OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 7 November 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

© Parliamentary copyright. Scottish Parliamentary Corporate Body

Information on the Scottish Parliament's copyright policy can be found on the website - www.parliament.scot or by contacting Public Information on 0131 348 5000

Tuesday 7 November 2023

CONTENTS

Col.

INTERESTS 1
DECISION ON TAKING BUSINESS IN PRIVATE 2
ALCOHOL (MINIMUM PRICING) (SCOTLAND) ACT 2012 (POST-LEGISLATIVE SCRUTINY) 3
SUBORDINATE LEGISLATION 25
Mental Health (National Secure Adolescent Inpatient Service: Miscellaneous Amendments) (Scotland) Regulations 2023 [Draft] 25
National Health Service (General Medical Services Contracts and Primary Medical Services Section 17C Agreements) (Miscellaneous Amendments) (Scotland) Regulations 2023 (SSI 2023/281) 40

HEALTH, SOCIAL CARE AND SPORT COMMITTEE

33rd Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Clare Beeston (Public Health Scotland)
Dr Aileen Blower (Scottish Government)
Ruth Christie (Scottish Government)
George Dodds (Public Health Scotland)
Lucie Giles (Public Health Scotland)
Douglas Kerr (Scottish Government)
Tara Shivaji (Public Health Scotland)
Maree Todd (Minister for Social Care, Mental Wellbeing and Sport)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 7 November 2023

[The Convener opened the meeting at 09:15]

Interests

The Convener (Clare Haughey): Good morning, and welcome to the 33rd meeting in 2023 of the Health, Social Care and Sport Committee. I have received no apologies for today's meeting.

Under agenda item 1, I welcome Ivan McKee to the committee and ask him to declare any interests that are relevant to the committee's remit.

Ivan McKee (Glasgow Provan) (SNP): I have no relevant interests to declare, convener. Thank you.

Decision on Taking Business in Private

09:15

The Convener: Under agenda item 2, do we agree to take items 7 to 10 in private?

Members *indicated agreement.*

Alcohol (Minimum Pricing) (Scotland) Act 2012 (Post-legislative Scrutiny)

09:15

The Convener: Agenda item 3 is an evidence session with Public Health Scotland as part of our post-legislative scrutiny of the Alcohol (Minimum Pricing) (Scotland) Act 2012. I welcome Clare Beeston, public health intelligence principal; George Dodds, chief officer; Lucie Giles, public health intelligence principal; and Tara Shivaji, consultant in public health, all from Public Health Scotland.

Before I open up the meeting for questions, I invite the panel to give an overview of Public Health Scotland's evaluation of the minimum unit pricing of alcohol.

George Dodds (Public Health Scotland): Thank you for the opportunity to attend the committee. The focus of Public Health Scotland's work has been to reduce the preventable harm that is caused by alcohol consumption in Scotland. We know that people in our poorest communities are five times more likely to die from alcohol-related disease than those in the wealthiest communities. If alcohol consumption trends continue, we expect life expectancy to fall and the cost of providing additional health and care services to increase by an estimated 3 per cent over the next couple of decades.

One approach that is encouraged by the World Health Organization is to reduce demand for alcohol by using pricing mechanisms. That is what Scotland has done, and the World Health Organization continues to advocate that as part of a range of measures to address the harm that is caused by alcohol. My colleague Dr Shivaji will briefly explain the convention that we have used in public health evaluation, and we will then hear from Lucie Giles about the key findings in our report.

Tara Shivaji (Public Health Scotland): I will briefly touch on the rationale for the methods used in our evaluation. Public Health Scotland follows the WHO's recommended best ways to prevent alcohol-related harm. We recognise that policies should be of a multi-component nature and that those components are interdependent and act synergistically. Our evaluation took an approach that was quite cutting edge for public health research. We asked a number of questions not only about whether the policy works, but about the context. We also looked for any unintended consequences and tried to set out the strengths and limitations of the policy in the context of a multi-component approach.

Lucie Giles (Public Health Scotland): MUP was implemented in Scotland on 1 May 2018 and it set a minimum price of 50p per unit of alcohol. In order for MUP to have the desired impact on alcohol-related health and social harms, a plausible chain of events—which we would call the theory of change—needed to be realised. The theory of change is, in itself, based on the evidence that was available prior to the evaluation and it is endorsed through consultation with a range of stakeholders and experts. That theory-based approach is recommended by the Medical Research Council for use in evaluating the effectiveness of complex policy interventions such as MUP. PHS believes that the evidence shows that, through that plausible chain of events, MUP has had a positive impact on alcohol-related harms, as I will now outline.

The evaluation showed that MUP was well complied with by retailers. There were some infrequent, isolated instances of non-compliance, but they were not typical and were generally associated with what we might call teething problems. Broadly, retailers have found the legislation easy to follow and apply, hence it being so well complied with.

Sales of alcohol priced at below 50p per unit virtually disappeared, compared with 40 to 50 per cent being sold at below 50p per unit prior to the implementation of the policy. The average price of alcohol went through an immediate and sustained increase of around 5p per unit, with products such as strong ciders and own-brand spirits, which were more likely to have been sold at below 50p per unit prior to the policy being implemented, increasing in price more. Sales of alcohol per adult decreased by an estimated 3 per cent. That reduction was entirely driven by sales through the off-trade, and particularly by reductions in the same products in which we saw the greatest increases in price. We found no impact on sales per adult through the on-trade.

Alternative data sources show that household purchasing of alcohol reduced, with the biggest reductions being estimated for those households that bought the most. One study showed that households in the top 5 per cent for volume purchased reduced their alcohol purchasing by nearly 15 per cent, while those in the lowest 70 per cent for volume purchased did not change their purchasing at all. Self-report survey data presents a bit of a mixed picture on the impact of consumption among different groups, but in general there is a consistent reduction among the heaviest drinkers.

MUP has been estimated to reduce alcohol-specific death rates by 13 per cent—about 150 deaths a year—compared with what we would have expected to happen had MUP not been

implemented. A smaller estimated reduction in alcohol-attributable hospital admissions of around 4 per cent, equating to around 400 admissions per year, was also found. The largest reductions were for chronic conditions such as alcoholic liver disease among males and those living in the most deprived areas of Scotland. Conditions such as alcoholic liver disease are experienced only by people who drink at levels that are sufficient to do themselves harm.

I hope that you will see that the findings follow a logical sequence of events, with one preceding the other. Many of the findings were consistent across a number of different studies and data sources and, importantly, they were specific to the timing of MUP. PHS is therefore confident that the evaluation provides robust evidence that, overall, MUP has had a positive impact on population-level health outcomes and alcohol-related health inequalities.

The findings are all from large quantitative studies that use routinely collected data and statistical methods to analyse the data in order to understand and isolate the impact of MUP at population level. However, as Tara Shivaji said, it was also important to understand people's experiences of MUP and the strategies that they might adopt to account for it. We did that by including in the evaluation a range of different qualitative studies whereby individuals were asked about their experiences. From those qualitative studies, we found some evidence of individuals, as a consequence of MUP, possibly engaging in potentially harmful strategies such as reducing their spend on food and, for those who already used drugs, increasing drug use. Although those findings are obviously important and it is really important to minimise harm for individuals, it is also important not to lose sight of the main findings that there was no evidence of widespread social harm and that we have seen population-level improvements in relation to consumption levels and alcohol-related harms and inequalities.

Tara Shivaji: I will draw our comments on our findings to a close. What we have illustrated is that it is a complex and nuanced picture. There is a really strong need for a range of interventions, particularly to support people with established dependence and those who are affected by alcohol dependence, as well as other measures to address youth usage. We estimate that, in the absence of the implementation of minimum unit pricing as a policy, the number of people who would have died as a direct result of alcohol would have been higher and the inequalities in health due to alcohol would have been wider. On that basis, we recommend the policy as an effective component in addressing the levels of harms that we see in Scotland.

The Convener: Thank you for that overview. We move to questions from committee members, starting with Ivan McKee.

Ivan McKee: Thank you for coming along and talking us through the approach to the data. There are a couple of things that I want to dig into a wee bit deeper, if that is okay. First, just to get one thing out of the way, when you talk about a 3 per cent reduction in sales, is that by value or volume?

Lucie Giles: It is by volume of pure alcohol.

Ivan McKee: Got it—thanks. Some modelling work was done in advance of the implementation. I think that it was in the University of Sheffield study of 2016. It would be useful if you could refer back to that, say what was fundamentally different there and say what you believe the outcomes were that related to that. I am also interested in digging into the theory of change. There was a 13 per cent reduction in deaths caused directly by alcohol, which you compared, in effect, against the counterfactual—what you think would have happened otherwise. Is that trend going upwards or downwards? What has been the actual difference in alcohol-related deaths during the period since MUP was implemented? Can you give us a number and say whether it is higher or lower than previously?

Lucie Giles: I do not know the exact numbers. Alcohol-specific deaths went up during 2020, 2021 and most recently 2022, but that was following quite a large dip in 2019 after MUP was implemented.

Ivan McKee: What is the difference between the latest year and the year prior to MUP being implemented?

Lucie Giles: I do not know what the actual, absolute difference is, but the number is higher than it was prior to MUP being implemented.

Ivan McKee: The number of alcohol-related deaths is higher now than it was prior to the implementation of MUP?

Lucie Giles: It is.

Ivan McKee: Just to be clear, the theory of change is telling you that the number was increasing anyway and that it would have increased by more had MUP not been introduced. Is that right?

Lucie Giles: That is essentially what we are saying. If we had not seen that dip in 2019, we could assume that we would be at a higher number now, had MUP not been implemented.

Ivan McKee: Okay. The other thing that I want to explore a wee bit more is where MUP has had an impact. I would certainly expect that there would be some impact on heavy drinkers and those who are, unfortunately, at the stage where

they are quite likely to succumb to alcohol-related deaths. However, I assume that a big part of the policy objective is to address people who are starting to drink by reducing their access to cheap alcohol—young people, perhaps. Is there any evidence about that? The sad reality is that price will be an issue for somebody who is going to drink excessively but, frankly, it is an issue that they will deal with if they need to get a drink, whereas a big part of the impact will be on early-stage drinkers. Is there any data to support any behaviour change at that stage?

Lucie Giles: I ask Clare Beeston to comment on that.

Clare Beeston (Public Health Scotland): We did a qualitative study with young people under the age of 18 who are already drinkers—it was not a quantitative study on general impact—and we heard their stories about how MUP had impacted on them. It is fair to say that there was not much evidence that price was a big factor in what they choose to drink. That was driven more by peers, trends and so on. There was no evidence of MUP having a substantial impact in changing what young people who are under 18 are drinking. They are people who are starting out on their early drinking careers, but we do not have evidence on how their habits have changed. We would need to look at that over the longer term, so it is not a question that we can answer at this stage.

Ivan McKee: Do you have any comments on how the data that you arrived at in the evaluation compares with the data that was on the table prior to implementation of MUP?

Lucie Giles: Do you mean the data from the modelling?

Ivan McKee: Yes.

Lucie Giles: I would caution against comparing what we have produced with the data from the modelling, as they are different things. The modelling was there to illustrate how different types of policies or levels would alter outcomes such as consumption and harm. That said, however, I note that the modelling and what we have produced on consumption are quite similar. The 2016 modelling suggested a reduction of 3.5 per cent, which is fairly comparable with what we found.

It is also a wee bit difficult to compare the findings in relation to harms because they were typically looking 20 years ahead. If I recall, they estimated some 2,000 deaths over 20 years. I do not want to assume that the impact of MUP will continue at the current level over time, but you can see that the findings are broadly comparable in terms of that annual increase.

09:30

Ivan McKee: Okay. Thanks very much.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practicing national health service general practitioner, and I suppose that it is important to say that I met three of the four panellists and we had a discussion about MUP last week.

Lucie, I was deeply disappointed not to hear you say in your statement that the 4 per cent reduction in hospitalisations is not statistically significant. That is quite an important statement that you left out. You went on to mention other studies, but what studies back up what you said, which was that deaths have reduced by about 150 annually and there has been a 4 per cent reduction in hospitalisations?

Lucie Giles: I did not specifically say that there were other studies looking at admissions and harm. On deaths, the study that we in Public Health Scotland performed was the only study that looked specifically at that outcome. There were lots of different studies looking at things such as purchasing data, price and consumption, and they generally showed a very consistent picture.

You are absolutely right that the overall admissions figure was not statistically significant, based on the p-value. I would now prefer to look towards confidence intervals, which give a much better picture of how likely it is that there will have been a change in one direction or the other. The confidence interval was very largely to the right of zero, indicating that it is much more likely to have been a reduction than anything else.

Sandesh Gulhane: Did it cross zero?

Lucie Giles: It did just cross zero, yes. If we look at chronic conditions, which is where we have seen the biggest impact, that reduction was statistically significant, as was the reduction in admissions in males. They were all statistically significant, and the figures on three of the four most deprived areas of Scotland were also statistically significant, if that is the most important thing.

Sandesh Gulhane: Accuracy is.

The Convener: We will stay with you, Dr Gulhane, for your further questions.

Sandesh Gulhane: Thank you, convener. Tara, what is your definition of a dependent drinker?

Tara Shivaji: A dependent drinker would be somebody who has a physiological and psychological dependence on alcohol. It has less to do with the volumes that people are consuming. You would expect a dependent drinker to be consuming a higher volume of alcohol, but when

that stops, they will experience withdrawal symptoms as a result.

Sandesh Gulhane: Looking at the bill and the modelling, what would you have expected and what did you actually see when it came to the spend of dependent drinkers?

Tara Shivaji: The patterns of spend in people who are the heaviest drinkers tend to involve the lowest and strongest alcohols, and their purchases tend to be from off-sales. We would therefore have expected minimum unit pricing to have had a particular impact on purchasing decisions in that group. However, we see in the broader context that dependence is quite a complex phenomenon, and we saw reports of individuals prioritising their spend on alcohol over other commodities where household budgets were finite.

Sandesh Gulhane: They spent less money on feeding their kids and things like that. What mitigations were put in place to help dependent drinkers, who we knew would be spending more money on alcohol?

Tara Shivaji: I guess that that is outwith the scope of the policy evaluation, in some ways. A wider range of interventions are necessary, including support for dependent drinkers and recognition of the impact on their families and those around them. Those are key interventions that we would want to see.

There is a concept called the prevention paradox, whereby those who are particularly affected by a policy may not benefit from it the most, while we expect those in the middle to benefit substantially. There is therefore a need to have targeted measures that are focused on those at the very highest risk, those people being dependent drinkers and those who are affected by alcohol dependence.

Sandesh Gulhane: Given that you are a consultant in public health, and given your specialisation, can you say whether there has been a decrease in alcohol brief interventions when it comes to referral rates for people seeking help? Surely something should have been put in place to help those people if a policy was being put in place that, as you have just said, would possibly affect those who most need help. Perhaps some extra money should have been put in to help those who needed it the most.

Tara Shivaji: Public Health Scotland produces indicators and statistics on the numbers of alcohol brief interventions that are delivered. They are short conversations that are designed to change people's consumption patterns. They are not actually aimed at people with dependence. We also produce statistics on referrals to treatment.

Looking back over the past 10 years and thinking particularly about the brief interventions programme, there was a standing start of zero, after which there was a substantial increase in the numbers of recorded and reported brief interventions that have been delivered across the healthcare sector, although that has started to tail off over the past five years. Similarly, there has been a decline in the number of referrals to treatment. We do not yet have explanations for that, or an understanding of what is driving that decline in referrals to specialist treatment. We are undertaking a piece of work on that at the moment. Given the work that has been done in England, where there was a similar problem, we would expect the explanation to be multifactorial in nature.

Sandesh Gulhane: From what you have said, it seems to me that we have sort of abandoned our dependent drinkers, but thank you for your answers.

David Torrance (Kirkcaldy) (SNP): Good morning to panel members.

In relation to the consumption of alcohol, the different types of drinkers and the Sheffield model, can you expand on how minimum unit pricing has affected the different types of drinkers and their consumption?

Lucie Giles: I ask Clare Beeston to pick that one up. A few studies have examined different types of groups and have found a bit of a mixed picture. We should bear it in mind that that comes from self-report survey data, which has limitations. Do you recall the harmful drinker study and specifically what it said, Clare?

Clare Beeston: The harmful drinker study had three components. One involved drinkers recruited through treatment services, who were screened to have probable or likely alcohol dependence. There was no consistent evidence of a reduction in their consumption. There was a mix: some people said that they had reduced consumption, and some said that they had not. There is no consistent evidence on people with probable alcohol dependence recruited through services.

Regarding people recruited through the community, there was, again, no consistent evidence one way or the other. Some people said that it was a qualitative matter, which was not generalisable, some people said they had reduced consumption, and others said that they had not.

There was a study using a market research company called Kantar, which does what is called an alcovision survey. That surveys lots of people who drink and collects detailed evidence. It found no change in consumption. Again, that is self-reported. The survey found that the proportion of people who were drinking at a harmful level did

not change, but there was a significant reduction in the proportion of people drinking at hazardous levels.

We have to be a bit careful about self-report data. It is subject to recall bias—how much people remember what they drank—particularly when you are looking retrospectively. Therefore, the sales data is a better measure of population change, but sales do not tell us who has changed what. That was the harmful drinking study.

As Lucie Giles referred to earlier, the purchasing data found that the households that purchased the most reduced their purchasing the most after MUP was introduced. Therefore, the heavier-drinking households reduced their purchasing most.

David Torrance: What about moderate drinkers and the overall consumption of alcohol?

Lucie Giles: One of the studies of household purchasing data to which Clare Beeston referred found that the bottom 70 per cent—the people who you would call the moderate drinkers—did not change their purchasing habits.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I am interested in how we compare with other countries that have introduced minimum unit pricing. I know that Canada, Wales and Ireland have done so. I have in front of me a World Health Organization report that talks about how we are reducing alcohol deaths by introducing minimum unit pricing.

What work has Public Health Scotland done to look at other countries? Canada introduced MUP in 2014. Is there something that we can learn from other people?

Lucie Giles: Scotland was the first country to implement MUP that applies to all alcohol. In Canada, it has been introduced in different areas in different ways and applies to only certain types of alcohol, so it can be a wee bit difficult to draw comparisons. As yet, we do not have a lot coming out of Wales, because the Welsh were behind us, but we see a broadly similar picture there, where MUP was implemented in a similar way.

Carol Mochan (South Scotland) (Lab): Thank you very much for the evidence. I am interested in the various income groups. Early on, there were concerns about MUP disproportionately affecting low-income groups and, on the other side, whether it would have an impact on people in more affluent areas.

I am interested to get clarity on the current pricing. For MUP to work, do we need to increase the price? Will it continue to have the same broad effects on those groups or do we have any concerns about it disproportionately affecting lower-income groups because of the other crises in income that people face?

Lucie Giles: The evidence from the evaluation shows that the increased expenditure or the price that people pay for alcohol is much more closely linked to the volume that they purchase than to income. From the data that we have, there is no systematic patterning that shows that lower-income households increased their expenditure more. The pattern is much more closely linked to how much people buy.

Tara Shivaji: It is difficult to answer your question about the impact of the current cost of living crisis, Ms Mochan, but there are considerations that are worth sharing. In a situation where there is wider economic difficulty, alcohol sales, and alcohol consumption, as measured by sales, fall as alcohol becomes less affordable across the population.

09:45

In the context of the cost of living crisis, there are important considerations about how inflation affects different commodities in different ways. Therefore, it is important to consider what that means for alcohol and how to keep the value of minimum unit pricing such that it continues to have the effects that we have seen. However, it is somewhat outwith the scope of our evaluation to touch on that.

The final thing that is worth reflecting on is the impact that the cost of living and economic crises have on people's health and mental health. Other countries have experienced an increase in mental health difficulties, problematic substance use and problematic alcohol use. The drivers of that are loss of income, unemployment and the distress around that.

In that context, we need to think about how we protect people who are most vulnerable to those effects, including people with established dependants and young people who may be more touched by an economic crisis than others. Thinking about the issue in that broader context, there is a need for a general preventative policy that allows us to address the harms that are associated with alcohol and a need for targeted interventions that support people who are at the highest risk of harm.

Carol Mochan: Is it helpful to think and talk about minimum unit pricing as part of a package of public health measures that aim to change the direction in this country away from alcohol harm?

Tara Shivaji: That is exactly the approach that we are taking.

Carol Mochan: Thank you very much.

Paul Sweeney (Glasgow) (Lab): I want to raise concerns about poly substance use—for example, using benzodiazepines and alcohol. Have you

observed a substitution effect in people who have problematic substance use generally where there is a price consideration? Do they substitute with other products that are potentially more harmful?

Clare Beeston: I will start and then hand over to Tara Shivaji. We found no evidence that people who did not use illicit substances started to use illicit substances. There was evidence that some people who already used drugs substituted substances. It is probably worth saying that there were a number of that type of unintended harmful consequence, and there were exacerbations of existing tendencies. People who already took drugs perhaps took more drugs, and people who had to make decisions about their food spending had to make more decisions about that. There was evidence that people who already took drugs occasionally made different decisions in relation to taking drugs instead of alcohol.

I hand over to Tara on what that means and the wider impact.

Tara Shivaji: My remit also covers drugs, and benzodiazepines are one of the key substances that contribute to the higher level of drug harms and drug deaths in Scotland. They are a very common finding as part of poly substance use among people who die and among people who experience overdose.

It is important to bear in mind that the drugs market is a global market, and there have been shifts in that market in the past five years. It has moved from diazepam and temazepam, which featured commonly in the early 2000s, through to what we call street benzodiazepines. I refer to substances such as etizolam, which is currently being replaced by a new substance called bromazolam. That shift has a lot to do with wider market forces. Globally, it has a lot to do with regulation. As substances are banned and regulated by the United Nations, synthetic substances are manufactured.

However, alcohol and benzodiazepines are depressants and, where benzodiazepines are used, they are commonly used together. Therefore, as Clare Beeston says, it is less about a substitution effect. We need to think much more holistically about our approach to people who use substances, and the support that we provide needs to take into account much more the range of substances that people use, including alcohol and benzodiazepines, because they do not tend to use one or the other.

Paul Sweeney: If the policy is influencing behaviour and causing substitution in any way, can you suggest any mitigations that could assist in reducing the harms that might be present? I know that the interdependency that you described is complex, but are there any specific measures that you might consider?

Tara Shivaji: We did not see that substitution effect, other than in people who already had established dependence. That brings us back to the need for support and treatment services and for outreach services—proactive care that meets people at the point that they are at and deals with the issues. Those issues often occur in the context of other complexities, such as homelessness, so there is a need for targeted interventions that sit alongside MUP.

Paul Sweeney: Obviously, 100 per cent of the additional revenue that is generated by minimum unit pricing flows to the private sector, not the public sector. Do you have a view of how much revenue has been raised as a result of the policy?

Clare Beeston: There was one study using our data. We did not do the study; it used our sales data. It examined the additional revenue in Scotland and compared it to England. The study assumed that the revenue trends would have been the same in Scotland if MUP had not been introduced and it estimated that there was £270 million of additional revenue over four years, which equates to £67.5 million each year.

Paul Sweeney: Could any adjustments be made to the scheme that would allow for the public sector to capture a share of that? Is it possible?

Clare Beeston: That is a good and challenging question. It was not possible to say from our study on the economic impact on the alcohol industry how that extra revenue had translated into additional profits and how much had landed with producers versus retailers and large retailers versus small retailers. It is not that everybody benefited uniformly, and not every retailer benefited uniformly. Overall, there was a net increase in revenue, but we were unable to say where that landed. Therefore, we cannot answer the question with a policy solution.

Paul Sweeney: I appreciate your time.

The Convener: Ivan McKee has a question. Is it on this theme?

Ivan McKee: It is directly on it.

On the revenue raised by retailers and the private sector as a consequence of the policy, I think that Clare Beeston is saying that the tax levers are currently reserved. If those tax levers on alcohol duty were devolved, the Scottish Government would be in a position to benefit from and bring some of that revenue into the public coffers. Is that correct?

Clare Beeston: I think that that is raising—

Ivan McKee: In theory.

George Dodds: Convener, might I help a little here? We are trying to describe for the committee's benefit the approach to an impartial study. I totally respect that question, but, with respect to the committee, it takes us into a space around levels of taxation and who can tax who, and, for an independent organisation, that is probably outwith the scope. It would be great if members could respect that response.

Ivan McKee: Thank you.

The Convener: Your point is noted, Mr Dodds.

Gillian Mackay (Central Scotland) (Green): I will follow on from the previous two questions. Were any comparative studies undertaken or commissioned to compare how the money raised in other countries by minimum unit pricing is used, or is that a gap that you feel should be looked into?

Lucie Giles: It was not covered specifically in the evaluation.

Clare Beeston: I am not aware of any studies looking at that in other countries.

Gillian Mackay: The report says that the theory of change hypothesised that the alcoholic drinks industry might make changes to the size of products. To what extent has that happened as a result of minimum unit pricing?

Clare Beeston: There is evidence of changes to product size. For example, large 3-litre bottles of very strong cider have largely disappeared from shelves in Scotland, and there has been a move towards smaller 1.5-litre bottles. It is important to remember that the effect was limited because Scotland is a relatively small part of a UK-wide industry, and it is difficult to disentangle the effect of MUP from other things that might drive producers to make different sizes and different strengths of alcohol products.

We were not able to say that strength had changed, but there was some evidence that some products had got smaller. There was evidence that single containers had got smaller and that there were fewer bottles or cans of beer in a pack.

Gillian Mackay: The report also said that there was no discernible positive or negative impact on the drinks industry as a whole. Can you give us more insight into the evidence that brought Public Health Scotland to the view that there was no discernible impact one way or another?

Clare Beeston: One study undertook quantitative analysis of five metrics of economic performance—number of business units, employment, turnover, gross value added and output value—and was unable to determine any impact from MUP on those measures. In terms of qualitative analysis—that is, from speaking to industry and people on the evaluation advisory group, survey responders and participants in interviews—the general message was that MUP is now business as usual and that, "We've dealt with it. It's what we do now."

It is fair to say that there was not clear evidence that any increased revenue that retailers accrued from MUP was being passed on to producers. There were discussions about how that was shared, but it was not clear that it was being shared. The impact on individual businesses depended on what they sold or made in the first place.

A retailer who only ever sold alcohol that was a lot above 50p per unit did not see much difference, because their products were not affected. Some of the retailers who sold a lot of products that were affected said that they had seen a negative impact on their revenue.

10:00

The Convener: Ivan McKee has some questions.

Ivan McKee: I have covered everything that I have to cover.

The Convener: Including on theme 8, on policies and modelling?

Ivan McKee: Yes, I have covered modelling.

Tess White (North East Scotland) (Con): Good morning.

Alcohol-specific deaths are at their highest level since 2008. How does that fact correspond with Public Health Scotland's report, which shows that MUP reduced deaths by 13 per cent?

Lucie Giles: It is about the question that we asked. On the impact of MUP, the question that we asked was not whether the number of deaths that occurred after implementation of MUP was lower than before. The figure is a comparison with what might have happened had MUP not been implemented in the first place. We talked earlier about the dip in 2019 and the increases since then. Had that dip in 2019 not occurred, we would potentially be at a higher level of deaths now.

Tess White: So, is it an estimate?

Lucie Giles: It is an estimate compared with a counterfactual situation.

Tess White: Okay. Do you recognise that alcohol deaths are at their highest since 2008?

Lucie Giles: Yes.

Tess White: Figures for alcohol-specific deaths registered in 2022 show that the number of female deaths tragically rose by 31 to 440 while, as you

mentioned earlier, the number of male deaths remained unchanged. Why is that?

Lucie Giles: That is outwith the bounds of evaluation of MUP. I do not want to speculate about what those changes are about. It is obvious from the evaluation work that we have done that the reduction in deaths has been greater in males, so there might be something else going on there. I do not want to speculate.

I do not know whether Tara Shivaji wants to add anything to that.

Tess White: Just give us a view if you can, Tara.

Tara Shivaji: Women make up about 40 per cent of people who access treatment services, so the rise in alcohol-specific deaths among women has to get us thinking about what might be the particular risk factors that affect them. The stigma of alcohol use is one. Especially in the context of women being parents, that can be a real barrier to accessing support and care, and to engaging with treatment services. There are a number of gender-specific barriers that we need to focus on and address. Stigma is one; others include experience of domestic violence and co-existing mental health problems. For a lot of people, dependence follows a series of previous life traumas, and it is common for substantial alcohol use—alcohol dependence—to co-exist with serious mental health conditions. That is another area where we need to see strengthening and improvement.

There is a range of factors. In particular, with minimum unit pricing the question is about the products, consumption and where women purchase alcohol. However, I return to the point that we need multipronged intervention. MUP is one of a range of measures that we need.

Tess White: So, we need more data.

A Public Health Scotland report from June 2022 found no clear evidence that MUP led to reduced alcohol consumption or reduced levels of alcohol dependence among people who were drinking at harmful levels. Will you explain how that finding corresponds to the June 2023 report?

Clare Beeston: The finding that you cited is from the harmful drinking study, which looked at a particular group of people who were drinking at harmful levels—predominantly, people with alcohol dependence. Although there is a relationship between drinking at harmful levels and alcohol dependence, they are not the same thing. People with alcohol dependence are a subset of the people who drink at harmful levels, but far more people drink at a harmful level. The reduction in deaths and hospitalisations illustrates that there has been a reduction in harmful drinking, because a death is the ultimate harm that is caused by drinking. They tie up in that way.

Tess White: Is that an estimate?

Clare Beeston: The study that you cited was an estimate of the impact that MUP had had on reducing drinking by people with alcohol dependence, who were recruited through treatment services.

Tess White: So, one result is an estimate and one is a fact, which makes it difficult to draw comparisons.

Clare Beeston: I am not sure that I answered that question very well, because that is not what I meant to say.

Lucie Giles: Everything that we are presenting today is based on evidence and data that have been collected in one way or another. We use the term “estimate” to convey the idea that there is still some uncertainty around some of that, but all research has assumptions and uncertainty associated with it, so use of the word “estimate” does not undermine the results and findings that we have presented in the evaluation. I am slightly concerned by the suggestion that it would.

Emma Harper: I have a quick supplementary question. We went into lockdown on 23 March 2020, just two years after the policy was introduced. What effect did the pandemic have on your research and on alcohol consumption? Tara Shivaji mentioned women in response to Tess White’s question. I am interested in that area, too, but we have not talked about the pandemic. Did that have an impact on your research on alcohol consumption?

Lucie Giles: I will answer about consumption first. The pandemic obviously had an impact on consumption because on-trade services ceased to operate for a number of months and we saw off-trade sales going up as a result of that. Overall, at population level sales were lower in Scotland and in England and Wales. I will explain why I am talking about England and Wales in a minute. We estimated that, during the first three months of lockdown, sales were 6 per cent lower in Scotland and in England and Wales.

The pandemic also impacted on our research. We dealt with that in a number of ways. We used a control area for a lot of our studies, which was already planned and was something that we would have done anyway. By “control”, I mean an area where the policy was not implemented, which is why I am talking about England and Wales. Most of the time, we used England, or England and Wales, as our control area, which allowed us to account for external factors that we might not have expected. If those happened in both areas, that

essentially levelled the playing field. That is one way that we accounted for things.

Some of our studies were of only the first year of MUP and so were not impacted at all, but in other studies we added into our modelling data to account for the restrictions that were introduced during the pandemic. The pandemic absolutely had an impact on consumption. Some of the data from lower-than-population level shows that different people changed their habits in different ways. People who were lower or more moderate drinkers prior to the pandemic tended to stay the same or to reduce their consumption, but those who were drinking at the higher end were more likely to increase their consumption. There was definitely an impact and we have done our best to account for it within the studies that we have conducted.

Evelyn Tweed (Stirling) (SNP): Good morning. Tara, in your opening remarks, you said that unintended consequences of the policy would be one of the things that would be looked at. Can you expand on that?

Tara Shivaji: That relates to nuances, in that when the policy was implemented, not everybody in the population was impacted in the same way and to the same extent. My colleagues—either Lucie Giles or Clare Beeston—can describe that in more detail. Within the population, different subgroups have different purchasing and consumption patterns. For example, as a population, people who drink within the chief medical officer's low-risk drinking guidance of no more than 14 units have a particular purchasing and consumption pattern, and were affected differently to people who drink above the guidelines. As we have discussed, people with quite severe dependence were impacted in various ways. Therefore, what I was referring to was that we set out to try to identify the impacts on the key groups.

With hindsight, I say that it is really difficult to identify all the groups that you want to learn from. However, some of the findings about young people that Clare alluded to demonstrate that we might have wanted them to be a key consideration at the start, to see how the policy would affect them. The subgroups of interest were set out in our protocol for investigation but, with hindsight and given the impact of the pandemic, we would probably want to broaden that and to think much more about equalities and equalities groups within that.

Evelyn Tweed: Thank you. Are there gaps between impacts in different areas, such as between rural and urban areas or island and mainland areas?

Lucie Giles: We did not specifically look at the impact in urban and rural areas. Clare—do you want to add anything?

Clare Beeston: The study of people drinking at harmful levels did case studies of rural and urban areas, and there was not really any difference between them. The main difference was seen in areas that are close to the border with England because people travel across the border to shop, depending on where the nearest supermarket is, and that continued. I think that one study found that there was less evidence of an impact on purchasing for people who live within 12 miles of the border. However, the issue of cross-border purchasing was very limited—to people who lived near the border. It was not widespread.

Sandesh Gulhane: Lucie Giles said that 70 per cent of people did not change their purchasing habits. Why do you think that was?

Lucie Giles: That was the finding of one study in particular, which looked at the household panel purchasing data. That 70 per cent were the lower-purchasing households—the more moderate drinkers. This is speculation to some degree, but based on that pathway—that plausible chain of events—I can only assume that those households were not impacted by the change in price because the products that they were purchasing prior to implementation of the MUP were already above the 50p premium. However, that is speculation. I do not know the answer on the basis of that specific study.

Sandesh Gulhane: That is speculation, but it makes sense, does it not?

Lucie Giles: It does.

10:15

Sandesh Gulhane: It makes sense to say that most people—including everyone in this room—are not affected by MUP with the type of alcohol purchases that are made. Why 50p and not £1, £10, £20 or £50?

Lucie Giles: That is not something that we have included in the evaluation. We have evaluated the impact at 50p, which is the level that was set by Parliament. I guess that that decision sits with you.

Sandesh Gulhane: When MUP was introduced, Buckfast sales surged by 40 per cent. There were also increases in sales of Mad Dog 20/20 and Dragon Soop. Those drinks are all associated with heavier drinking and antisocial behaviour. Why do you think there were increases in the sales of those types of product?

Lucie Giles: I do not think that it is necessarily to do with the specific type of product; I think it is to do with the level at which they were priced prior

to MUP, and whether they were impacted by the policy or not.

Sandesh Gulhane: So, people moved into purchasing those drinks, then.

Lucie Giles: The sales work that we did cannot 100 per cent say that individuals switched from one product to another, because we do not have that data at an individual level, but we did see sales reductions in cider, perry and spirits, a smaller reduction in beer and an increase in fortified wine. It makes sense to think that some people, potentially, were switching from one product to another.

Sandesh Gulhane: Tara said earlier that MUP needs to be part of a package or range of measures. What are the other measures that have come in with MUP?

Tara Shivaji: There are the other measures that are set out in the Scottish Government's "Alcohol Framework 2018: Preventing Harm". The measures that I am alluding to would be the World Health Organization's "best buys" and those that are set out by the WHO European framework. They relate to restrictions on availability, perhaps through licensing, but also through structural separation of alcohol. There are examples from Ireland on that.

There are also restrictions in marketing. Public Health Scotland's focus on restrictions in marketing would apply particularly to marketing that targets children and young people. As has already been discussed, there is a need to strengthen early access to treatment and the quality of treatment. Those are the broad measures that have been taken.

Sandesh Gulhane: Of those, what has actually been introduced with MUP?

Tara Shivaji: Alongside—[*Interruption*.]

Sandesh Gulhane: I am asking the panel as a whole.

Tara Shivaji: Alongside MUP, there is the alcohol licensing legislation, and we have a programme of brief interventions and treatment. Those measures, out of what has been recommended, are the things that are currently available.

Sandesh Gulhane: You said to me earlier that the alcohol brief interventions have plateaued and fallen.

I do not know who to direct this question to. What has been the impact of the push towards 0 per cent alcohol drinks that we have seen in the past couple of years?

Tara Shivaji: From a public health point of view, the answer is that we do not know yet. That is currently a subject of research. There has been growth in what we would call the lower end—drinks with no alcohol, or 0 per cent—and in drinks with lower alcohol by volume—lower ABVs. We are asking whether that presents an opportunity for public health, through improving health by reducing consumption. The thing that we do not really know is whether people are switching from full-strength products to low-strength products.

Does that present particular opportunities among key groups—pregnant women, for example? The advice is that women who are planning to conceive, are pregnant or are breastfeeding should abstain from alcohol. The question is whether that shift offers particular solutions, but we do not have the answer yet.

Sandesh Gulhane: I have one final question. Am I right in saying that MUP is not a panacea or magic bullet to reduce health harms with alcohol, and that your argument is that it should be introduced with a suite or package of measures?

Tara Shivaji: Yes. Our approach would be that it would be part of a package of well-calibrated measures to respond to the high levels of alcohol-related harms that we see in Scotland.

The Convener: Before we move on, I remind committee members that it is me who is convening the meeting and that you speak through the chair, not across the tables.

Tess White: The latest Public Health Scotland report states:

> "We therefore cannot completely exclude alcohol treatment as an alternative explanation for the observed impact on alcohol-attributable deaths and admissions."

Does Public Health Scotland plan on doing any more work on alcohol treatment services and the effect that they have on alcohol-related hospitalisations and deaths?

Tara Shivaji: We are currently conducting a review or investigation into what led to the decline in referrals to treatment services. That should help to inform what we need to do to improve access to care.

There is also wider work across the UK, and there is four-nations guidance on alcohol treatment. It is the first time that we have had guidance on the quality of alcohol treatment services. Work will need to be done to implement that guidance and to explore the extent to which it is improving care and people's experience, and their move into recovery. We expect to have a role in that, but at this stage we do not know what that will be.

Tess White: I have one follow-up question for Dr. Shivaji. Is MUP, in your view, being billed as the magic bullet, to the detriment of other support

and solutions for people with alcohol dependence? You have highlighted that further work will be done. I suppose that my concern is that surely addiction to alcohol should be addressed holistically rather than using just one lever.

Tara Shivaji: I would answer that question by referring to the fact that the harms of alcohol are quite broad. Dependence is a particularly serious harm associated with alcohol, but alcohol is also related to cancers and hypertension, which we project will increase substantially in the next 20 years. That is why we are concerned about the 23 per cent of our population who are drinking above the low-risk threshold.

Of course, those who are drinking in the most harmful and risky way—people with dependence—are at the highest risk of experiencing harm. What we are saying is that a mix of measures is needed. The primary prevention measures—as we would call them—including minimum unit pricing, are often very useful for targeting the harm that is associated with alcohol in the wider population, who are not at extremely high risk. That is why a mix is needed. That is how we would frame the problem. It is very important to have both.

Tess White: Thank you.

Emma Harper: I know that there is a lot of work going on regarding sales, marketing and advertising. I am interested in following what is being done in Ireland and the evidence for segregating sales.

I want to pick up on what Clare said about cross-border purchasing, because there needs to be some myth busting and debunking of the idea that folk are driving fae Ecclefechan tae Carlisle to pick up whatever alcohol they want. If they did that, they would have to buy 33 bottles of vodka to save the five quid on petrol that it costs to go the 20 miles fae Ecclefechan tae Carlisle. Also, my understanding is that the price of alcohol is the same in Hawick and Berwick, so if you live in Coldstream you would be crossing the border to go for your shopping anyway. There are not the booze cruises that keep being touted.

I would be interested to hear about the research that is debunking the myths about cross-border purchases. Can you tell us about that?

Clare Beeston: There are a number of aspects to what we did on that. For example, we looked at the number of licences around the border. If lots of booze cruises were happening, you might expect a boost in licences at the border to service those booze groups. We did not see that.

Another important element that we looked at, which might be the work that you are referring to, was the costs that are associated with driving across the border, in terms of petrol and time, and how much alcohol one would have to buy and what it would cost to make the savings. On the whole, it is not economically beneficial. We did the research in 2020, I think, so we used fuel prices for 2020: fuel has gone up a lot since then. Therefore, the economic argument for travelling has got less over time. It is largely not beneficial to cross the border just to buy alcohol, because the savings do not offset the cost.

It does happen, as you said, when people already cross the border because that is where they do their shopping—because that is where the biggest supermarket is, or they work over the border and are just going to the shops on the way home, or whatever. That is largely where it is happening.

Emma Harper: Conversely, if I want to get my shopping delivered to Ecclefechan fae Asda in Carlisle, there would be a price for delivery of the groceries, as well.

Clare Beeston: Yes.

Emma Harper: So, it doesnae make economic sense to shop across the border, especially since, as I have just said, the price of alcohol in Hawick is the same as the price in Berwick. I guess that debunking that booze-cruising myth is something that we should be doing.

Clare Beeston: Yes. With a lot of those things, we can say that they are not happening on a large scale. You will be able to find an individual who says, “I do that”, but I agree with you about the larger scale; we found no evidence that shopping across the border was happening on a large scale.

Emma Harper: Okay. Thank you.

The Convener: I thank the panel for their evidence. The committee has certainly learned a lot this morning, and I am sure that it will help us in our post-legislative scrutiny of MUP. We will take a short break to allow panels to change. Thank you.

10:28

Meeting suspended.

10:38

On resuming—

Subordinate Legislation

Mental Health (National Secure Adolescent Inpatient Service: Miscellaneous Amendments) (Scotland) Regulations 2023 [Draft]

The Convener: Our fourth item today is consideration of an affirmative instrument. The purpose of the instrument is to add the national secure adolescent in-patient service, Foxgrove, to the list of secure mental health services in the Mental Health (Safety and Security) (Scotland) Regulations 2005. The instrument also adds Foxgrove to the list of qualifying hospitals in the Mental Health (Detention in Conditions of Excessive Security) (Scotland) Regulations 2015.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 3 October 2023, and it draws the instrument to the attention of Parliament on the general reporting ground, in that the title of the instrument is not in line with standard drafting practice.

The DPLR committee also draws its correspondence with the Scottish Government to the attention of the Health, Social Care and Sport Committee, for its information, in relation to the additional material provided by the Scottish Government in its response to the committee.

We will have an evidence session with the Minister for Social Care, Mental Wellbeing and Sport and supporting officials on the instrument. Once we have had all our questions answered, we will proceed to a formal debate on the motion.

I welcome to the committee: Maree Todd, the Minister for Social Care, Mental Wellbeing and Sport; Dr Aileen Blower, child and adolescent mental health services psychiatry adviser; Ruth Christie, head of children, young people and families unit; Douglas Kerr, Scottish Government legal department and Dr Gavin Reid, principal medical officer, forensic psychiatry. All are from the Scottish Government.

I invite the minister to make a brief opening statement.

The Minister for Social Care, Mental Wellbeing and Sport (Maree Todd): Thank you, convener. I thank the committee for asking me to attend today to give evidence on the draft Mental Health (National Secure Adolescent Inpatient Service: Miscellaneous Amendments) (Scotland) Regulations 2023.

Before we begin the questions, I thought that it would be helpful for me to provide some short opening comments. I am pleased that, after many years of planning and development, the national secure adolescent in-patient service—known as Foxgrove—is almost ready to admit patients. Foxgrove will be a vital and important addition to children and young people's mental health services in Scotland.

Foxgrove will provide services for children and young people aged between 12 and 18 who are subject to measures for compulsory care and treatment, have a mental disorder, present a significant risk to themselves or other people and require a medium-secure level of security in order to meet their needs. Having the facility in Scotland will mean that young people with extremely complex needs can have their needs met in a purpose-built and designed facility, with expert care delivering high-quality mental health care and treatment.

Members will hear me speak more about the mental health strategy in the chamber this afternoon, but the opening of the facility supports the vision that is set out in Scotland's "Mental Health and Wellbeing Strategy" for a Scotland that is

> "free from stigma and inequality, where everyone fulfils their right to achieve the best mental health and wellbeing possible."

One of the outcomes within the strategy is:

> "increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs."

Foxgrove will play a key part in that by providing a dedicated and appropriately skilled multidisciplinary healthcare team to deliver the level of care that young people deserve, closer to home.

Adding Foxgrove to the regulations will ensure that the service can implement a range of safety and security measures to support the therapeutic environment and ensure the safety and security of children and young people as well as staff and visitors. The measures will be applied only when necessary, and they will be applied in a proportional way that is sensitive to the developmental stage of the child or young person.

Of course, it goes without saying that, when the measures are applied, they will also uphold and protect the human rights of children and young people.

Moving on to the specific the statutory instrument that is before the committee today, the regulations make amendments to the Mental Health (Safety and Security) (Scotland) Regulations 2005 and the Mental Health

(Detention in Conditions of Excessive Security) (Scotland) Regulations 2015, so that the same safety and security measures that are available in other medium-secure in-patient settings can be applied, where necessary, in Foxgrove.

Children and young people who are detained in Foxgrove will also have the same right of appeal against detention in conditions of excessive security as those detained in other medium-secure in-patient settings. I consider that a right of appeal is an essential safeguard in the process, and that children and young people should have that right when they are detained in Foxgrove.

The regulations do not create any new enforcement or monitoring mechanisms; they simply apply the existing mechanisms to Foxgrove.

Laying the regulations is an important step in preparing Foxgrove to admit patients, which it hopes to do early in 2024. They lay the framework for a safe, secure and—importantly—therapeutic environment, where children and young people's human rights are upheld and protected, and they allow them to appeal the level of security at which they are detained.

I am happy to answer any questions that the committee has.

The Convener: Thank you very much, minister. We will now move to questions, starting with Ivan McKee.

Ivan McKee: Good morning, minister and officials. My questions are on the consultation process. There was a fairly short consultation period, with a limited number of respondents. Does the Government consider that the period was sufficient, and that the consultation was shared widely enough, given that only nine responses were received?

Maree Todd: Yes, we do think that it was sufficient. Although there were only nine responses received, they were from key bodies that were charged with upholding the human rights of children in Scotland.

Subsequent to receiving the responses to the consultation, my officials met each of the respondents to ensure that we captured any concerns that they had about the legislation. Therefore, I think that, in addition to the formal consultation, there has been a good level of engagement with people who are charged with scrutinising the process in this situation.

10:45

Ivan McKee: That is helpful—thanks. Were any consultations undertaken with children and young people?

Maree Todd: Yes, there were. There is a children's panel, which helped us with the development of Foxgrove and has been part of the process of designing the building to ensure that it meets children's needs. It also engaged in some consultation with children and young people who had been detained in medium-secure settings. Ruth Christie can say a bit more about that process.

Ruth Christie (Scottish Government): The development of the Foxgrove facility has been ongoing for a number of years. NHS Ayrshire and Arran, which is the health board that is responsible for developing the service, has set up a public and patient reference group and has engaged children and young people a great deal in the development of the facility so that the environment is in line with what children and young people feel would be beneficial to them. The health board has carried out quite a lot of consultation with children and young people throughout the process, so I feel confident that that their views were taken into account in the design of the physical building and of how the service will operate.

Ivan McKee: Great; thanks very much.

Gillian Mackay: What assessment of the new unit has been undertaken in relation to the United Nations Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities?

Maree Todd: I will ask Dr Blower to tell you a little bit more about how CAMHS operates.

In general, and as you would expect, medical services that are available to children operate with UNCRC at their heart. In Scotland, we use getting it right for every child—GIRFEC—as a framework for all public service interaction with children and young people, so you would expect that to be human rights compliant and age appropriate.

With regard to the consultation, we have not done a formal children's rights and wellbeing screening sheet and impact assessment to assess how compliant these regulations are, but we have asked a lot of the questions relating to the CRWIA as we have gone along. The reason for not doing a formal CRWIA is that these regulations are an amendment to existing regulations and they do not contain any new protective measures; they are about applying measures that are already available to a new site. We would certainly consider doing a full and formal CRWIA if that was what Parliament wanted.

Gillian Mackay: That is great; thank you.

Maree Todd: Do you want to hear from Dr Blower about how CAMHS operates from a human rights perspective?

Gillian Mackay: Yes.

Dr Aileen Blower (Scottish Government): The main function of Foxgrove will be to ensure that children and young people are given effective treatment in the care of developmental specialists. The multidisciplinary team will have a unique role in ensuring that every aspect of care, including the nature of the building, the procedures that take place in it and the more clinical aspects of care, are delivered under the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003. That includes the principle of meeting the welfare needs of the child, and it applies for all under 18-year-olds. Those principles will be met, but also, in the everyday care planning, there will be attention to GIRFEC principles and SHANARRI indicators—safe, healthy, achieving, nurtured, active, respected, responsible and included—in terms of outcome measures. All of that looks towards upholding rights.

The purpose of the regulations is to ensure that there are safeguards around the use of particular procedures relating to safety and security. The whole purpose of this is to ensure that there is a level of oversight and scrutiny for all the measures that are used for young people in the facility for the duration of their stay.

Gillian Mackay: What are the criteria for undertaking a full or partial CRWIA and will those criteria change if the UNCRC bill does come into force?

Maree Todd: A full CRWIA was not required because the regulations do not create any new enforcement or monitoring mechanism. As I said earlier, they simply take mechanisms that already exist and apply them to a new hospital. I do not think that that will change because of UNCRC incorporation. In everything that we do, and with all the public services that we deliver to children, the Government tries to work—as it has done for many years—according to and in compliance with UNCRC principles.

The difference was that, when UNCRC incorporation did not happen, that was justiciable. There were consequences to it not happening. However, incorporation would not make any difference in practice to how we approach the issues, because we try very carefully to be UNCRC compliant at all times anyway.

Carol Mochan: I am interested in the right of the child to a family life, because we can all imagine this subordinate legislation having an effect on that. How can we ensure that young people who are in that situation have that right? Does the legislation comply with the provisions in the European Convention on Human Rights and the UN Convention on the Rights of the Child regarding the right to a family life and support for legal agency?

Maree Todd: I will ask Dr Blower to say a little more about how the legislation is likely to operate in practice, but all the legislation that comes through the Scottish Parliament is ECHR compliant and we always try to develop legislation that is UNCRC compliant, even though we have not yet incorporated that fully.

The right to family life is really important. Dr Blower was trying to explain just how much care is taken regarding the child's developmental stage and their welfare. Family life is really important to all that. Restrictions on the use of mobile communications, for example, might be applied on some occasions, but that will be done thoughtfully and the general principle will be that it is important for children who are being held in the unit to be able to maintain their links with family and friends outside that unit.

I will let Dr Blower say a little more.

Dr Blower: In general, family life and family relationships are core to the work of CAMHS. We know that the children and young people who are in the facility in Ayrshire will come from all over Scotland, perhaps from a long distance away. The referring team will make the referral in discussion with the child's family and relatives. Even if the child is in care, the family will be involved from the beginning of the referral process and in their detention under the act.

The act says that every child under the age of 16 has a default "named person", who is usually a parent. That person has a particular role under the mental health act. They are a party, can make appeals and have the right of access to all the legal documents. Young people who are 16 or 17 years old can nominate a named person, which is often a parent or another relative that they trust and are close to.

All actions within the unit will be discussed with the family. There will be provisions for family members to visit, and local authority colleagues such as mental health officers will be involved in supporting visits. If families come from a distance, there will be support for them to stay overnight, if that is helpful for them and if it facilitates contact. The named person would need to be informed about any of the measures under the regulations. As good practice, the parent would be informed of the child's progress, in the same way that any hospital would communicate with family members about how a young patient is doing. Parents' advice would also be asked about everyday things.

Carol Mochan: Given the complexities of the young people and the amount of support that would be required to maintain family contact, does it seem realistic that that could be maintained?

Dr Blower: I can say yes to that because, currently, if children are in any of our regional adolescent units in Scotland, they can still be quite far from home. That also applies to the national child inpatient unit in Glasgow, which covers the whole of Scotland. Our services are well used to involving families in the care of children, even very young children.

Maree Todd: Convener, could I talk a little bit more about the safety and safeguards that are in place?

The Convener: Yes, minister.

Maree Todd: They have been built in as safety and security measures that seek to protect rights while also protecting safety. There are conditions for how measures can be used. There are record-keeping requirements and, importantly, there is oversight and scrutiny by the Mental Welfare Commission for Scotland. All of those provisions act as safeguards for the rights of children and young people who might be detained in Foxgrove, while enabling the necessary measures to be taken to ensure that they are safe.

David Torrance: Good morning, minister and members of the panel. What steps are being taken to address the concerns about appeal rights that were highlighted in the Scottish mental health law review, particularly in relation to the way in which they apply to children and young people?

Maree Todd: There is a right to appeal built in. As I said in my opening statement, that is absolutely crucial. The treatment interventions for children and young people who require a certain level of security are not brief: the average length of stay at the NSAIS is about 12 to 18 months. The appeal process is rigorous and thorough, and we consider the timeframes suggested within the current regulations to be appropriate and proportionate.

As for the care and treatment that is provided, each individual who is detained will be managed under the care programme approach, which is a legal framework. There will be regular review, with accountability for the responsible medical officers. There are safeguards built in. There are appeal processes at certain points during the care planning journey, which I think is crucial to upholding children's rights.

David Torrance: Thank you for that. What consideration has been given to the timescales in which appeals are permitted? Is the current six-month period appropriate for children and young people? What consultation have you done on that?

Maree Todd: We think that the timescales are right, because the patients are not likely to be short-stay patients; they are likely to be longer-term patients. We think that the appeal processes are appropriate.

I do not know whether it would be reasonable to ask Dr Blower about that. Would you like to give a little bit more information about that, Aileen? Ruth Christie could perhaps then pick up on the question about consultation on the timescales.

11:00

Dr Blower: All the young patients in Foxgrove will have access to independent advocacy, which is a mechanism for discussing their views, feelings and wishes and ensuring that those are properly communicated and taken account of. They will all have access to legal representation and, if they do not have capacity to instruct, a curator can be appointed at relevant stages.

There are lots of opportunities for appeal. They can appeal their detention and against excessive security. At each stage, the young person can seek legal representation. There are also safeguards. The young person can contact the Mental Welfare Commission themselves. They can ask for the RMO to review, in a timely way, the use of particular safety and security measures and other specified persons.

In practice, any measure will be reviewed much more frequently than the regulations might indicate. Care planning for young people is a daily thing, and is done at least weekly by the whole team. Again, that would be done in discussion with family, and the mental health officer would be involved as a link with that.

As well as legal safeguards, there is the practice of ensuring that a rights-respecting approach is taken, because all that promotes recovery, too. Young people are much more likely to have a speedy recovery if they are involved in that as much as possible.

Ruth Christie: The point about appeals in the consultation is obviously one that several respondents raised. After further discussion with the respondents, I think that they were satisfied that we had considered whether the appeal process would be appropriate to be applied to children and that the timescales would still be applicable. There is also a point to be made about ensuring that there is time for any appeal to be rigorous and for all the right information to be gathered so that children and young people are detained appropriately at the right level of security.

Emma Harper: Good morning, panel. I am interested in the secure care standards and pathways. I have just read that there are 44 standards that describe care that should be delivered with dignity, compassion, sensitivity and respect and in a person-centred way, in the sense

that children make their decisions but with the involvement of everybody in the team. How do the regulations intersect with the secure care pathway and standards, and should the standards be referenced in the regulations?

Maree Todd: Foxgrove will be working to the secure care standards, so in its consideration of how it will operate once the regulations are in place, it is looking carefully at the secure care standards. It is a slightly different environment, but there is a lot of learning to be had from looking at how the secure care environment operates. It also looked at national standards that apply in England to pick up on good practice points. Therefore, to reassure you, Foxgrove will operate to the secure care standards.

Emma Harper: Foxgrove is intended to be a medium-secure care facility. Is that right?

Maree Todd: Yes.

Emma Harper: We talk a lot about helping to deliver the aims of the Promise. How does that align with what is being proposed for the work at Foxgrove? That work is in addition to the secure care pathway, and it is also delivering the outcomes of the Promise.

Maree Todd: It is a step forward for the care of children with complex problems. These regulations will help us to uphold and protect children's human rights in those situations. It is generally regarded as a positive step. Children who find themselves requiring secure care are currently usually transferred to England for medium-secure care. Being able to care for them in Scotland and therefore provide continuity of education—different education systems operate in the two countries—will help us to uphold the Promise rather than cause any challenge to those principles.

The Scottish Government is absolutely committed to delivering on the Promise. We made the Promise and we intend to uphold it.

Emma Harper: I have a final question. Foxgrove is aimed at young people between the ages of 12 and 18. We need to make sure that the care is age appropriate, so that we are not just transferring care from an adult facility and lifting and shifting to deliver and provide for young people. Will the care be targeted at the specific age of the young person?

Maree Todd: That is absolutely correct. The application of the safety and security measurements are to help to protect the safety of children and young people who require to be detained in Foxgrove in conditions of medium security. The measures will be applied only when necessary and will be proportionate to the potential risk.

As we said in a number of previous answers, the service will absolutely be UNCRC compliant. The child will be at the centre and the child's wellbeing will be core to all the facility's work. Family links will be maintained and all those important pieces will be in place. It will be a child-centred service first, as well as being a medium-secure service.

Tess White: I have two questions, minister. One is about staffing and one is about training. My colleague asked about the consultation. One submission to the consultation said:

> "there also needs to be robust consideration of staffing in the community and links with appropriately confident and trained clinicians. Staff are already overstretched to capacity in existing teams."

How confident are you that the new unit will be fully and appropriately staffed?

Maree Todd: I am very confident that it will be fully and appropriately staffed. As I said, the service has been many years in development and we recognise that particular care needs to be taken of children and young people who find themselves in that situation.

It is a specialist in-patient service that we have not had previously, but we have expertise in forensic CAMHS in Scotland—for example, we have Dr Blower. We can look to examples from the secure care estate and at how the estate operates in England to learn what might be required in terms of training and operational procedures for the unit to work well.

We operate CAMHS in a way that has the child or young person at the centre of their care. The care plan is developed in line with GIRFEC, and trauma-informed practice is an important part of that jigsaw. Our aim is that our entire public services workforce will be trauma informed. For CAMHS, it is absolutely crucial that staff are trauma informed and that that training is available to them. Most of them will already be trauma-informed practitioners.

I do not know whether Dr Blower wants to say more about the workforce.

Tess White: My question was just, "Are you satisfied?", and you have answered it fully. Thank you.

My second question is around training. Has a children's rights impact assessment taken place, and if so has a training program for the staff been put in place?

Maree Todd: I will let Ruth Christie give a fuller answer, but, as I said previously, we have not done a full CRWIA. We have asked many of the questions as we have gone along and we have been satisfied that we are child rights compliant, but we have not done a full CRWIA.

Ruth Christie: I can give a little bit of information about that. Obviously, NHS Ayrshire and Arran is overseeing the recruitment and training of the staff who will work at Foxgrove, and it has already started to recruit staff. That has been gradual process that has been building up as Foxgrove gets closer to opening, which has allowed the recruitment of staff who might not necessarily have a forensic mental health background. There is time for staff to develop and to undertake training in conjunction with NHS Education for Scotland and with experts. As the minister said, that will draw on the experience of units in England. That process is already in place, so by the time the facility opens there should be a really well-trained and well-informed staff group ready to go and to link in with other local services.

Tess White: That does not actually answer my question. My background is as a human resources professional. Normally, you would do a risk assessment and then, on the back of that, you would make sure that you have a training programme in place—ideally before the staff start. What you are saying is that the staffing is being done, but the complete risk assessment and the training programme have not yet been done.

Maree Todd: To be clear, all of those operational details are the responsibility of NHS Ayrshire and Arran. A question with that level of detail should probably be put to NHS Ayrshire and Arran, which will be charged with that. It is easy for us to say what we expect to happen, but if you need reassurance on whether a risk assessment has happened and whether training needs were identified during that risk assessment, it is probably best to put that question to NHS Ayrshire and Arran.

The Convener: I am going to pick up a little bit on that, because my question is about operational issues and some of the concerns that have been raised by stakeholders, particularly around about technology and mobile phone policy. I accept that we already have very well-established CAMHS services across Scotland, which will more than likely already have well-established policies on things such as mobile phones and iPads. Can the minister tell us what on-going discussions have been taking place with stakeholders in regard to that? I refer members to my entry in the register of members' interests as a registered mental health nurse.

Maree Todd: As mentioned in an answer to a previous question, access to a telephone to maintain contact with family and friends is a pretty crucial matter for any patient in hospital, and the Foxgrove team will ensure that young patients can safely use telephones within the unit. Procedures will be developed—again, those will be operational procedures developed by NHS Ayrshire and Arran—around access to mobile phones for all young patients in the unit and for children and young people as part of their individual care plan.

Under separate regulations, the use of telephones can be restricted if the RMO determines that a telephone call made to or by the person detained might cause distress to the person detained or to any other person who is not on the staff of the hospital, or significant risk to health, safety or welfare of the person detained for the safety of others. It is not a measure that is used lightly or in a blanket way. It is used very proportionately where there are specific care needs that need to be met.

11:15

Paul Sweeney: The submission from the Children and Young People's Commissioner Scotland says that the proposals

"appear not to address issues such as training for staff".

That is now a critical consideration for the committee, given that the Children and Young People's Commissioner Scotland's response cites that the proposals lack detail on training. The response from the panel so far has been that that is an operational matter for Ayrshire and Arran NHS Board.

There has been discussion about vague ideas about starting to recruit. I understand that the opening is to be in January next year, which seems quite close. How can the committee have any confidence that the concerns that the Children and Young People's Commissioner Scotland raised are being addressed?

Maree Todd: The opening is now scheduled to be in mid-March 2024. There have been some building challenges, as is often the case, in the completion of the construction projects, which have meant that there is a slight delay. The building is now expected to be completed and operational in mid-March next year.

The committee can have confidence that the health board—as in all the sites that it operates—is capable of identifying the staffing requirements for, and the training needs of, the people who are going to work in the unit.

As we have said, the recruitment process has already begun. As the service is completely new, we would expect that that process would need to begin early to enable the opportunity for any shadowing or networking that might be required on other sites. We do not have anything like that in Scotland yet, so we would expect that the process would begin early and that there would be a slightly longer lead-in time than there would be if we were just building a hospital like what we already have in Scotland.

Paul Sweeney: Given that it is quite a new model, is it important to have more direct oversight of the detailed training programme, the detailed operational mobilisation for the facility, and information on where it currently stands on vacancies, recruitment and the appropriate training programmes for each person recruited, so that we can have more confidence that the concerns that were raised by pretty serious stakeholders are addressed?

Maree Todd: I am confident that I have enough oversight to be certain that NHS Ayrshire and Arran is well prepared for the opening of the hospital, and I am confident that it is able to identify the right staff mix and that any training needs can be met through internal training, courses that are available through NES and informal networking.

I am confident that I have enough oversight that the building will be successful in opening. It has been many years in planning, and for many years it has been identified as a need for Scotland. Generally, aside from some construction constraints, we are motoring towards opening it healthily.

Paul Sweeney: If I may be clear on the fundamental concerns, the national youth justice advisory group said:

> "NYJAG don't believe the measures should be authorised as they stand as children under eighteen have different levels of need and maturity and require appropriate age and developmental stage supports."

The Children and Young People's Commissioner Scotland said:

> "We would recommend that alternative proposals be developed, using as a starting point the Secure Care Standards and Pathways".

The centre for mental health and capacity law at Edinburgh Napier University said:

> "There should therefore be a detailed human rights impact assessment undertaken in addition to this limited consultation."

Is the minister's position that the committee should disregard what those stakeholders have said?

Maree Todd: As we stated earlier, officials have met each of the stakeholders who contributed to the consultation. They have had detailed discussions and have reassured the stakeholders that the processes are appropriate. We are comfortable that we have the support of stakeholders, that we have been able to adequately explain how the service will operate with regard to children's rights, and that the service is an important step forward in upholding children's rights.

I do not know whether Ruth Christie wants to say a little more about those meetings with stakeholders, which took place subsequent to the consultation.

Ruth Christie: Having those discussions and discussing the concerns that stakeholders raised was helpful. The framework is broad, and being able to discuss how it would be applied in practice to children and young people was helpful. We were able to reassure the respondents that we had thought it through and taken proper advice, and that we consider that what we propose is the right course of action.

The Convener: I thank the minister and her officials.

We now move to agenda item 5, which is the formal debate on the affirmative instrument on which we have just taken evidence. I remind the committee that members should not put questions to the minister during the formal debate and that officials may not speak in the debate.

Emma Harper: I will make a short comment. The regulations introduce a brand new facility for Scotland. It will be the only specialist adolescent in-patient service in Scotland, and I look forward to its progress. Because it is a completely new facility, I would be interested in the committee continuing to get further information by correspondence or face to face as the matter progresses so that we can inquire about operational issues and the facility's effectiveness.

Paul Sweeney: Having listened to the statements and evidence from the minister and the officials, I do not have enough confidence to support the recommendation that the Parliament approve the instrument, given the human rights concerns outlined in submissions to the committee.

I have noted the reassurances received but, until we have documentary confirmation of those, it is hard to come to a firm and confident conclusion that the stakeholders who are critical are content. Therefore, I propose that the statutory instrument be deferred with a view to incorporating safeguards that stakeholders feel are absent and to allow for a detailed human rights impact assessment and a children's rights impact assessment to be undertaken.

I will outline the key takeaways for me. First, the consultation was too short—it spanned just two weeks, and it received nine responses. The Children and Young People's Commissioner Scotland was not included in the initial consultation distribution, so contributed late.

There are also concerns about whether children and young people in facilities such as the one that is proposed can consent to measures that are authorised under the 2005 regulations, including invasive searches and swabbing. Adding a

children's facility to the list under the regulations that are used in adult services is, on the face of it, at odds with the Scottish Government's commitment regarding incorporation into Scots law of the United Nations Convention on the Rights of the Child. Although we have noted the reassurances received from the minister, firmer protocols are needed to ensure that we have confidence in that behaviour.

No children's rights impact assessment has been undertaken by the Scottish Government, which says that it is not necessary, as similar regulations are in place in similar facilities. However, the Children and Young People's Commissioner Scotland says that that itself is of concern and notes:

"We are concerned that these proposals appear to have reached this stage without the creation of a Children's Rights Impact Assessment (CRIA). It is likely that a CRIA would have brought to light, at an early stage, the concerns we outline".

On that basis, it is not appropriate to recommend approval at this stage.

Maree Todd: I am keen to proceed with the regulations. I am more than happy to conduct a CRWIA and to keep the committee informed of the outcome of that. I am more than happy to take on board Ms Harper's suggestion of getting more operational detail from NHS Ayrshire and Arran but, fundamentally, the regulations would not change. Much of what members seek assurance on is operational detail, on which I can, by liaising with NHS Ayrshire and Arran, reassure them. Those concerns would not fundamentally change the legislation, so I am happy to proceed.

The Convener: Thank you, minister. I ask you to formally move motion S6M-10534.

Motion moved,

That the Health, Social Care and Sport Committee recommends that the Mental Health (National Secure Adolescent Inpatient Service: Miscellaneous Amendments) (Scotland) Regulations 2023 be approved.—[*Maree Todd*]

The Convener: The question is, that motion S6M-10534 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division. I suspend the meeting briefly.

11:25

Meeting suspended.

11:25

On resuming—

The Convener: We come to the vote on motion S6M-10534.

For

Harper, Emma (South Scotland) (SNP)
Haughey, Clare (Rutherglen) (SNP)
Mackay, Gillian (Central Scotland) (Green)
McKee, Ivan (Glasgow Provan) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)

Against

Gulhane, Sandesh (Glasgow) (Con)
Mochan, Carol (South Scotland) (Lab)
Sweeney, Paul (Glasgow) (Lab)
White, Tess (North East Region) (Con)

The Convener: The result of the division is: For 6, Against 4, Abstentions 0.

Motion agreed to,

That the Health, Social Care and Sport Committee recommends that the Mental Health (National Secure Adolescent Inpatient Service: Miscellaneous Amendments) (Scotland) Regulations 2023 be approved.

The Convener: That concludes consideration of the instrument.

National Health Service (General Medical Services Contracts and Primary Medical Services Section 17C Agreements) (Miscellaneous Amendments) (Scotland) Regulations 2023 (SSI 2023/281)

The Convener: The next item on our agenda is consideration of a negative instrument. The purpose of the instrument is to amend the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018 and the National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018 to enable prisoners to apply to register with a GP prior to their release from a custodial setting.

The policy note states that the current regulations

"enable GPs to refuse an application to join a practice from a prospective patient if that patient does not live in the GP practice area. The effect of this for prisoners means that they are unable to register with a GP until after their release from custody, which can present delays to registration and access to healthcare."

The policy note further states:

"allowing prisoners to apply to register with a GP in the community prior to their release safeguards continuity of care during the early stages of their rehabilitation."

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 24 October 2023 and made no recommendations in relation to it, and no motion to annul has been lodged in relation to it.

I ask members for comments.

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

I have a number of points to make, the first of which is that it is vital for people who are leaving prison to have continuity in their primary care, because a lot of what happens in prison with regard to medication and treatment is quite effective. When prisoners leave, they do not always, but often, fall through the gaps, and they no longer receive the care that they should, or as anyone in Scotland should.

However, I have multiple concerns. It is all very well to say that a prisoner should have continuity of care, but that will not happen if the GP does not get a summary from the hospital. On about three occasions, I have had a prisoner in front of me with absolutely no record of what has happened. That is of no use to my patient or to me, and that is detrimental. Therefore, that needs to be addressed.

We also need to be clear about what is intended, and I would like a response to some questions.

The regulations say that a practice cannot refuse. What if that practice has a closed list? If it is already oversubscribed with patients and has closed its list, will that practice still be forced to take on a patient who comes from the Scottish Prison Service?

How can we be sure that the person will be living in the area where they say they will be living? Ultimately, the reason why practices have an area is that practitioners are expected to do home visits in that area. Although many people may want to go back to the practice that they attended when they were children because they feel that it is a good practice in which they had good experiences, it might not be located where the person is living now—it might not be the nearest practice to them. In that context, the measure might not be appropriate.

We just need a little bit of safeguarding to ensure that the practice is able to say that it might not be the best practice for a person, rather than making the blanket statement, “You have to take this patient.”

The Convener: That is noted, Mr Gulhane. I suggest that the committee write to the Cabinet Secretary for NHS Recovery, Health and Social Care asking him to answer the questions that you have raised. Would you be content with that?

Sandesh Gulhane: Yes.

The Convener: I have not had an indication that any other member wishes to speak. I therefore propose that the committee make no recommendations, but that we write to the cabinet secretary, in relation to the instrument. Does any member disagree with that?

Members: No.

The Convener: Thank you very much.

At our next meeting, next week, we will hold an evidence session on vaping and e-cigarettes.

11:31

Meeting continued in private until 12:00.

This is the final edition of the *Official Report* of this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

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