us with an overview of what your organisations do for your clients. Perhaps you can also outline some of the particular issues to which you would want to draw our attention with regard to people going into recovery.

Kirsten Horsburgh (Scottish Drugs Forum): Thank you very much for the invitation to attend today's meeting. The Scottish Drugs Forum is a national organisation with expertise in drugs policy and drugs-related issues. We have a variety of work programmes, including on workforce development, training and other policy areas; we have an addiction worker training programme; and we do a lot of peer research involving the voices of people with living experience of problematic drug use.

As for the main issues that we want to raise today, we would highlight the implementation of measures such as the medication-assisted treatment standards, the harm reduction interventions that we currently do not have in Scotland but which we should absolutely be focusing on and what the issues are in relation to some of the things that we still need to work on. More than 1,000 people died of a preventable drug death in 2022. That might be a decrease on the 2021 figures, but it is by no means a success story. Things are not moving quickly enough, there is a lot more that we can do and we certainly have some thoughts on where improvements need to be made.

The Convener: I want to press you on your comment about the interventions that we are not currently using. Will you expand on that?

Kirsten Horsburgh: Certainly. It is important to recognise that choice is the key aspect and that all approaches should be available to people. In a

drug deaths crisis, we need to move quickly and provide interventions that are evidence based; however, we also need to create evidence. It is important that options such as abstinence-based residential rehabilitation settings are available, but such approaches are not superior. Harm reduction is critical as an intervention to address some of the issues that we are facing, but, bizarrely, it is often criticised or undermined.

Medication-assisted treatment standards are very welcome and are certainly something that we should be focusing on. However, although there have been improvements, things have been too slow. We are still hearing from people with living experience that they are not getting access to the treatment that they need on the day that they present, and we are still hearing about punitive practices. In fact, in some recent work that we did, we heard about people who had tested positive for benzodiazepines or cocaine having their methadone reduced in response. Such punitive practices still exist, and we certainly want to raise that issue.

On harm reduction approaches that we do not have, it has been seven years since Glasgow made the compelling case for a safer drug consumption facility. We are still pedantically debating that, instead of just getting on with delivering it and dealing with issues as they arise. Those services are a place for connection and for supporting people when their alternative might be injecting in a public place that is undignified and unhygienic.

The Convener: The health case has been made for that, but it is bound up in justice issues and constitutional wrangling about where the powers lie to deliver it.

Kirsten Horsburgh: We believe that that sort of facility could be introduced now, regardless of any changes to the Misuse of Drugs Act 1971, which, in itself, is indefensible. We certainly want such a facility, but we do not want just one. They should be all across Scotland, in places where the alternative for people is injecting somewhere that is unsafe and undignified.

Another issue is drug-checking services. There are currently delays to providing such services, yet they would give people autonomy and information to make informed choices about what substances they use.

There are a number of harm reduction approaches that we do not currently have and that we should be delivering more quickly. We need to make bold, brave and substantial changes that will have a big impact on the outcomes of people's lives so that, when we look back on this time in years to come, we do not regret what we could and should have done.

The Convener: Thank you—that was very helpful. We move to Karen Reynolds.

Karen Reynolds (Renfrewshire Alcohol and Drug Partnership): Thank you very much for having me along today. I am the service manager for an alcohol and drug recovery service. There has been a fair level of criticism of services, and my colleague Kirsten Horsburgh has just spoken about punitive measures and the language that is used in services.

I will talk about the Renfrewshire experience, which might resonate to a greater or lesser extent across the country. In Renfrewshire, we had already been going through a whole-system review of treatment and care services, and then an alcohol and drug commission was established. Both of those were welcome, but it highlighted how much change needed to happen within services in Renfrewshire.

We have had a steep learning curve—we have had a steep hill to climb—but it is safe to say that we are making significant progress in those areas. We are trying to change the language that we use with people who use our services, so we do not want to refer to the punitive measure of "withholding" methadone or other prescriptions. We encourage our staff to consider using different terms in relation to that. They could say, "It might not be safe to dispense your medication today because of a number of factors." At the centre of that is ensuring that the people who use our services see us as being a viable option for when they have a health issue, in the same way as they might reach out to any other care group or profession across the country when they have a different health concern.

Great strides are being made in the Renfrewshire context and, as I said, that resonates across the country. We are attempting to make the best use of our digital capabilities just now, but there are challenges with that and with a number of the information technology systems that we need to record crucial information, which will help in planning and delivering services in the future.

We have put in place so many new initiatives. The Minister for Drugs Policy came along and opened a recovery hub called continuing in recovery changes lives entirely, or CIRCLE. We have seen a big increase in the number of people who attend that service. We had identified a gap and the hub is making an impact.

We are holding conversation cafes with strategic leaders to ensure that the voices of people with lived and living experience are heard. They are not just heard and then ignored; they are part of the progress that we are making in planning and delivery.

The Convener: What service gap is the hub filling? What is the hub doing that was not being done before?

Karen Reynolds: It is about the opportunity to move on from services. If people come into a treatment and care service, they should not just be parked on opioid substitution therapy. That should be a treatment option, but it should not be the final destination. They should be looking at what else they can achieve in their lives. They should be better than well, as opposed to our putting a cap or ceiling on where we think they should be.

CIRCLE is for people with lived and living experience of mental health and addiction. They can go along and partake in a planned programme. More important, they plan that programme and look at the opportunities for where they want to go in the future. What is their recovery plan? It is not something that we will do to them but something that they have identified for themselves.

A raft of partners are involved in CIRCLE, from Recovery Across Mental Health to advocacy and people providing employment opportunities, including barista training. It is an opportunity for people to come together in an non-traditional service environment—it does not look or feel the same—where they are free of stigma and shame, where their families can also access support, and where they can make a plan to allow them to eventually move on from services and take control of their own recovery.

Liz Nolan (Aberlour Child Care Trust): Good morning, and thank you for having us. I work for Aberlour, which many of you will know is Scotland's largest children's charity. We work with 26 local authorities, and with families in family support and community outreach services. We recently opened our mother and child recovery house in Dundee. We have had mother and child recovery houses in the past, but this is our first one in recent times.

We fully support the ambition to reduce drug deaths, and it has been part of the bedrock of all the work that we have done for decades. I have worked for Aberlour for almost 19 years. At times, I find myself repeating what I said 18 years ago about what needs to happen in support of mothers, children and families generally when it comes to drug use.

We believe that—you will have heard us as an organisation speak about this before—to succeed in that ambition, we must truly respond to those with lived and living experiences, and both my colleagues have spoken about that. We need to understand the whole person. We speak about personalised support and a personalised approach to addressing all the issues that surround drug deaths. That includes tackling poverty. A number of those who die from drugs are disproportionately affected by poverty. There are significant issues with mental health and poor housing. To progress and to achieve the ambition, we need to support all that work, support the whole person and take a whole-family, whole-community and whole-system approach to support.

Both of my colleagues have spoken about pathways and partnerships. We need to ensure that we are part of all the pathways to success and that the third sector, voluntary sector, alcohol and drug partnerships colleagues and our statutory partners are working together on that. To progress with that, we need resources.

We know from many of those who are impacted by drug use that there are differences in the provisions that are available locally. If we want to achieve our ambition, we need to ensure that services are available locally and that there is choice. Our residential rehabilitation home supports four mothers and their babies. We hear from mothers that that should not be the last choice for them. We need to ensure that residential rehabilitation is seen as a much earlier option for women. They must be given the choice to come in with their babies and children to get that wraparound nurturing care and support, to allow them the time to find themselves. For many of the mothers that we support, we can address the substance use or whatever it is, but underneath all that, there is real trauma that needs to be addressed, and that needs time.

Another gap in the services that are provided is that many of them are time limited. It takes time to make relationships and for trust to be built with the people whom we serve, and that does not always happen in 12 weeks—certain plans are constrained to 12 weeks. We do not want the service to be time limited.

We want it to be a recovery pathway that people can come back to. We have to allow for mistakes to be made, and we have to allow people the opportunity to come back to us time and time again if that is what is needed. Time and time again, we hear the women and mothers we support who have lost care of their babies say, "If only I had the opportunity to" or "If only a residential rehabilitation service had been available when I lost my baby." We need to stop that from happening. Being brave is part of Aberlour's mission, which means that our strategy has to be brave, so I echo Kirsten's comments about being brave and taking risks.

10:15

One gap that we found at Cowan Grove mother and child recovery house is that, although referrals

are made to the service, professionals fear allowing women to have their babies with them. We provide a nurturing, safe environment in which mothers can be with their babies, and where we can work with and support them to address their trauma, drug use or other substance use. At the same time, we support them to find themselves and learn to parent their babies and children in that safe and nurturing environment. However, we have only one of those houses, although we hope to have another. If we truly want to achieve our ambition, we must ensure that that service is available to all mothers who want to have their babies with them while they recover.

Justina Murray (Scottish Families Affected by Alcohol and Drugs): Good morning. I work with Scottish Families Affected by Alcohol and Drugs, and we support anybody who is concerned about somebody else's alcohol or drug use. We do not work directly with people who are using alcohol or drugs. Instead, we support their parents, partners, siblings, adult children, young adults in the family and pretty much every other relation that you can imagine.

Our work with families is about helping them to have a voice first of all, and to find themselves again in a world where everything that the family does revolves around their loved one's substance abuse. A lot of the work is about helping them to understand the impact of substance use on the family, helping them to look after themselves and changing some of the dynamics in the family around things such as communication and boundary setting. We help families to recover even if their loved one does not.

The big barriers that prevent us from affecting change are around implementation. In Scotland, we are really good at writing down what we want to do—we have all the right things written in legislation, strategies and policies—but we do not implement what we say we will. We are good at saying what we are going to do, but we are not so good at doing what we should be doing. There is not really any accountability in the system. We speak to families about their experiences of trying to support their loved ones every day, and there are still significant failings in treatment, care and support services.

The Convener: Is it the case that it depends on where people are in the country?

Justina Murray: There is definitely still a postcode lottery, but I know that people do not like that phrase.

However, we have good standards written down—we have the medication-assisted treatment standards, for example—but, every day, families tell us stories about those standards not being upheld. This week, we heard from somebody who asked about attending rehab appointments with her son. She was told that her son was not showing enough commitment for rehab, so she asked the worker if there could be a checklist of what needed to be achieved before her son would be considered for rehab because he was already attending fellowship meetings, doing drug tests and attending all of his appointments, and the worker said, "Oh, it doesn't work like that."

Somebody else attended their appointment and saw a poster about medication-assisted treatment standards and same-day access to treatment. When they asked about that, they were told, "We are not doing that here." They replied, "I have just seen a poster in the waiting room." The next time that they were there, the poster had been removed.

There are a lot of examples showing that, although we know what we should be doing, some barriers in culture and attitude are definitely getting in the way. Families find that they are very judged, excluded and ignored by services. Often, they are blamed for their loved one's substance use. We need to do less writing and get more involved on the ground alongside services to understand what is getting in the way of workers doing what we all agree is evidenced best practice.

The Convener: Thank you. I will bring Karen Reynolds back in and then I will go to my colleagues.

Karen Reynolds: I think that it is a fair criticism to say, as Justina Murray did, that there is a postcode lottery in relation to services. I have certainly seen that. I came into Renfrewshire in 2019, having worked in Glasgow, so it was a hop, skip and a jump over the border but there was a stark difference in what was available.

I believe that the staff working in these services are working extremely hard and they come at this from the right place. Staff are worried that they could make things worse for people. If somebody is on opioid substitution therapy and they are stable, and then they enter residential rehab, staff are worried about the risk, and they are worried that the risk could result in death. The training of staff is vital. It is about making sure that they understand why residential rehab should be on the table, why it should be a choice, and why people should be asking about it. They should understand the process of entering into residential rehab.

We are not the judge and jury on residential rehab; we should be the gatekeepers. We need to make sure that people's expectations and the expectations of families are proportionate and it takes a lot of skill to do that. We welcome the opportunity to work alongside the SFAAD, the Scottish recovery consortium and the residential providers. In fact, we will be having a three-day

training event to make sure that workers understand what their roles and responsibilities are and what that assessment process looks like. Crucially, on the third day, we will make sure that our workers get a residential rehab experience. One of the other panel members spoke about feeling as though they are saying the same words over and over. I certainly know that, when I was working in the east end of Glasgow 20 years ago, I had that same experience of wondering, "What does it feel like to be admitted to residential rehab?" We worry about the big things—about their aftercare plan, about the detox—but our service users can be worried about things such as, "Who's going to be feeding my cat?", "Who's going to be paying the bills?" or, "Am I going to be able to have a cigarette when I go?", and those are some of the barriers that sometimes—

The Convener: To come back to what Justina Murray has just said, though, you used the word "gatekeepers"—that sounds like quite a negative term, suggesting that people are closing the gate too firmly when the family and the person involved may see residential rehab as an option.

Karen Reynolds: I apologise if that sounded negative. In fact, I feel that it is the opposite—I mean that we should be opening the gates to say, "Here are all the opportunities that are available," but people need to know about what is available.

The Convener: Justina Murray has just said that, across the country—and she is not pointing at your service, necessarily—the gatekeeping seems to be about saying, "No, we don't do it that way," or, "No, that is not available."

Karen Reynolds: That will be an accurate observation of what is happening on the ground, so we need to make sure that our staff are appropriately trained and that they understand that their role is not about saying, "You're going," or "You're not going," but is about exploring the options and the possibilities and about making sure that people understand what they are about to embark on and that their expectations are managed. It is about understanding that it is a choice that staff absolutely should be advocating for.

The Convener: Thank you. I have let you have a massive amount of time setting out your stall, but I can see my colleagues looking at me and thinking, "When can I get a go?", so I will hand over to Audrey Nicoll.

Audrey Nicoll (Aberdeen South and North Kincardine) (SNP) (Criminal Justice Committee): Thanks very much, convener.

I have some questions about throughcare support on leaving prison. You may be aware that, recently, the Criminal Justice Committee has been considering the Bail and Release from Custody (Scotland) Bill. That process is on-going. The bill seeks, among other things, to reduce our remand population and therefore our overall prison population in Scotland. It also aims to improve the release process from prison, with a particular focus on reintegration.

As part of the submissions for today's meeting, we received a case study from Aberlour on Sarah's story and the support that she has been receiving at Cowan Grove in Dundee. There is reference to a period of time in prison when she was abstinent but, following that, she went into a long period of instability. I am sure that, sadly, that is not unusual. The bail and release bill also places a duty on ministers to publish throughcare standards for both remand and sentenced prisoners so that the level of consistency in support is improved. We have spoken about the postcode lottery across Scotland.

I will start with Justina Murray. Thinking about this as an opportunity to develop good law and robust throughcare provision, from your experience, what do you think throughcare should look like, particularly for women coming out of prison?

Justina Murray: I am glad that you came to me first, because my last job was in community justice, so I am passionate about this issue.

I will return to what I said before—we have to focus on implementation. I would be surprised if there is anything written down in the new legislation that has not been written down somewhere before. There is nothing getting in the way of good throughcare just now other than commitment and accountability. We have some really good national and local throughcare services—I was involved in establishing the Shine Women's Mentoring Service in my previous role. However, there was never enough money put into it. There is sometimes a bit of professional cynicism from statutory services about what the third sector can deliver. However, we know that people need time, as Liz Nolan said—time to establish relationships with workers and time to reconnect with their families and with everything in the community. I would spend more time talking about how the new legislation will be implemented and where accountability is going to lie and I think that it will almost write itself if you speak to people who are on the ground.

Audrey Nicoll: Thank you, Justina. I put the same question to Kirsten Horsburgh.

Kirsten Horsburgh: Before I answer that question, I will say that we need to be cautious that we do not turn the drug deaths crisis into a strategy about how to get everyone drug free. It is important to make sure that we are focusing on all the options.

The broader picture is that we also criminalise and stigmatise people for experiencing drug problems when those problems have emerged from often unimaginable trauma. The majority of people who are coming out of prison probably should not have been in prison in the first place. How we decriminalise people who use drugs in the first place is an issue.

It is such a high-risk period of time for people when they are released from prison. In relation to overdoses, in particular, we know that people are significantly more at risk of dying from a drug-related death in the first few weeks after release. Often, there are issues with the prescribing processes for people leaving prison, and there is a need to ensure that the community link-up is there. We talk about reintegrating people into society when, a lot of the time, people were not fully integrated in the first place.

It is so important that we connect up our services in the community in a much better way around prison release. My background is working in a drug treatment service. Often, we would not know that people were released until they turned up looking for their prescription, or they were released on a Friday and we were not able to get their prescription to them on time, resulting in people having periods over the weekend where they were without a medication that could save their life. There are definitely issues in terms of communication and the linking up with community prescribing services as well as other types of approach.

Audrey Nicoll: Thanks. I will bring in Liz Nolan and Karen Reynolds next. I am very interested in the challenges that women in particular face. Given the new women's unit in Dundee and the way it is supporting women, I will bring in Liz on that point.

10:30

Liz Nolan: On the point about throughcare and aftercare, throughcare has to begin much earlier in the process. We had a significant number of years working in Cornton Vale, so we were aware of the risk that women released from prison would face and took account of that when we looked at the process for our residential rehabilitation service.

We offer a pre and a post-service and provide outreach support to the mothers and their children once they leave us. That can be for up to six months or a year. As I said earlier, we have to provide the opportunity to return—to come back if support is needed—and it not be seen as a failing. We have to provide it for as long as is needed, because everybody's recovery journey will take however long it takes.

When we developed the service, we spoke to mothers. We spoke to people with lived and living experience about what would support them on their recovery journey. They all spoke about the pre-residential support. Getting ready for residential rehabilitation was very important, as were residential support itself and then the post-residential support and reintegration into communities.

Kirsten Horsburgh made a point about that. Some of the families that we support were never integrated into the community in the first place. We have to support them to integrate and then to reintegrate, so to speak. For many, it is not ideal either to return to the communities that they came from. We have to support them to integrate into new communities as well. We have to give them that option and choices.

For us, the issue was ensuring that post-residential support was provided and could work for as long as was needed. Therefore, we are very supportive of a throughcare and aftercare policy, especially for those who are coming out of prison, but it has to start much earlier, not just at the point of release or of somebody coming out of rehabilitation.

Audrey Nicoll: It was evident in the committee's work that the point when someone is walking out of the prison gate is too late for throughcare and aftercare.

Karen Reynolds: I think that everybody can appreciate how daunting it is walking out the gate—I certainly felt that walking in here today. It would be much easier if you had a link already established so that, when you leave residential rehabilitation or prison, you have a person who you have met before and who you were able to talk to about your worries and fears.

In Renfrewshire, along with our colleagues in the Scottish Prison Service, we are trying to focus efforts on ensuring that those pathways are as robust as they can be. It was heartening to hear that the Scottish Prison Service was talking about having a recovery cafe in the prison setting so that people get experience of it and it does not feel like something that they cannot aspire to when they leave. If they have been exposed to a recovery cafe within the Scottish Prison Service, talking about one in the community might not be such a big leap when they are discharged.

It is important to establish those relationships. As Liz Nolan already said, that takes time. It doesnae happen overnight. People need to have confidence and trust in the workers. People sometimes come out of prison to quite difficult situations, such as the housing environment that they left or their benefits. There are lots of different, complex needs that need to be

addressed while we have an opportunity to talk about them in a different environment so that the links are established when they come out. That makes the transition much easier.

Natalie Don (Renfrewshire North and West) (SNP) (Social Justice and Social Security Committee): I will focus on the whole-family approach. We have spoken about the importance of families being involved in rehabilitation and support and we have the Scottish Government commitment to the whole-family approach. How are your services working to ensure that family are involved? In what ways could that be improved or expanded, given further support?

Liz Nolan: Our approach in Aberlour is to work with the whole family. We know that, as Justina Murray said, it is not just the person who is using drugs who is affected; there is a much wider context. We provide individual support to mothers and fathers, and also to the children. Many of the children we work with will have seen a parent die. For a lot of those children and young people, it is the aftermath of a parent's death that we need to address. As an organisation, we want to get in there much earlier and provide that wraparound care for the family and individualised support to each member of the family.

We cannot forget that there are often kinship care arrangements with people such as grandparents and uncles. We need to provide that support to the whole family and we need to tailor it to their needs. As an organisation, we do not go in with a preconceived idea of what support we are going to provide to families. It is very much based on building those relationships, making time for them and working with those people on what would actually provide them with the best means of support.

I have probably said this already, but we cannot forget about poverty and mental health. We need to empower people and provide them with the mechanisms that they need to get out of situations. We can do quite a lot when it comes to family support and being there for families, but a lot of families need practical support when it comes to having enough money to feed their children and pay their bills. Once they have that, they can start to concentrate on their recovery from a traumatic experience and work on their parenting, for example.

We need to get the basics right first. It is about the whole family and about working with everyone individually. It is about working with communities and the whole system. When we talk about systems, we mean that all the partners need to be involved. We have heard several times over that one organisation will say this and another organisation will say that. We need all organisations to be saying the exact same thing, respecting people and understanding them and their needs, then acting accordingly.

Natalie Don: Absolutely. I am glad that you mentioned children, because I wanted to ask what efforts are made to ensure that the views of children are taken into account. Often, children can feel very alone in these situations, and they can have specific thoughts on what can help and what support they or their parents need to get out of a situation.

You touched on poverty and other issues, and their impact on the ability to support people. With regard to the whole-family approach, can you describe how those sorts of issues—poverty, disadvantage, poor physical and mental health—impact on the ability to deal with drug misuse and whether your organisations are taking a joined-up approach to try to make an impact on all those issues at once? I genuinely do not believe that we will fix one thing without fixing the others.

Karen Reynolds: From a service perspective, it is fair to say that we have focused on individuals and taking a whole-family approach. The Renfrewshire community planning partnership's alcohol and drugs commission recommended a review of whole-family support. We are working through those recommendations, and some of the ones that we have implemented have been around making sure that families are supported when a parent has been using substances. We have a family support worker in CIRCLE, the recovery hub, and they will be looking at building those relationships. That will not be in a traditional service sense but in an environment that is conducive to therapeutic work, such as a cooking group or a homework club, where you can start to hear about young people's experiences and how they felt when mum or dad were using substances.

The youth health and wellbeing service is another initiative that was developed through the alcohol and drugs commission. It is about early intervention before children have to come to the attention of statutory services or have to use services themselves. It is in the Lagoon leisure centre, which is an environment that does not have a traditional service feel. Young people go in and talk about things that are relevant to them, such as bullying and online cyberbullying, low-level anxiety and alcohol and drug awareness.

Some steps have been taken, but there are still some steps that we need to take to address that issue in particular. We are working through recommendations from that review now.

The Convener: I am conscious of the fact that a lot of members want to come in, and we have very limited time. I am sorry about that.

Paul O'Kane (West Scotland) (Lab) (Health, Social Care and Sport Committee): Good morning. I will continue the conversation about the interventions, programmes and projects that are run, particularly in the third sector. I am particularly interested in sustainability, as there is clearly a funding focus. One of the key recommendations of the national mission is funding that is fit for the public health emergency.

I will direct my question at Liz Nolan. How sustainable does Aberlour Child Care Trust feel? How sustainable is its ability to continue services? I know that, in 2015, residential rehabilitation services were withdrawn in the Glasgow area, for example. Obviously, there is a huge focus on the issue now, but we need to sustain that, because the danger is projectitis. I think that everyone would recognise that. Will you comment on that?

Liz Nolan: You are absolutely right. We had a service in Glasgow in 2015, but it closed. We were very concerned about that at the time.

We advocate long-term funding. I have spoken about what we need. Families are coming forward and asking for help. We have to be able to provide that help. In order to do that, we need services throughout the country, and we need our statutory partners to be funded appropriately. The third sector needs to be funded appropriately in order to sustain services.

I have spoken about relationships and time. Year-on-year funding is no good when it comes to building relationships. We need to know, and families need to know, that services will be there for the long term as long as families need them. We will always seek long-term funding that is outcomes based. When we talk about funding, we have to be able to evidence that we are meeting the needs of those whom we serve and the people whom we work for, but we need long-term funding. We have had services for which we have had short-term funding. By the time we have taken three months to recruit and provided six months' worth of support, we have had to stop taking referrals.

I refer to a point that was raised earlier. There is a real fear among, in particular, the mothers whom we work with that, if they come forward and ask for support, their babies will be removed. We have to be able to respond to that. Again, that takes time. We have to build up relationships and trust. That does not happen when we are not there for the long term, because those relationships take time.

I think that we are all worried about sustainability. We are all signed up to, and we all support, the mission. We all want to do what is right and what is best but, in order to do that, funding needs to be made available.

I have spoken about the Cowan Grove mother and child recovery house, which we have just opened. We are due to open another house later this year. However, they will be full pretty soon, and there will be other mothers and their babies who deserve to have those opportunities. In order to provide those opportunities, we need more small local mother and child recovery houses where people need them, and they should be available when people need them.

Justina Murray mentioned a poster. Support was wanted, but the poster was removed because the service was not there any more. If families come to us requesting support, they want to recover, and we must have the services available. Currently, we do not. Justina Murray made a point about there being a postcode lottery. That continues to this day. We do not have equitable provision of the services that are needed across Scotland, and that has to be provided.

Paul O'Kane: That is a very helpful contribution.

Can Karen Reynolds give the ADP point of view? Obviously, a line of funding has been sustained, but I wonder about the knock-on effects of local authority budgets and, indeed, other areas of work to which we would often see signposting. As those services decline, is that a challenge?

10:45

Karen Reynolds: There is a challenge with funding, how it is disseminated and how long it lasts. I echo what Liz Nolan said about sustainability. When we speak to service users, the most telling thing that we hear is, "This is great. Will it be here in six months?" We are always managing expectations.

We have seen in a two-year period one person going into residential rehab compared with five in the past six months. People's expectations will increase. They will quite rightly make demands of our services, and we need to take a consistent and sustainable approach regardless of other pressures. We need to make sure that the alcohol and drug recovery services, the third sector and all the partners are funded appropriately, that funding is sustained and that, regardless of where someone goes in the country, they will get the same service and it will still be there in six months.

The Convener: Pauline McNeill has a question on a similar theme.

Pauline McNeill (Glasgow) (Lab) (Criminal Justice Committee): Thank you for your presentation, which was really informative.

Reading through all the information that we have been given, we can see that the plan and law reform are needed and that we have additional Government funding of £50 million a year. How

wisely is that money being spent or being planned to be spent?

There are a lot of priorities. One of the key points for me is that men are by far the biggest cohort of people who are losing their lives. Is the money being directed in the right way? Can we see where it is being spent? Are you, as the experts in the field, clear that the £50 million is being spent in the right places?

Justina Murray: I love being a third sector chief executive officer, but probably the most soul-destroying part of my job is constantly chasing money, as any third sector organisation will say.

On drug policy, there is not a lack of funding in the system but, as Pauline McNeill alluded to, there is a lack of transparency. I would be the first to critique ADPs, as Karen Reynolds and others know, but it has been really challenging for them to have lots of demands thrown at them all of a sudden without them necessarily having the time to build up capacity. We have little pockets of money going to whole families, for MAT standards and for residential rehab, but we are also saying that we need to take a holistic approach to whole families—children, young people and adults—and look at all kinds of different treatment pathways.

We also need to recognise that it is about harm, not use. It does not matter if people are using alcohol and drugs—we need to make sure that we invest where there is harm.

There is tremendous pressure to deliver quickly without always taking the time to think through where the money would best be spent. I would say this because I work for a third sector organisation, but it has been difficult for the third sector in this scenario. The majority of funding goes to the statutory sector and we have not really seen the benefit of all that investment yet. It would have been a different approach to think about what the third sector could deliver while working in partnership, as we do every day.

The Convener: Let us get the ADP perspective.

Karen Reynolds: As Justina Murray said, it has been difficult. Who would have thought that getting money would have been such a challenge? It has been because of the different funding streams and eligibility criteria. We do not have the luxury of closing up shop to rearrange, train staff, plan, design and evaluate whether something is working. All of that has been a challenge. Even working alongside our third sector colleagues comes with a commissioning process. Knowing how long the funding will last helps us to decide whether to go out to tender. Is the award going to be direct?

All that must be taken into account in a very short time when, again, we are trying to show the public that the services are sustainable and viable options. However, in order to do that, we need time to plan and evaluate—to see what is working and what is not working—so that we do not make the same mistakes.

MIST—the medication-assisted treatment standards implementation support team—is a peripatetic team that goes around helping us to overcome any obstacles. It also shares the good practice that there is nationally. That has been really useful, and I would welcome that type of forum in the future, because we do not want to make mistakes that have already been made. If someone has tried something and it has not worked, why would we go down the same route? We can learn from that. It is also about sharing good practice. People can say, “Here’s what we’ve done. That could work in your area, and here’s how we overcame any obstacles.”

Pauline McNeill: I feel that the committee needs help in drilling down into that. Karen Reynolds talked about where the money would best be spent. Justina Murray said that there is not a shortage of money. Can you help the committee with that? From what people are saying, there does not seem to be a clear picture of where the money should be spent to get the results that you want.

Lots of pleas have been made about the importance of residential rehabilitation and connected services. Is that an important starting point to fix this? As a legislator and a committee member, I am struggling to understand what it is that you want to say to me about that. Where should we push Angela Constance to get results with the money that you say is available?

The Convener: Is that question for Karen Reynolds?

Pauline McNeill: It is for Karen Reynolds and Justina Murray, if that is okay.

Justina Murray: I do not mind jumping in on that. We have clear plans for what needs to happen around alcohol and drugs. There are strategies in place, but funding is often still provided annually. Even if there is indicative funding for future years, the goalposts often shift as we go through the year with regard to what is supposed to be funded.

Karen Reynolds mentioned the fact that funding has gone largely through health boards to alcohol and drug partnerships to distribute. We then get tangled up in all kinds of procurement and commissioning regulations around what could go to the third sector, for example. The third sector has largely had to compete for funding through the national drugs mission, through Corra funding and so on, which is a competitive process, whereas local alcohol and drug partnerships and local

statutory services are gifted, if you like, their allocation, so it is not a level playing field to start with.

We work in partnership across the sectors, and that needs to continue, but it has been difficult to keep reacting to these shifting sands as money has come out the door.

Karen Reynolds: I echo what Justina Murray has said. It is good to hear that the third sector and the ADPs are saying many of the same things. There are strategies in place, and the people who work in the services have a real sense of what works, what does not work and whom they need to work with in order to achieve better outcomes. The issue is the pace at which the funding comes through and the pace at which we need to change. That does not always chime with, for example, the recruitment process, the commissioning process and staff training.

As I said, we need to bring the public along with us. It looks great that everything is changing just now and they might see pockets of that change, but they need to know that the services are sustainable and will be there in the future. Staff need to know that, too. Some are on temporary contracts, and they are affected by the cost of living. They want to know that their employment is secure so that they can then invest in the sector.

We have been very fortunate in that staff have a real interest in this. People come into this field because they want to make a difference, but we need to ensure that they are being well supported and well trained. That includes people with lived experience, too. We need to ensure that, when they come into the sector, they are supported in the right way. How does the national health service absence management policy apply to people with lived experience when they come into the service? All that takes time. There are clear strategies in place, but we need a bit more planning and thought. Monitoring and evaluation are really important.

Kirsten Horsburgh: I will give a very quick response, and I will touch on the points that others have made, too. We definitely see the workforce as a major issue in all the things that we want to deliver. That touches on the points that were made about it being quite frustrating to see small tests of change not being sustainable.

There are major issues in recruitment into the sector, partly for the reasons that Karen Reynolds mentioned about the quality of the services that people are able to provide when they are at overcapacity and are not able to deliver the interventions that they want to deliver. There needs to be huge investment in the workforce. We have seen people receive funding for posts but not be able to fill those posts because they are short term. There is definitely a need for longevity of funding to bolster the workforce so that it can deliver what it wants to deliver.

We also need to properly finance all the interventions that we do not currently have, which I mentioned earlier. If we truly want to achieve choice—we have talked about heroin-assisted treatment being available as an option—we need to invest massively in such interventions across the country. Lots of different service provision should be available so that people have a true choice. We need to provide more investment in that.

I disagree that there is plenty of money. There will always be a need for additional investment in the sector, because people are dying in mass numbers every year, and they do not deserve mediocre responses to this crisis. We need to invest everything that we can to avoid those preventable deaths.

Gillian Mackay (Central Scotland) (Green) (Health, Social Care and Sport Committee): On this committee, and on many committees in the Parliament, we agree that lived and living experience should be at the heart of every service that we design but, given the intensity of being involved in this work and the long-term nature of service change and evaluation, how can we ensure that people with either lived experience through loved ones—which Justina Murray spoke about—or those who have previous or current substance use issues are able to engage in the work meaningfully and in a way that does not cause them further harm?

Justina Murray: We need to engage with people all of the time. We tend to badge lived and living experience as different things than what they are, but we support families that are affected by someone else's alcohol or drug use, and you probably do not need to look outwith this room to find people who are in that category; lots of people in Scotland are in that situation. It is not always about them wearing a badge or standing on a platform.

It is not very helpful to put someone who has lived experience and is in recovery on an alcohol and drug partnership committee if their day-to-day engagement with the service is disrespectful, judgmental and stigmatising. It could be said that one might change the other, but I think that it is about us engaging with people on a human level all of the time and respecting what they bring to the table.

Families do not always have a lot of time. They are pretty much run ragged just trying to put one foot in front of the other, and they are not always going to have time to take part in consultation responses or to join committees and groups. That

is why we need to engage with people in a meaningful way all of the time, ensure that we capture their experiences and respond to what they need.

Kirsten Horsburgh: Those are great points. Of course, it is important to hear the views of family members and people with lived experience, but not at the expense of people who are currently experiencing drug problems.

At SDF, we try hard to ensure that those people are represented in discussions. We have a great programme of work at the moment to introduce living experience engagement groups across the country. Those provide a space for people to come along weekly to air what is important to them, and we can feed that back to ADPs and local providers for them.

We are also involved in a lot of peer research. It is essential that we get the views of people who are trying to access services or who have current service experience. We have been doing a lot of work on capturing experiential data for the medication assisted treatment standards, and that work gets to the reality of the situation. Unfortunately, we have found that some of the experiential data recording would make it quite easy to fudge some of the experiences, so it is absolutely crucial that we get the reality of the situation, because, ultimately, that is how services will improve. They will not improve by hearing flowery stories about how a particular part of the service has improved; they will improve by hearing the reality for everyone and not just hearing from the people for whom the service has worked.

11:00

Liz Nolan: I agree with what Justina Murray has said: it is about relationships, understanding people, giving them time and having a flexible approach. Some of the families that we work with want to give their views individually and some want to do so in groups. We can set up forums and really support them, because they are living and sharing their experiences, which are personal to them. It is also about understanding that those personal experiences are theirs and not somebody else's, so we must ensure that we get a broad range of experiences. We often hear from families that they tell their story, tell it again and then repeat it somebody else, but they do not get feedback. What they are not seeing—Justina spoke about this earlier on—is that we repeat the stories. We know that families want to see that put into action now.

On the question about where we see the funding—where should it go—we have to be brave. We have to disinvest in what is not working for families and invest in what really supports them. That would provide some sustainability for services, because we would be investing in what we know actually works and provides positive outcomes for the families that we support.

It is really important that, if families tell their story, they are given feedback and listened to, and that they feel that their voices count.

Gillian Mackay: That is great. I want to touch on something that Karen Reynolds said earlier about people's expectations for the end of the journey. For the Parliament, the aim of a lot of these pieces of work is to reduce the number of drug deaths, but, from your service users' point of view, what are the other measures of success that we should be looking at? After all, what one of your service users might consider a success might not be something that we have picked up on in different threads of our work. If we are missing something, or if there is a piece of success that we should be measuring from your service users' point of view, what would that be?

Liz Nolan: I will give you live examples. We have an intensive perinatal service through which we work with women during the perinatal period from conception to when their baby is a one-year-old. We are currently working with 21 women, which we have been doing over the past two years. Of those 21 women, 17 have managed to keep their babies with them, but 11 of the 21 women have previously lost babies to the care system.

The support that they are being provided with is whole-family support; it uses a flexible approach, it is relationship based and it really gets in and about what is needed practically to support them with their substance use and with being a parent. Many of the women who we support—it is the same situation in Cowan Grove—have had multiple babies removed from their care because of their drug use. For the 17 out of 21 women who, without the service, would potentially have lost their babies, that is an outcome. The support that we provided was practical, working with the women to reduce their drug use or the harm of their drug use, so that they could keep their babies.

I worked with one of those women 17 years ago, when she lost three of her babies. However, I met her a couple of weeks ago and her baby, who is six months old, has come off the child protection register. She is drug free, she is supporting other parents and she has a beautiful baby. She continues to need to work through the trauma and experiences of the loss of her babies. That is another gap in the provision: we need to be mindful that the parents who have lost their babies need to continue to have support. They are retraumatised time and time again. When we talk about a whole-family support approach, we must

remember that they, too, need significant amounts of support.

Kirsten Horsburgh: I want to quickly note that Gillian Mackay is right that outcomes are different for different people—and rightly so. The most effective intervention for someone is the intervention that they want at that particular time. This is surely all about quality of life and whether people are healthy and happy. The only person who can determine their quality of life is the person who is living that life. That is why it means many different things for different people.

Karen Reynolds: As panel members have already said, the measure of success is different for different people but I think that, in services, we get caught up in measuring how many people are in treatment, how many people are on methadone, or how many people have not entered residential rehab. Our mobile harm reduction rapid response team, which is in a mobile van, is about reaching people who are not in our service, who potentially would never have come into our service. We need to start monitoring and evaluating that—how many contacts are we having? Do they result in people accessing treatment? However, somebody coming along to the mobile van and talking to one of the team about picking up new needles or potentially getting a dried blood spot test or thinking about going into treatment as an option would be a measurable outcome for us as well.

The Convener: Thank you. Russell Findlay has the next question.

Russell Findlay (West Scotland) (Con) (Criminal Justice Committee): I will begin by apologising for my colleague Sue Webber, who cannot be here today. She was keen to be here but she has a clash with the Education, Children and Young People Committee, which she also sits on. I think that she has asked whether this joint committee might meet on another day in future, so we will see whether that transpires.

As often happens, you come to these meetings with a number of questions and then hear the evidence and the benefit—or perhaps it is not a benefit—of being last is that you have way more questions than you have time to ask. However, I would like to pick up on something that Kirsten Horsburgh referred to at the outset, and that is the drug consumption rooms issue.

Kirsten, you said something along the lines of a case having been made for those rooms seven years ago in Glasgow. You also said that these rooms could be introduced now, as far as the legal issues are concerned.

The Scottish Drug Deaths Taskforce called for those rooms last July in its final report. Yet, in January of this year, the Criminal Justice Committee, of which Audrey Nicoll and I are members, received a letter from the Crown Office that essentially says that the Crown Office is still in communication with Police Scotland about the issue. We know that there was opposition to those rooms from Police Scotland. However, what struck me when the issue arose at the Criminal Justice Committee was some surprise that they were still just talking about it if there is no legal blockage and it is purely about practicalities.

Do you understand why there are still concerns about the ability to introduce drug consumption rooms? Do you think that it will happen? If there is a logjam involving the police and the Crown, is there something that the Scottish Government can do to break that logjam?

Kirsten Horsburgh: Police Scotland has been supportive of the introduction of drug consumption rooms but it wants clear guidance about what its role will be when those rooms are established. That is an important distinction to make.

The discussions that I am aware of have been about trying to establish a service that both parties feel is acceptable under the current guidance from the Misuse of Drugs Act 1971 and also about what can be delivered within a Scottish context.

We firmly believe that the Lord Advocate has a role to play in relation to being able to provide these services, by providing the necessary prosecution waivers if they are required for the service to operate. I think that we will get them; I think that we should have had them well before now. We are not trying to reinvent the wheel here—more than a hundred of these services exist all over the world and they have been around since the 1980s. We have a good evidence base and we should just be getting on with it.

I think that the questions on the part of the Crown and the police can only be addressed once the service is in operation. That is what I mean about just getting on with it and delivering it. Tweaks will undoubtedly be required to the service as it progresses, as was the case when needle exchanges were first introduced—there were issues around the introduction of those and they have developed over time to become what they are now.

Russell Findlay: Another thing about this letter from the Crown Office is that there is no indication in that as to timescale—there is no sense of urgency. Going back to the original question, should the Scottish Government intervene? What would you suggest?

Kirsten Horsburgh: Absolutely, there is a need to really press on this issue. There was a call for these facilities in the first place in Glasgow because of the HIV epidemic. There is still an issue with HIV and the Glasgow situation has been described as the most compelling case in

Europe for a drug consumption facility. There is a clear need to move fast to get it introduced this year.

Russell Findlay: Justina Murray, some of your written evidence was similar to what you have said—perhaps even stronger. One part that jumped out at me was:

> "Families repeatedly find there is no accountability in the system – no-one is accountable for repeated service and system failures, and their concerns are just dismissed",

and that is on top of the implementation gap, which is a neat way of describing the difference between all the millions of words saying what we should be doing and what is actually happening. This might be a bit of a broad question, but why is there a gap? Is it about money or inflexibility? What can be done to improve delivery?

Justina Murray: To be honest, we do not really know, but that is what we need to focus on. We normally say, "We need another plan. We need another strategy. We need another commission." but we really need to focus on what is happening on the ground that gets in the way.

Families tell us about being allowed to attend appointments with their loved ones so there is that sort of gatekeeping. There is a withholding of information and a refusal to implement agreed standards. There is no transparency. There is really just a lack of a treatment plan or pathway in services. If it was another chronic or long-term health condition such as cancer, the family would be involved in conversations and there would be a plan or a pathway. We would want to try something and, if it did not work, we would try something else.

We seem to have a disconnect in Scotland. We look at drug policy through a public health lens and we are proud of that, but the way in which we implement that policy is still quite punitive and judgmental; some of that criminal justice lens still lurks around. If we truly want to take a public health approach, it means shifting the culture and attitudes within services.

We can see where change has been made. As Karen Reynolds and I were saying before this morning's meeting, services can change. People can change the way that they deliver them. We need to give workers permission to work differently. I often say that I do not need to phone my staff in the morning to tell them to be nice to families—it is just what we do. What on earth would make somebody go to their work and treat somebody in a disrespectful and judgmental way? We need everybody to love their job and, if they do not, we need to understand what is getting in the way of that.

The Convener: We have a few minutes left and I promised Audrey Nicoll that, in that case, she could come in to talk about drug law.

Audrey Nicoll: Thanks, convener, although much of what I wanted to cover has been covered by Russell Findlay.

We still work within the context of 50-year-old misuse of drugs legislation that might have been fit for purpose back in 1971 but most people agree is less relevant now, particularly in Scotland, where we are looking to develop a public health approach. A justice approach to drug use and possession is appropriate at the higher end where it is more about supply and possession, but we are talking only about possession. I fail to see the benefit of criminalising an individual who, because of their circumstances, experience and environment, is living with a drug harm problem. They would not choose that but circumstances have taken them to that place.

It might be helpful to open that question up to the other witnesses. Kirsten Horsburgh responded to the questions that Russell Findlay asked, but do Liz Nolan or Karen Reynolds have any comments about drug law in the context of what we are trying to achieve in Scotland?

Liz Nolan: I fully agree that the law is extremely outdated. From our perspective, where there is criminalisation for the possession of drugs, we have seen mothers imprisoned, for example, which has meant that their children have gone into care. The impact of that loss and breakup of family is significant and long-lasting. We would therefore support a complete overhaul of the drug law from 1971.

11:15

Karen Reynolds: I echo what my colleagues have said. The law is outdated. I say again that we need to make services into viable options. We have heard from people who think that being arrested and going into prison is more attractive than attending services or living in the environments that they live in just now. We need to turn that on its head and make what is happening in communities the more attractive option.

Mr Findlay talked about scrutiny, monitoring and evaluation of services. We are currently involved in making sure that we have all the evidence to show that we are implementing the MAT standards. That is a level of scrutiny that has not necessarily existed before, but it is not an easy task. There are three different strands of evidence that need to be submitted—process, numerical and experiential evidence—to show that we are meeting 10 MAT standards. The key is to make sure that we maintain those standards and that we

are evaluated against the benchmark that we have already set.

The Convener: I thank all of you for your attendance this morning and for everything that you have said. It has been extremely helpful and powerful.

I suspend the meeting to allow the witnesses to leave.

11:16

Meeting suspended.

11:22

On resuming—

The Convener: I welcome our second panel of witnesses. Angela Constance, the Minister for Drugs Policy, is accompanied by Orlando Heijmer-Mason, deputy director for drugs policy, and Maggie Page, unit head for the national mission on drugs, both from the Scottish Government.

We will move straight to questions. I start with not so much a question, but an invitation to the minister to give an update on the progress that has been made towards meeting the task force's recommendations.

The Minister for Drugs Policy (Angela Constance): I appreciate the opportunity to join the meeting and I commend the three committees that are involved for joining forces and ensuring that there is joined-up scrutiny of our national mission, which aims to be joined up throughout every tier of Government and across Government.

Members will be aware that our work in response to the task force pre-dates the publication of its vital final recommendations. Work on the implementation of MAT standards and on our national naloxone programme has preceded the task force's final report. Committee members will also be aware that, in January, we published a full response to the task force's 20 recommendations and 139 action points. As well as holding a debate in Parliament, I shared our response to the 139 action points with the relevant committees. Since then, we have endeavoured to keep the committees and Parliament fully informed about where we are.

Colleagues, particularly those on the Criminal Justice Committee, have been following the Bail and Release from Custody (Scotland) Bill since January. That bill is of particular interest to me because it will put an end to prisoners being released on Fridays or before a public holiday, which will improve standards of throughcare. The bill will also change how we use bail.

Members will recall that I gave an update yesterday on the Government's response to the rapid review of better ways to join up healthcare for people with co-occuring mental health and substance use conditions. As you would expect, I have met the Minister for Transport to work through some of the finer detail of the pilot of concessionary travel. We also continue to be very focused on the implementation of MAT standards. The committee will be well aware of the ministerial direction on that and of the monthly and quarterly reporting that different areas are subject to. I will update Parliament on that again in June.

We continue to make progress on access to residential rehabilitation, which is another pillar of the national mission. The monitoring report that Public Health Scotland published yesterday shows that, in the quarter from October to December last year, we had 228 statutorily funded residential rehab placements, which is the highest-ever number. That means that, over the lifetime of the national mission, we have funded more than 1,100 residential rehabilitation placements.

Our national mission reporting arrangements underlie all of that, and members will be aware of the outcome framework that we are working to. We also publish an annual report each year. The most recent one was published in August last year and there will be a further report later this year.

The Convener: I am not sure whether you heard the evidence from the previous panel, but I will assume that you did not. Some of the evidence from stakeholders suggests that we still have something of a postcode lottery for services and MAT standards. We heard from some witnesses that people and families often do not get the support that they think they might be entitled to, which might be contrary to the direction that you, as the minister, have set out. How do you bridge those gaps? How do you respond to the fact that, in some areas, things are not working as you would expect them to?

Angela Constance: That is fundamental to the work that I lead on MAT standards, residential rehabilitation and improving support for families. Accountability and scrutiny are important at every level. The Government must model that to demonstrate that we are accountable and will engage constructively with any critique or performance review, and that we expect to find that throughout the system.

We must use every lever that we have available to us, and some of that will involve more regular reporting. We have quarterly reporting of residential rehabilitation placements that details area by area where the placements are being funded, and we can see a general improvement across the country. Similarly, on MAT standards, some areas are subject to monthly reporting and

others are subject to quarterly reporting. It is also about investment and our following that investment very closely. There is a belt-and-braces approach. There is much more rigorous scrutiny and regular reporting, but that is coupled with additional investment.

11:30

There is a hands-on approach. Given the nature of the portfolio, my officials are in regular engagement with each and every area, and I spend a lot of my time directly engaging with families and local services. I will give the example of the work of the medication-assisted treatment standards implementation support team. We are being pretty hands-on with that. It needs to implement and ensure that we have an acceptable standard of delivery irrespective of where an individual or a family resides, notwithstanding that some areas will need to do things a little differently.

On our investment in family-inclusive practice and the whole-family approach, money has been directed to ADPs, but money has also gone to third sector organisations via the Corra Foundation. Through our multi-agency expert delivery group, we are doing an audit of how ADPs have utilised that uplift. We are currently working through that.

The Convener: I imagine that colleagues will want to reference some of that in their lines of questioning.

Audrey Nicoll: Good morning. In your opening remarks, minister, you mentioned the Bail and Release from Custody (Scotland) Bill, which the Criminal Justice Committee is considering. As you said, a key part of that bill is about improving the process of release from prison. I know that removing barriers to people accessing services and treatment on release from prison is dealt with in some detail in the cross-Government response to the task force's report.

In the Bail and Release from Custody (Scotland) Bill, there is a duty on ministers to publish throughcare standards for remand and sentenced prisoners so that there will be an improvement in the consistency of throughcare support. In the context of drug harm, the work that you are doing in response to the task force's report, and the vulnerability that individuals face at the point of release, when they have perhaps come from a period of abstinence but are vulnerable to going back into an environment that will place them at risk of harm from drug use, will you give some commentary on what those throughcare standards should look like?

Angela Constance: That is a very important question. A range of colleagues across the Government have a direct interest in throughcare standards. You can well understand that, although they may be primarily a matter for justice ministers, there has to be an interest from housing ministers and other ministers who are focused on community services.

From my perspective, aftercare is one of the key issues. When people are released from custody, there is a period of transition, and any period of transition comes with risks. We know from all the evidence that, for some people, there can be a heightened risk of overdose when they are released from prison. That is why the peer-to-peer work that we are funding—which will be extended into all prisons—in respect of naloxone, for example, is so important.

I should perhaps have mentioned in my general update that we published on Monday our updated pathway from prison to rehab. I am a big advocate of prison to rehab. Rehab is not for everyone, but it should be there as an option for everyone for whom it is considered appropriate. We needed to do further work to ensure that both prison staff and people who are leaving custody are better prepared for what to expect when someone moves from a custodial setting into rehab.

It is about the continuity of connections with a community, even if the person been removed from that community. Planning for someone's release should not be left to the last minute. I have a great personal interest in this area given that I have been a prison social worker in three establishments and my last post, prior to being elected to the Scottish Parliament, was at the state hospital. As with all planning, it needs to start not just early but at the point at which people start their sentences.

Audrey Nicoll: In the Criminal Justice Committee's evidence-taking sessions, we have discussed release from prison, and particularly the challenges with unplanned release from remand. That can create difficulties for individuals whose release has not been anticipated but who nonetheless walk out of court.

How can we ensure that those people are supported, given that the support that they require will not necessarily look the same as the support for people who are released from a completed sentence? How do we ensure that that point of vulnerability does not take them back into a problematic situation where services and key worker support are not in place? I am interested in your views on that, because it is something that the committee has grappled with.

Angela Constance: I can well understand why the committee has grappled with that, because unplanned discharges from court with little or no support elevate risk. The baseline approach is that

we need to reform and change the whole system. That begs the question of whether remand should be used less so that we can get better bail arrangements in place. That would help to prevent those unplanned discharges from court.

Some interesting work is being done around the country in this area. In Edinburgh, there is a really interesting nursing team that does crucial court work. I met it some time ago. Again, that is all about continuity of treatment for people with substance use difficulties.

I absolutely agree that we could reduce the number of unplanned discharges from court by reforming the use of bail—where that is appropriate, obviously, because public protection is always paramount—and reducing the number of people who are on remand. It really has to be about every part of the system—whether it is justice, health or social work—being in a position to respond to needs much more quickly and swiftly. That goes back to the importance of the throughcare standards.

Natalie Don: Good morning, minister. We have spoken about the importance of families being involved in rehabilitation and support, Obviously, the minister touched on that in her opening statement, but I would be grateful if she could outline how the whole-family approach is being developed, who is or will be involved in its development and how local organisations will be supported to act on that.

Angela Constance: Where we need a cultural shift or a shift in mindset is that, first and foremost, we need to see families as partners because, at the end of the day, they often know their loved one better than any service provider does. As well as working to support the loved one who is affected by substance use, we must ensure that individuals within families receive support for all their needs. Families have expertise that we really need to tap into, respond to and listen to. That is the raison d'être of the family-inclusive practice that is at the heart of the whole-family approach. We have attached funding amounting to £6.5 million a year to that via ADPs and the Corra Foundation. There is continuity of that funding.

That is why the audit is really important. Although it might not make me universally popular, I am asking for more information than ever before about what people are doing with Scottish Government funding, because it is important in improving consistency and accountability. I am accountable to Parliament and local services and local politicians are accountable to their communities. We are currently working through that audit.

As well as bearing down and scrutinising what is or is not happening, we are, through the multidisciplinary expert group, trying to provide practical, hands-on support.

Natalie Don: We know that families affected by substance misuse are often dealing with other issues such as poverty, poor housing or poor health. It would be fair to say that recovery is far more difficult when those issues are also present. How do you see the whole-family approach having a positive impact on those other areas?

Angela Constance: That is why we should not look at the whole-family approach in isolation. It is why our response to the task force came from Government as a whole, although individual work to tackle poverty and inequality is being led by Shona Robison and there is work to reform our justice system and an investment in housing. All those things are connected.

The idea that drug policy must not be seen in isolation lies at the heart of the national mission. The social determinants of good or poor health must be tackled. The cross-Government approach means that we are making commitments not just for this year but for future years.

Natalie Don: I have one final question. We know that drug-related deaths among women are increasing. The evidence from the previous panel was that women are at greater risk during the perinatal period, partly because they are afraid of seeking help because of the possible consequences. The evidence submitted by Aberlour, and what we have heard this morning, touched on the difference that mother and child recovery houses, such as Cowan Grove in Dundee, make to women's lives. Although such houses may not be appropriate for every woman, how do we ensure that services such as those are available to all pregnant women who might require them? On a wider note, what more can be done to ensure a gender-informed approach to tackling drug misuse?

Angela Constance: Our equalities framework has six outcomes and six cross-cutting themes, one of which is recognising equality. That includes the particular needs of women but is also about how we can better reach the black and minority ethnic community.

As well as the Aberlour work that you outlined, and the work of Phoenix Futures at Harper house, which I will touch on in a moment, it is also really important to look at the perinatal mental health work that Kevin Stewart and Clare Haughey are involved in. There is substantial investment in refreshing and updating that work to support women who have mental health issues or use drugs. Much work has been done to change generic, universal and specific health services.

11:45

I had the great pleasure of visiting the first of Aberlour's mother and child recovery houses in Dundee a month or so ago. It was quite an experience. The initiative is part of our work to keep the Promise. As a former social worker, I know the impact of families not being kept together.

We also know that, although significantly more men than women die, the rate of increase among women has been faster in recent years. Ten or 15 years ago, the ratio of deaths between men and women was wider; now, it has narrowed. To take, as you suggest, a gender-informed approach, there are many reasons for that, but at the heart of it are the trauma and grief that women experience when they lose their children. We need to work harder to keep families together—to keep mothers with their babies.

Aberlour will open another mother and child recovery house in the central belt. I await an update on that and I hope that we will have more to say on it in the not too distant future.

The work that Phoenix Futures is doing in Harper house will also be revolutionary. It is a national family service for mums, dads and children aged up to 11. Not just as a minister but as an MSP, I take very seriously my obligations to keep the Promise. Families should not be parted due to a lack of support and a lack of service. The evaluation on Harper house will inform us all for many years to come.

Paul O'Kane: Good morning, minister. We had a discussion with the previous panel about progress on safe consumption facilities. We heard from a number of the stakeholders that were represented about the importance of pace on that work.

At the beginning of the year, we had a communication from the Crown Agent, which said, essentially, that there had been back and forth, if you like, between Police Scotland and the Crown Office and Procurator Fiscal Service. You wrote to me on 20 February—about a month ago—setting out the fact that there was no timescale, because of the complexities involved. However, I think that you also said in that letter that, through your discussions with the Crown Office and Police Scotland, essential progress had been made and that the parties understood the urgency.

We are a month hence from that, so I wonder whether you are able to give an update on those developments and on the urgency, because it is critical that we see progress—I think that everyone on the committee wants to see that.

Angela Constance: All of us are at one on that, I think. I do not need to repeat to this audience the worldwide evidence about safe drug consumption facilities, which is irrefutable. They are not a silver bullet but they save lives, and the scale of the challenge in Scotland is such that we need all solutions at our disposal.

There would have been an easier way to do it. I will happily answer questions on that, if required. However, I and my party made a commitment that we would leave no stone unturned.

It is not all in my gift. We have an operationally independent police force, and the Lord Advocate and the Crown Office are independent; nobody here needs me to give a lecture on why that is. However, it is encouraging that the proposal that was submitted to the Crown Office was supported by Police Scotland and Glasgow City Health and Social Care Partnership.

It will be for the Crown Office and the Procurator Fiscal service to take matters forward. They are continuing to work well with Police Scotland and it is important that they continue that work, which, as the committee will know, is around the policing of any facility, should it be required. It is imperative that clarity exists on that point for both the public and police officers.

I have done everything that I can up to this point. As everybody else here is doing, I am waiting on the conclusion of those vital discussions between the Crown Office and the police and on any forthcoming decision from the Lord Advocate. I will have to respond to that decision—whatever it is—in due course, and I give you my absolute commitment that I will do anything that I can within my gift, because safe drug consumption facilities work.

Paul O'Kane: I appreciate what the minister has said with regard to the progress that is being made. Is there any sense of timescale around that work? Obviously, changes are about to come in with regard to Police Scotland's leadership, which might be of concern. Does any clarity exist around when we might see a decision that you, as minister, can then take forward?

Angela Constance: My sense—it is just my sense—is that we are further away from the start of this journey and are now closer to a conclusion, although I appreciate that it is perhaps not the specificity for which Mr O'Kane and other colleagues are looking.

I will say, and I hope that this is reassuring for the committee to hear, that, given the journey that the task force underwent and the work in which the Crown Office and Police Scotland were involved, we have come to a point at which we as a country and with all our different partners understand what the evidence tells us.

The question that remains is ultimately one for the Lord Advocate, around what she can and cannot do within her powers around statements of public prosecution policy. Criminal Justice Committee members will remember the statement that the Lord Advocate made to the committee about the need for a "detailed and specific" proposition that the community and Police Scotland would buy into. That is what we have worked towards. I am not the arbitrator or the judge of that work—that duty lies with someone else—but, whatever the outcome of this journey, I will always look to get the right solutions in place.

Paul O'Kane: I have further questions on data, convener, but I am happy to defer at this stage if colleagues have further questions.

The Convener: I will bring in Pauline McNeill now and will bring you back in at the end if we have time.

Pauline McNeill: Good morning, minister. People on the earlier panel, who were really excellent, were trying to pinpoint priorities for what needs to be fixed and where the gaps are. A couple of things came out of that discussion: first, an issue exists about recruitment and the funding of posts—some of the posts are temporary, so staff are not applying for posts that need filled; and, secondly, the whole funding process seems so bureaucratic that it seems to me that simplifying it might be an important step. What do you think about those two points?

Angela Constance: Ms McNeill raised important pragmatic issues. After having put £10 million into the implementation of MAT standards, we have closely monitored recruitment. It is a mixed picture—some areas have done very well with recruitment and others have struggled more.

We have always provided continuity of funding and I have continuity in my budget. People can apply for multiyear funds through the Corra Foundation. Some of that resource has been accessed by services as well as by the third sector. We give alcohol and drug partnerships clarity and continuity.

I understand the argument for simplifying funding routes. We may get to that point if we have a simpler, whole-system approach. However, I wrestle with the need to ensure that investment that has been earmarked and allocated to support families has gone to support families, or that money that I have earmarked and allocated to improve access to residential rehabilitation is being spent on residential rehabilitation and after care.

I am not unsympathetic to that point about a simpler process, but the position that I have arrived at is that, in order to tackle the drug deaths crisis here and now, I have to follow the money and ensure that resources get to where they are needed. I appreciate that that will require a level of monitoring and that we will need some bureaucracy to scrutinise that. We may be able to change that when we get to wider reforms, perhaps of the ways in which alcohol and drug partnerships, or wider drug and alcohol services, function. At the moment, I am absolutely following the money and will not apologise for that.

Pauline McNeill: I will follow that up with a specific question. What progress has been made on expanding residential services? I know that that is only one part of the picture, but it is an important part. Has there been an expansion of services? Can you tell us now, or will you be able to tell us later, what exactly that amounts to?

Angela Constance: So far, I have committed to and allocated an investment of almost £40 million for existing or new services. That investment touches upon seven services. Those are in Argyll and Bute; at Harper house in Ayrshire; in the Lothians and Edinburgh alcohol abstinence programme; and the new mother and child recovery house in Dundee. We recently announced funding for the north-east, where Phoenix Futures will take forward a project to address the needs of that area. There is also additional investment for Crossreach in Inverness. Those are among the seven distinct investments in new and existing services or projects. That £38 million will increase capacity by 40 per cent.

I am pleased to say that some of those new services are now up and running. We made a commitment to go from 425 to 650 beds. The investment thus far takes us to 600, with some of those beds already in use.

As well as increasing capacity, we are improving access. We wanted to ensure that the existing capacity within the system was being fully utilised. Our information is now a couple of years old, but some establishments were not full to capacity following lockdown. That is why we directed £5 million of funding for residential rehabilitation and aftercare to ADPs across the country. We should never forget aftercare, which is a crucial part of the whole-system approach.

I hope that is helpful.

12:00

Gillian Mackay: Earlier, Natalie Don touched on the family approach. Although I totally welcome that approach, there might be various reasons why people do not have their immediate family involved in their recovery. Their immediate family might be the source of trauma or they might be estranged from their family for various reasons. Do you have plans to issue guidance around that, to make sure that, whatever that family set-up is—whether it is a

biological family set-up or friends that someone treats as family—that support network is around that person and is involved in their treatment?

Angela Constance: With regard to the whole-family approach, there very much is a presumption in the MAT standards that family involvement is, by and large, a good thing. Of course, individuals will have different circumstances in which that might not be appropriate, or it might not be what the individual who is in treatment or recovery desires.

However, even in cases such as, for argument's sake, that of a son who does not want his mother fully informed, there are actually reasons for some involvement, and some residential establishments do that very well. The Lothians and Edinburgh abstinence programme, which is led by Dr David McCartney in Edinburgh, has a families group. On a week-by-week basis, the staff do not necessarily go into the care of individual loved-ones but they will say, "This is the shape of the programme—this is what we are doing this week and this is what you might expect." There are always ways to engage and be helpful and support a family member, even if consent has been withdrawn to share private medical information. Scottish Families Affected by Alcohol and Drugs is also doing some work just now, which is much more focused on models of care and service delivery and standards in and around that. I think that that will be very important moving forward.

As I indicated in my last update to Parliament on MAT standards, we are on a journey to really bear down on people to get the standards, as they stand, implemented. However, at some point, we need to come to the question of how MAT standards evolve. MAT standards will need to be more explicit about treatment in and around different substances, and they could be more explicit around things such as leadership, how we better support women and how we work better with families, because working with families is core. It should be core not only to what we do in drug policy but to what we do in the early years, education and housing support. That is not a nice extra—it has to be our core business, and we have to get the core and the foundations right.

Gillian Mackay: Thank you, minister—I absolutely appreciate that. I asked the previous panel about contributing to service design and how we ensure that that is sustainable for anyone who is engaging. I previously asked witnesses how we do that in relation to the national care service, because it is often an onerous and time-intensive thing that asks people to relive trauma. How do you think we can make sure that we take on that valuable experience and that those people can contribute fully to service design, while not negatively impacting their recovery or wellbeing?

Angela Constance: I have been around Parliament and Government for a long time. When I came into this post, I very much brought with me work that had been done in and around social security experience panels, which was about how we build things from the ground up and meaningfully engage lived, living or, indeed, front-line experience, to help build a system or new services. Again, that needs to be core business not only in drugs policy but elsewhere because, ultimately, services will not be as effective as they should be if they are not built in collaboration with the people who are going to use them or need them. That sounds obvious but, historically, many of our systems, such the healthcare system, can be quite hierarchical. With no disrespect to the clinicians out there, there can be a bit of "Doctor knows best".

Over the past five to 10 years, we have begun to see a shift in mindset. It is about cultural change, which is why the work of the national collaborative is really important at national level, as is the work locally. There is funding for work to take place at local level to meet our expectation that every area needs to engage with lived and living experience. It is a fundamental principle in our work to tackle stigma that those who are impacted by drugs and alcohol have an expertise, and it is not just about listening to their voice—they have a role to play in redesigning services. That actually makes sense for everybody.

Gillian Mackay: I have another question, convener, but perhaps I can come back to it at the end.

The Convener: Carry on—we have about 25 minutes.

Gillian Mackay: Lovely—thank you.

It is on a slightly different topic, and is on behalf of my colleague Maggie Chapman, who is looking for an update on the implementation of the Dundee drugs commission. What progress is being made on the recommendations of that commission?

Angela Constance: That is an important point. Obviously, local partners are accountable for the implementation of both reports from the Dundee drugs commission. The commission has done an impressive amount of detailed work. From my engagement with the local ADP and, crucially, senior leaders in the integration joint board and the health board, I know that there is a commitment to taking that forward.

What is most notable to me is that there have been attempts at a real reset of the relationship with the third sector. We have not spoken much about the third sector this morning but, not just in Dundee but elsewhere, we need leadership in that regard. We need meaningful partnership and a bit

more parity of esteem between statutory services and the third sector. I see some movement on that in Dundee. I am happy to provide further information on that to Ms Chapman directly.

Gillian Mackay: Thank you.

Russell Findlay: Good afternoon, minister. When was the last time that you spoke with anyone from Police Scotland or the Crown Office in respect of drugs consumption rooms?

Angela Constance: There is on-going engagement with my officials, as you would expect. I would have to check when I last spoke to Police Scotland. In the past, I have had lots of engagement with Assistant Chief Constable Gary Ritchie, who was very involved in the task force.

Russell Findlay: You cannot recall when the last conversations were.

Angela Constance: I have had many conversations with people over the piece in different formats. When I came into this post, I had a lot of introductory meetings but, given the independence of Police Scotland and the Crown Office, it is better to have a lot of the discussion at official to official level. The last thing that I would want to do would be to derail any plans or progress because it was perceived that I was interfering with the operational independence of Police Scotland or the Crown Office.

Russell Findlay: The pilot scheme for heroin-assisted treatment has cost in the region of £4 million, which I understand includes start-up costs. Those who favour the rehabilitation route accept that it is not an either/or between rehabilitation and harm reduction, but they point out that it costs in the region of 17 times more to treat someone with that particular programme than it costs for typical public sector rehabilitation. How do you respond to their concerns?

Angela Constance: I will talk about evaluation and the monitoring of resources, but first and foremost, I want to say, as a point of principle, that I do not hear many, if any, debates and discussions about the cost of treatment for other health conditions. It always seems to me that we have more in-depth discussions—or, if I can put it this way, more concerns are raised—about the cost of treating people with drug and alcohol problems. We have to move beyond that, because part of our problem relates to stigma and the perception that exists sometimes in our society that some people are deserving and others less so.

My starting point in all of this is to ensure the right treatment for the right person at the right time. Different treatments cost different amounts of money. There is a difference between the cost of methadone and the cost of Buvidal; residential rehabilitation is considered expensive by some people, and I think that it is fair to say that heroin-assisted treatment is expensive, too. However, I am determined to get the right treatment for the right person at the right time.

The HAT project will, of course, be evaluated by Glasgow Caledonian University, and that evaluation will put all the facts in one place. Heroin-assisted treatment works for some people. Indeed, there is an international evidence base showing that, for people who have very long histories of using, in this case, heroin and other substances and for whom other treatment has not been successful, this treatment provides an opportunity to stabilise them, engage with them and have a discussion about other supports that they might need. The evidence also shows that such treatment reduces the use of street drugs. If, as I have done, you have ever met parents who have lost a child, you will well understand that the priority is not necessarily the cost of a particular treatment, but whether the treatment will work for a particular individual.

Russell Findlay: I do not think that the concerns are about the cost, as such, but about working out the effectiveness of such treatments and the significantly higher costs of going down these routes. That will be assessed in due course.

It has been two years since the Scottish Government declared its national mission to respond to the needless deaths of thousands of people through drugs, but we have just heard evidence from Aberlour that residential rehab is still sometimes seen as the last resort or is not being offered as quickly as it could be and from Scottish Families Affected by Alcohol and Drugs that no one is accountable for repeated service and system failures. Those are pretty stark assessments of the landscape, and given that it has been two years since the national mission was declared, they are quite damning assessments, too. What would you say in response to those criticisms?

Angela Constance: On your point about the evidence around heroin-assisted treatment, I should say that it is used more frequently in other countries—in Switzerland, for example, about 8 per cent of people with problem drug use receive it—and there are different models elsewhere that, arguably, are more cost effective. We have a very high-threshold model, partly because of Home Office regulations.

With regard to the national mission, I have been absolutely crystal clear about residential rehabilitation. It is not for everyone but, under my stewardship, we will invest £100 million in residential rehabilitation and aftercare and in improving pathways to accessing it.

The statistics—the evidence—show that more and more people are being publicly funded to access residential care. For me, it has always been a balanced ticket. We need to be serious about abstinence-based recovery and the option of residential rehabilitation, but we must also be fearless about harm reduction.

12:15

Accountability is important—I have never made an appearance in Parliament or in front of a committee without talking about accountability. It is probably the thing that I have spoken about most in my current role. I never walk away from my own accountability, and I am always open to scrutiny. We need accountability at each and every level. Families and service users are right to point out where it is not working, because, through our work on residential rehab and MAT standards, we now have more information than ever before about what is and is not working. As we progress with the national mission, we will sort what needs to be sorted.

Russell Findlay: On a similar theme, the Auditor General said last year that data on drugs and alcohol is not good enough and that there is a lack of transparency. Have improvements been made in that respect?

Angela Constance: Sorry—would you repeat that?

Russell Findlay: Around this time last year, Audit Scotland said that drug and alcohol data is not good enough and that there is a lack of transparency on how money is spent, which means that it is hard to assess the effectiveness of how funding is used. Has that been improved? Has the lack of transparency been fixed?

Angela Constance: Yes, I believe that it has. As it often does, Audit Scotland made an important and serious point about our needing transparency. The criticism of that is that we will have to ask for lots of information that we then have to publish and people will complain about the resource that is attached to that. We have heard Ms McNeill raise a fair point about the bureaucracy around that.

For clarity, I accepted Audit Scotland's point, and I believe that we have demonstrated transparency through our reporting on the national mission; our annual report, which is available for people to read; and the publication of quarterly reporting around things such as publicly funded residential rehabilitation.

Russell Findlay: Just so that I understand, do you mean that the quarterly spending on every project is now published, or is that the plan?

Angela Constance: Do you mean every single project?

Russell Findlay: Yes. Will information on Government money that goes into those services be published quarterly?

Angela Constance: There is certainly publication around where the Corra Foundation money is allocated. That is publicly available, and I will double check how often it is published. There is a great deal of scrutiny of alcohol and drug partnerships, much of which is published, too, either quarterly or through our annual report.

The Convener: Paul O'Kane has questions on data.

Paul O'Kane: The minister and I had an exchange about data in the chamber yesterday, and she agreed to write with further detail across the wide spectrum of data. However, I am particularly interested in the spike in the number of suspected drug deaths in the past quarter, which I referred to yesterday.

There is a sense from public health experts and experts in the field that the spike could be related to the new drugs that are arriving on the streets and their availability. It is about data and surveillance to understand the new drugs and how to tackle the new challenges that come with them. Naloxone will be part of that, as is surveillance and tracking where the new drugs are coming from. To what extent are the minister's officials doing work in that space in order to understand it?

Angela Constance: That is where our support of the work that is led by Public Health Scotland is really important. I know that Mr O'Kane is familiar with the RADAR—rapid action drug alerts and response—work, which is about putting out alerts when there are reports of new or novel substances.

We know that there was a spike from October to November. The overall figure for suspected drug deaths in 2022 was down 16 per cent, but there was an increase in the final quarter of last year. The figure in that quarter is the highest since 2021, although the number of suspected drug deaths for the year as a whole is the lowest that it has been in five years, and the figure in the quarter in which there was a spike was the ninth lowest out of the past 24 quarters. Nonetheless, I reiterate the point that I always make, which is that the figure remains too high.

We will have to wait for the passage of time. We will get more evidence when we receive the annual report, which deals with confirmed deaths. Until then, we will not know whether there is a relationship between the spike in deaths that we saw in the last quarter of last year and the public health alert in relation to nitazenes.

Synthetic opioids worry me greatly. Although we have a problem with synthetic benzodiazepines, that is not so much the case with synthetic opioids. However, it is necessary only to look at the experience in America and Canada to realise why I am deeply concerned. As far as engagement is concerned, I attended last week's United Nations conference on narcotic drugs, which was in Vienna, although I can assure the committee that I saw very little of Vienna. That was an opportunity to engage with countries where synthetic opioids are an issue. I wanted to get a better understanding of treatment opportunities and what we would have to do differently.

If we were to have an issue with synthetic opioids, that would add to the case for safer drug consumption facilities, but the American experience thus far points to the fact that some of the treatments for opioids would continue to be effective. There are some issues that need to be managed with regard to the introduction to treatment—from a clinical point of view, that can be a bit harder—but the international evidence-based treatments for opioid addiction can work for synthetic opioids. We are highly alert to that.

Orlando Heijmer-Mason (Scottish Government): I would like to add to the minister's answer, if that is all right.

Paul O'Kane's question is really important in highlighting the importance of drug testing as a dynamic means of surveillance of what is going on. Last week in Vienna, we heard about a range of impressive evidence from countries that have a very mature system of harm reduction, which, rather than depending on, say, post-mortem toxicology, involves asking people what they think that they have bought and giving them information on what they have actually bought.

Crucially, the evidence that was presented to us showed clearly that people adapted their behaviour on the strength of the information that they were given—in other words, people might not take the drug that they had, based on what they were told that they had. Crucially, they might take less of it, or they might take it in company, with a friend, to make sure that there was naloxone available, for example.

That is an illustration of countries where harm reduction measures are really mature and embedded, and how quickly they can respond to that kind of evidence.

The Convener: I want to mention the issue of a national stigma action plan. Throughout this discussion, we have talked about things that are measurable and for which people can be held accountable. The minister has said many times that stigma kills, but stigma takes many forms. The development of a stigma action plan and a stigma charter is one thing, but there needs to be action in relation to the organisations that are working on the ground. I am talking not only about the agencies that provide treatment to people with substance problems, but other agencies that they may come into contact with. How will you make sure that stigma is tackled by every service that people might come into contact with?

Angela Constance: I just want to say—very briefly and without trying to interfere with the management of the committee—that my officials met with police on 17 January in relation to safe drug consumption facilities. They also met with the Crown Office on 18 January, and they met with the Glasgow Health and Social Care Partnership on 23 January. I want to put that on the record.

The charter was published in November, and the stigma action plan was published in January as part of our response to the Drug Deaths Taskforce report. The principles of the plan are that stigma kills and we need to tackle it, that people who are impacted by drugs and alcohol need to be at the heart of shaping and informing service and, crucially, that we need to consider drug and alcohol problems as health conditions first and foremost. However, the purpose of the plan is to take the charter and turn it into concrete action, and the vehicle for doing that will be the accreditation scheme that will be developed.

It is important to say that the Scottish Government will start by looking at where in our policies we are inadvertently excluding people as opposed to proactively including them. It is also an important point that the Government will lead by example.

We have had considerable local interest—people are beginning to approach us and ask more about the action plan and how they could be involved in any accreditation scheme—and there is also a bit of international interest in the work that we are pursuing in the area. Although some of the work of the national collaborative is focused specifically on the human rights bill, it will also amplify voices, and part of its work will be on the sharing and dissemination of best practice in tackling stigma and responding in a human rights-based way.

The Convener: I have a final question. In the past couple of years since you came into your post, have you seen any shift in stigmatising language and approaches in the media or in politics as a result of the conversations that have been had?

Angela Constance: It is fair to say that we are on a journey and we still have some distance to travel, but the Scottish social attitudes survey provided some quite interesting reading about people's responses to a public health approach.

The majority of people who took part in the survey said that they are not concerned about working next to someone who has a drug or alcohol problem but, when asked whether they would be concerned about living next door to someone with a drug or alcohol problem, they gave different answers. We are beginning to see a shift—although I appreciate that that may appear to be anecdotal—where people are moving toward a public health approach, and they want to focus on what actually works to get people the help that they need and get them into treatment and recovery.

Of course, I think that the zeitgeist in all this is the lived experience community, because that community is visible proof that recovery is possible, and we know from the Scottish social attitudes survey and other evidence that contact with someone who has lived or living experience is what changes people's attitudes the most.

The Convener: I thank the minister and her officials for their time. That concludes the public part of today's meeting.

12:29

Meeting continued in private until 12:32.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba