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

Thursday 2 October 2025

The Scottish Parliament
Pàrlamaid na h-Alba

Session 6

Thursday 2 October 2025

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CRIMINAL JUSTICE COMMITTEE, HEALTH SOCIAL CARE AND SPORT COMMITTEE, AND SOCIAL JUSTICE AND SOCIAL SECURITY COMMITTEE (JOINT MEETING)

25th Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)
*Audrey Nicoll (Aberdeen South and North Kincardine) (SNP)
Collette Stevenson (East Kilbride) (SNP)

DEPUTY CONVENER

Bob Doris (Glasgow Maryhill and Springburn) (SNP)
Liam Kerr (North East Scotland) (Con)
*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

Jeremy Balfour (Lothian) (Ind)
Katy Clark (West Scotland) (Lab)
*Sharon Dowey (South Scotland) (Con)
Joe FitzPatrick (Dundee City West) (SNP)
Sandesh Gulhane (Glasgow) (Con)
Emma Harper (South Scotland) (SNP)
*Patrick Harvie (Glasgow) (Green)
Jamie Hepburn (Cumbernauld and Kilsyth) (SNP)
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*Pauline McNeill (Glasgow) (Lab)
Carol Mochan (South Scotland) (Lab)
Alex Rowley (Mid Scotland and Fife) (Lab)
*Alexander Stewart (Mid Scotland and Fife) (Con)
David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Steve Baxter (Wm Morrison Supermarkets Ltd)
Tricia Fort (Calton Community Council)
Kelda Gaffney (Glasgow City Health and Social Care Partnership)
Maggie Page (Scottish Government)
Dr Saket Priyadarshi (NHS Greater Glasgow and Clyde)
Dr Tara Shivaji (Public Health Scotland)
Maree Todd (Minister for Drugs and Alcohol Policy and Sport)
Annie Wells (Glasgow) (Con) (Committee Substitute)

CLERK TO THE COMMITTEE

Diane Barr
Alex Bruce
Stephen Imrie

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

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[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Audrey Nicoll): Good morning and welcome to this joint meeting of the Criminal Justice Committee, the Health, Social Care and Sport Committee and the Social Justice and Social Security Committee. We have no apologies.

Our first item of business is a decision on whether to take item 3, which is consideration of evidence and the legacy paper, in private. Are we agreed to take item 3 in private?

Members *indicated agreement.*

Reducing Drug Deaths and Tackling Problem Drug Use

09:00

The Convener: We will hear from two panels of witnesses this morning. I would like to welcome to the meeting Dr Saket Priyadarshi, Glasgow alcohol and drug recovery services; Kelda Gaffney, Glasgow city health and social care partnership; Tricia Fort, Calton Community Council; and Steve Baxter, Wm Morrison Supermarkets Ltd. I refer members to the papers that were circulated for this meeting. Due to our time constraints, we will move straight to questions. I will open with a scene-setting question, which I will put first to Dr Priyadarshi.

Will you provide information on the published figures that set out the number of service users and injecting episodes, as well as information on the type of drugs that are being used at the Thistle project? For example, are the levels of service users and injecting episodes as you would have anticipated them?

Dr Saket Priyadarshi (NHS Greater Glasgow and Clyde): Good morning and thank you for the invitation to give evidence today. We provided a data report to the committees yesterday with the most up-to-date figures, which go up until 30 September. As at that point, we had seen 461 unique individuals who had registered to use the service, which they had used more than 7,000 times, and there were more than 4,600 injecting episodes within the Thistle itself. The number of injecting episodes is probably an underestimate, because every time that a booth is used is counted as one episode, but a booth might be used for more than one injection per visit. It is likely that there have been more than 5,000 injections.

The balance between the different drugs that are used in the service is very much skewed towards injecting cocaine. During the eight or so months in which the service has been operational, about 70 per cent of injecting episodes were related to cocaine, which is significantly different from what would have been the case when the original business case for the facility was presented eight years ago. There are significant drug trend changes in the city, where there is an increasingly changeable and volatile drug market.

We have seen 60 medical emergencies in the Thistle, which have been managed with positive results for individuals. Those individuals have all recovered and come back and used the service again. Those medical emergencies were heterogeneous; they were not all the same. Some were relatively easier to manage in-house with

airway management and oxygen, whereas others were at the much more severe end and required intensive medical emergency treatment. We have had to use the ambulance service on 11 occasions. On seven of those occasions, an ambulance supported service users to hospital.

An initial review would suggest that there have been 5,000 injections inside the service that would otherwise have taken place in other places, away from home, which means that the needles used for those injections have been discarded within the facility rather than outside, in public places. There have been 60 medical emergencies, which have mostly been managed in-house, with positive results. Some of those medical emergencies were very severe—that was probably at the time when nitazenes were in the heroin supply in Glasgow. In those situations, the risk of fatality undoubtedly would have been extremely high.

Equally, as a result of the in-house management of those medical emergencies, the ambulance call-out rates have probably been significantly lower than they would have been if the individuals concerned had overdosed in public places or in hostels or other areas. In addition, the hospital admission rates for those people are, I would imagine, significantly lower. Those things will be measured through the formal evaluation.

With regard to your question about the extent to which what we have seen matches expectations, I think that the surprise for us has been the shift in the balance of the number of injecting episodes inside towards cocaine. We now understand that that reflects street drug trends. The data suggests that the number of people who use the service on a daily basis continues to increase. September was our busiest month so far.

It has been a promising start, but we still have some way to go to improve the coverage of usage of the facility for people who currently inject away from home in the east end and the city centre.

The Convener: Thank you. Some of that information on the growing use of the service was helpfully set out in the submission.

I have a follow-up question on drug trends, which you mentioned. We are very aware of the growing prevalence of nitazenes. How are those trends impacting on service delivery at the Thistle?

Dr Priyadarshi: If we take a step away from the Thistle and look at what we know about the drug market in the city, we can see that there has been a significant shift from injecting—injecting heroin, in particular—to smoking. The smoking of crack cocaine, in particular, is rising quite significantly.

We appreciate that there are nitazenes in the supply from time to time, but the extent to which they are found in forensic toxicology—although that has grown since last year—is still relatively small, compared with the extent to which other drugs are found in toxicology.

There was a cluster of very severe overdoses in March and April, which was experienced across the central belt and in Ayrshire. We experienced such overdoses in the Thistle, which meant that we were able to observe them. They required very intensive management. That gave us the first observable clinical picture of overdoses of nitazenes. Although such overdoses were being reported nationally, we did not have an objective clinical picture of them.

We were able to get some drug paraphernalia from people and to have it tested in forensic laboratories. That provided us with confirmation that we were dealing not simply with heroin but with heroin with nitazenes. Therefore, I think that, from a drug-trend monitoring perspective and an intelligence-gathering perspective, the Thistle was able to play a significant role in building a picture of what was happening at the time. We were able to share that information not only across our health board but across Public Health Scotland's national group, which had been set up to manage the incidents across the city at the time, and that informed a drug alert.

More recently, we have been concerned about the impact of adverse, atypical events for people who think that they are smoking crack cocaine. You will be aware of a cluster of overdoses that happened in the city centre. Some investigation into those confirmed that the supply contained synthetic cannabinoids, which are very strong cannabinoid agents that have played an important role in atypical and severe adverse events, some of which are likely to have been related to suspected drug-related deaths.

Regarding the impact of that for the Thistle and the development of safer drug consumption facilities, we are able to provide harm reduction advice to service users, but the adverse events amplify the importance of drug-checking services and adding a smoking inhalation space to our service, because that is where the drug trend seems to be heading.

The Convener: Thank you for that comprehensive response.

Paul Sweeney (Glasgow) (Lab): Thank you for your initial comments, Dr Priyadarshi. It is promising to hear that there has been an uptick in the patronage and use of the facility over the past six months or so.

I want to establish some of the trends that you mentioned around cocaine injection, because you said that 70 per cent of injection episodes were related to cocaine. Can you comment on the typical pattern of behaviour for cocaine injection,

particularly the frequency of the episodes relative to heroin and how it presents? Is there a greater frequency of injecting as a result of cocaine use?

Dr Priyadarshi: The first thing to make clear is that most people who use cocaine have at least a history of injecting heroin as well. Most people who inject cocaine who come to our service have a long-standing problem history of drug use, which includes injecting heroin. In more recent times, it seems that they have transitioned to cocaine as their primary drug of use.

The pattern of use is different, absolutely. People who use heroin will have fewer injection episodes than people who use cocaine. Cocaine, to put it in layman's terms, is very moreish, so when people start to use cocaine, they often go on short binges, which could last a day or two and involve multiple injection episodes. Somebody who uses heroin might inject two, three or four times a day; somebody who injects cocaine in the most extreme way might inject more than 10 times a day, so we see people coming back to the service again and again in one day.

The other big difference with that population is that we notice a pick-up in the latter half of the day and heading towards the evening. The vast majority of medical emergencies happen to people who use heroin—they often mix heroin and cocaine and end up snowballing—and they are the individuals who require the highest degree of post-injection monitoring in the recovery area. People who use cocaine often transition through the recovery area quite quickly and leave the service and come back later, but as the day progresses, their presentations can change and they can show signs of becoming affected more and more by the stimulant use.

Paul Sweeney: It is interesting that the frequency of injections per person is increasing because of the change in behaviour. From the outset, one of my concerns has been the facility's restricted operating hours. There has been commentary about drug-related debris in the wider community and, anecdotally, I have heard a suspicion that that could be related to increasing frequency of use rather than an overall increase in the number of people using drugs in the area. I have had recent correspondence from Matt Corden at the Drygate Brewing Company Ltd—the Ladywell is behind his business—who has described significant drug-related debris appearing overnight. What interaction is the service having with the council and other partners to monitor street injecting in the vicinity of the facility, particularly from 9 pm to 9 am, outside the facility's operating hours, and what adjustments could be made to the service model as a result of that?

09:15

Dr Priyadarshi: I will kick off, but my colleague Kelda Gaffney might also want to comment. The first thing to say is that many of those injecting sites existed before the Thistle facility was opened and that, by absorbing 5,000 injection episodes, the Thistle provides a degree of benefit already by reducing the likely impact on the community, especially as people move from injecting heroin to injecting cocaine, given the increased frequency of episodes and the night-time injecting that comes with that.

We have a community engagement forum with a full range of local partners who inform us about the sites that they are most concerned about with regard to injecting and drug-related litter. We work closely with Glasgow City Council's neighbourhoods, regeneration and sustainability service, which will respond to those concerns and go to clean sites that are in the public domain. As you know, there are challenges with regard to private sites. NRS instituted a Calton action plan to improve the social environment for the community through deep cleans of sites that were identified and the placement of two drug bins—one in Calton and one in Morrisons supermarket. The Morrisons representative can speak to that.

All that work is going on, but, day to day, we have two outreach sessions from staff at the Thistle—one in the morning and one in the afternoon. For example, when we heard about the issues at Drygate—we heard very quickly about those—we were able to respond. Our staff go out twice a day and try to engage potential service users who are using those sites by giving them information about the Thistle as an alternative. Many of our new service user registrations are a result of that outreach work and diverting people away from public spaces to inside.

However, as I said earlier, we do not have full coverage of all injecting episodes for a range of reasons, one of which might absolutely be the hours of operation. We have been made aware of that issue by staff and service users, and we have been told that it is an issue by our service user forum. We are only seven or eight months into providing the service. There will come a time when we need to review some of the basic operational elements, and we will need to review the operating hours at that time.

To be clear, in the original business case, we considered longer and overnight operating hours. At the time, the number of overnight injecting episodes that we were aware of in the city was much lower than it is now, so, having considered the cost benefit element of running an overnight service with the staff complement and everything that goes with it, we did not think that the need reached the threshold of benefit. However, as I

explained, and as you are alluding to, the dynamics of the drug market are changing. If cocaine is the primary injecting drug, we might need to reconsider our operating hours, and we will do that in due course.

Kelda Gaffney (Glasgow City Health and Social Care Partnership): I will add something very briefly, because it is a good point and a good question. As Saket Priyadarshi said, we looked at the operating hours before devising the operational model. That involved consultation with people with lived and living experience in that city centre population. However, the trends have changed, so we will always keep that under review. The model that was proposed and funded was based on that cost benefit analysis—and that has to be the case moving forward. However, we also engage with our partners fairly regularly.

As you will know, there will be a formal evaluation, but that will not report for another couple of years. The discussions that we are having internally are on how we report and record the outputs and any of the barriers and gaps that we experience along the way. Operating hours are absolutely a part of that. That aspect is and will continue to be under consideration, and we have a number of governance forums in which we discuss the operating model.

Paul Sweeney: The needle exchange programme has operated in Glasgow since 1987. You said that the Thistle has removed around 5,000 injections from the street environment. Does the Thistle provide a dispensing element in the form of sterile injecting equipment? If so, how does that operate? Also, how does the Thistle operate in concert with the well-established needle exchange programme? How does that work, bearing in mind the restricted operating hours of the Thistle?

The Convener: I ask that you make your comments as succinct as possible. We have got a lot of questions to get through in slightly limited time. I ask for your forbearance on that.

Dr Priyadarshi: I will do my best.

Yes, the Thistle provides injecting equipment to people who register at the service or who are leaving the service after injecting, if they ask for that. It is the same injecting equipment—a one-hit kit—as that provided throughout the city. The rationale for that is that we are becoming aware that not all injecting episodes are inside the service. Also, we are aware that there is a background of HIV, hepatitis C, wound infections and so on. We are employing a pragmatic harm-reduction measure.

We can see that our injecting equipment provision becomes more popular as the day goes on and into the evening as well. Again, that builds into the trends that we are seeing around injecting cocaine into the evening and night time.

Sharon Dowey (South Scotland) (Con): Good morning. I want to ask about the impacts on businesses and the community. Will you set out some of the drug-use issues that businesses in the community faced prior to the Thistle opening and the impact that its opening has had on those issues? I invite to Steve Baxter to respond first.

Steve Baxter (Wm Morrison Supermarkets Ltd): I can speak only to Morrison's in Barrack Street. There has always been a problem with drug use in the area of our store, which I think has been linked to the needle exchange that has been mentioned.

We have tracked the data closely and have engaged with the Thistle and the local authority. The particular issue that our store suffered from was users taking drugs in the car park and in the surrounding curtilage, and the needle debris that came about as a result of that use. The fact that there were significant deposits of needles was of huge concern to our colleagues and our customers.

The data that we have provided to the committees demonstrates that there has been a significant reduction in the amount of needle debris that is recovered, which is really positive. Needle recoveries have fallen by 94 per cent. We have a clear process for how we deal with used needles, how they are recovered and how they are reported.

There is a qualifier, in that there was a slight underreporting of needle recovery in-store because of sickness and leave over the summer period. However, if you look at the results since the needle bin went in in May—we co-operated with the local authority on that; I think that it is the first local authority needle bin on a private site—you will see that there is a direct correlation with the number of needles that were recovered in the car park before that was put in. From our point of view, those are really positive changes.

The anecdotal feedback from colleagues in the store pre and post the opening of the Thistle is, for the most part, positive. They say that they see many fewer incidents of drug taking in and around the car park. Such incidents are obviously very disconcerting for everybody in the community; nobody wants to see that. The examples that I provided included needles being recovered in parent and toddler parking bays at our shop, and in disabled toilets, which is unacceptable, is it not? Colleagues are seeing fewer examples of that now. In addition, fewer needles are being recovered in the car park, although that is still happening. The 96 needles that have been

recovered from the needle bin means 96 fewer being put in our bins.

Something that colleagues talk about is the increased footfall into the Thistle by strange people. It is a very tight community, and people are well known. Colleagues say that there are many more faces in and around the store, and that begging has increased. We report begging incidents and, previously, there would have been just one individual involved; now, people are begging in twos and threes. I have picked that up with the Thistle's operational manager, and he is very supportive.

Sharon Dowey: Do you have a breakdown of the figures that you sent in? Your submission refers to "All Business Incidents". When you say that there has been an increase in—

Steve Baxter: Those are all crime related, although they would not necessarily all be reported to the police. The overwhelming majority—about 50 per cent—of those are incidents in which packaging is recovered in-store. There has been a theft, but there is no evidence of who committed the theft, and we cannot track back on the closed-circuit television because of the volume of such incidents. That accounts for about 50 per cent of the incidents in-store, followed by standard shoplifting, abusive behaviour to staff and antisocial behaviour in Barrack Street, which is linked to begging, as well as the discarding of needles.

Sharon Dowey: How big an impact did the underreporting that you mentioned have?

Steve Baxter: We are probably looking at underreporting of about 10 per cent, specifically in relation to the needle debris. In addition, we had an operational issue with our freezers, bizarrely, over the summer, which meant that our footfall was slightly down. There was therefore a natural reduction in the number of incidents, by virtue of fewer people coming through the door.

Sharon Dowey: Thank you. Tricia, would you like to respond?

Tricia Fort (Calton Community Council): Thank you for inviting the community council along. Most of our evidence is anecdotal, as we do not have the capacity to collect any figures.

I moved from elsewhere in the city to live in Calton almost nine years ago, and I was immediately aware that there was drug refuse. At that time, the Simon community operated nearer to the Thistle—far nearer than it does now—and it was quite near my home. After a year or two, I started volunteering there, and I was one of the people who issued needles to people in the needle exchange. That upset a lot of my neighbours.

I can only agree with what Steve has said; it now appears that more people are coming into the area. There was a fear beforehand that dealers would move in and, anecdotally, that has been confirmed.

The Convener: We will come back to you, Tricia, if that is okay. I am conscious of time, because we still have quite a lot of members who want to ask questions. I will bring in Alexander Stewart and then Pauline McNeill.

Alexander Stewart (Mid Scotland and Fife) (Con): I would like to extend the point about engagement. It would be good for us to get a flavour of what has been happening as regards engagement with the community and the business sector. I believe that a community engagement forum is held in the community. Could you give us a flavour of what has been discussed at the forum and how issues have been addressed? Has that vehicle been used? If so, have you found it useful in managing the situation in the community? Are there areas that you have concerns about?

09:30

Steve Baxter: Is that question addressed to me? I do not run that forum.

Alexander Stewart: Is the business involved in the forum?

Steve Baxter: Yes, the business is engaged with the forum. Sadly, we have had a change of managers in store since the beginning of the year, and we are now on to our third manager, so the continuity is not quite as we would like it to be. The new manager is now being fully brought up to speed. He has been across to the Thistle facility and has met the team there. I have introduced him to the local police and local authority representatives. At those levels, the engagement is good. We have encouraged colleagues, many of whom live locally, to attend the forum, and we have given them information about it. I am reasonably confident that the uptake has been pretty poor.

Alexander Stewart: Tricia, do you have any involvement with the forum? Is the community council involved in it?

Tricia Fort: Yes, I do. I would say that it is a very positive thing. The number of people involved has increased since the forum started, and there has been some positive engagement from people who were initially very hostile to the Thistle. People still have concerns, but there has been some good discussion. There was a meeting on Tuesday, which Saket Priyadarshi chaired. One new person was there, who had also been coming to community council meetings, and she had lots of questions about where she lived. Those

questions were all answered and noted for further action.

I would say that, through the forum, through the discussion and through the involvement of the local authority and the police, things are improving. Before the Thistle was there, the view was, "It's Calton—that run-down area at the east end of the city that nobody's concerned about." That was definitely a view among people who have always lived in the area. The city council is now clearing areas where there has been drug use, and needle bins are being put there, as Steve Baxter said. Indeed, Steve's figures are very encouraging.

There is still concern, and people are still seeing drug dealing. It has moved around the area. I am sorry that this is not about the forum, but we in the community council involved the police when there was drug dealing up near the Moxy hotel and Havannah Street, for those who know the area. We then had some on Parsonage Square, which is further south, and on St Andrew's Square. There has been drug taking near St Luke's. It moves around, as the police follow those involved.

Overall, good is coming out of what was seen as a big infringement on the area.

Alexander Stewart: So, there has been a change in the antisocial behaviour and drug taking around the area. Have you both experienced that?

Tricia Fort: Well, I am sorry—I am not sure. I do not have that detail. There is still a lot of drug taking in and around the area. I understand from people who have talked to drug users that there is a reluctance to use the Thistle on the part of some people, although some people are going along.

On Tuesday, we heard from members of the outreach team, who are being exceedingly positive, friendly and welcoming to drug users who they meet outwith the Thistle. They encourage them to start using it, rather than injecting outside.

My personal opinion is that the facility is doing good. However, as I mentioned in my short paper, there is still a lot of concern. We did not have any involvement in the setting up of the Thistle; it was just imposed on us. It was put there, and now we have to live with it.

Steve Baxter: We would certainly say that we have seen a reduction in drug activity around our store.

Pauline McNeill (Glasgow) (Lab): Good morning. I want to continue on that theme. I know Calton well. I have been to the facility and I am aware that, as Tricia Fort said, there has been a lot of apprehension in the local community. That is understandable.

I have noted what you have already said, but the media reporting seems to suggest that there has been an increase in drug-related crime. Is that related at all to what you are telling the committee? Is there any evidence that there has been a reduction or an increase in drug-related crime? Which is it?

Steve Baxter: I cannot talk to Police Scotland's statistics on drug-related crime. All that I can tell you is our experience, which is that we have not seen an increase in theft—shoplifting—or other incidents in our store linked to the opening of the Thistle. In fact, we have seen a reduction.

Pauline McNeill: Tricia, is that the view of the local community?

Tricia Fort: As far as drug-related crime is concerned, I have no knowledge of that at all. People are concerned that they see drug taking and evidence of it, but that has been the case for many years. I do not know whether it has gone up or down. It has certainly moved.

Steve Baxter: Could I make a point about the media? This is a high-profile issue for Morrison's and our media team received complaints in social media posts that were made. Initially, when the centre opened, there was a huge wave of social media. However, in recent times, we have not had much contact at all in respect of concerns being raised on social media.

Dr Priyadarshi: Police Scotland is a very important partner in the community engagement forum and is a partner of the service. When it has come to the forum and presented its data, it has confirmed that there is no clear evidence of an increase or change in drug-related crime, as recorded by it, in the vicinity. It was able to give that feedback to the residents and the other stakeholders in the forum. I believe that it made a submission to the committees confirming its data.

When we opened the service, the media coverage was more positive. We can talk about the media coverage later if there is a question on it but, in recent times, it has been challenging for us, as it has not been informed by evidence or by clear, objective opinion.

Pauline McNeill: My colleague raised the specific issue of drug dealing. Does that data include drug dealing?

Dr Priyadarshi: I think that the drug-related data that Police Scotland presents—and has presented to the committee—is likely to include drug dealing in its breakdown, but that is not something that I am able to answer definitively.

Pauline McNeill: My next question is about the way that you engage with the community. There is still a long way to go, given that we are only seven

months in, as you said. How regular is the contact with the community to keep it engaged?

Dr Priyadarshi: The community engagement forum meets six-weekly. We have one meeting during the day and one in the evening, and we try to meet at different locations to allow as many stakeholders as possible to attend. Some people work and cannot attend daytime meetings, while others find evening meetings difficult. As you have heard, the meetings are valued by the members of the community who attend, including the community resident and business reps who are regular attenders. We also have registered social landlords attending, who represent many tenants in the area.

The forum is valued and is taken seriously. I think that members of the community have confidence that the issues that they raise are taken seriously by the service leads and by partners—in particular, Glasgow City Council and Police Scotland.

On a day-to-day basis, we have made two of our senior officers in the service, including the operational manager, and the Thistle phone number and email address available for contact. We are contacted—for example, the Drygate issue was raised through a phone call to us, and we responded immediately the next day. We had feedback from the registered social landlord that its tenants were really satisfied that there had been an immediate response. That was a visible response that the RSL could feed back to its tenants.

The community engagement forum is very active and, as you have also heard, it provides an opportunity for a community that, in many ways, previously felt marginalised to work with a range of key partners in the city to improve social amenity. The forum is almost like a vessel or a vehicle for wider improvement in the area.

Pauline McNeill: Thank you.

The Convener: You referred to Police Scotland's submission. It has highlighted that

"Crimes of Supply of a Controlled Drug or Possession with Intent to Supply were lower than the same period in 2024, halting a three-year trend of increasing offence numbers."

That is helpful clarification.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Good morning. I am interested in referrals to and from other services and how that process has developed while the Thistle has been open.

Thank you for the information that was supplied in the submission, which states that the number of referrals is "likely to be" an underestimate. I want to put a little bit of a narrative around that and think about somebody's journey before engaging with the Thistle, how the relationships with other organisations are built up through assertive outreach and the importance of the fact that they can be referred to other services after, for example, coming in to use the shower facilities and getting to know people. How important are such relationships? It is a long journey for somebody in a chaotic situation from when they start to engage in services to when, eventually, they perhaps start making use of residential rehabilitation. Can you talk about that?

Kelda Gaffney: Your very last point was an exceptionally good one, because, to go back to some of the media coverage, there is this idea that you can somehow compare what happens with someone who is in recovery with what happens with someone who comes into a harm reduction service at a point when they have not engaged with services for quite a long time or have experienced challenges in engaging with services. Such people have experienced trauma, had addiction and drug issues for significant periods of time, and had their family relationships disrupted in such a way that the networks of support that we would hope for are not available to them.

Part of the business case for the Thistle involved the possibility of building those blocks of support around people to enable them to trust and access services—that was always our hope. We know from a trauma-informed perspective that it can take a significant amount of time for individuals who are accessing the service and have been through those circumstances and situations to build trusting relationships.

For most people, the vehicle for change involves building such relationships, trusting in people and believing that recovery is possible—often, we hear from people with lived experience who come to our service that they do not believe that recovery can be part of their journey. As you say, it can be a long journey for people, but it is a journey that we absolutely encourage people to go on.

Recovery is different for every person, so you have to focus on the individual when you talk about recovery. One aspect that we considered carefully when we designed the service—it was absolutely co-designed with people from our recovery communities, including people who have experience of using and injecting drugs publicly—concerned the facilities that we could introduce that would encourage people to use it. The service has showering facilities and laundry facilities as well as the injecting equipment provision. There are many examples of people coming in to use services without injecting, but then returning to inject, as they trust the service and understand that it is a compassionate, caring service that will allow people to take the time to do that. We will

monitor that situation as we go on, but that is why we have a difference in the figures.

09:45

Those facilities are important for women, who are underrepresented in the service—about 20 per cent of the service users are women. We know that it is more difficult for women to engage with services, and we are doing a lot of work around that. We engaged our lived-experience women's group, who were very influential regarding the shower and laundry facilities, and they have considered pursuing some kind of group work on how we engage with women. It is really important to give people an opportunity to come into the service so that they can start to trust the service and begin using it. Some of those people will inject immediately, and some will take a longer time before they do so.

We discuss with folk who are using the service what is in their interests and what they are seeking from their recovery journey. On social media and in the media, there has been some conflation of services. It is important to understand that people coming into the service are not in a position to enter residential rehabilitation, for example. That service would not accept those people because of their needs, and their needs are so great that they have to work towards that point, if they desire it.

I know that we are short of time, so I will conclude. We have made about 350 referrals to other services, as was stated in our submission. The majority of them were for housing, with people being engaged with services under the housing first approach. Their needs are very basic. The service allows us to reach people and meet their basic needs, and then help them to move on in their recovery journey.

Elena Whitham: May I ask another short question, convener?

The Convener: We need to have brief questions and brief responses. I still have quite a number of members looking to contribute.

Elena Whitham: My question is about understanding the journey that is involved following someone's choice to seek a path to residential rehabilitation, and how you help them to engage with services such as stabilisation in order to enable the person to reach that point. A lot of people do not understand that someone cannot just walk into resi rehab or get referred there straight away. If someone is using, with a high volume of usage, it is very difficult to go straight to rehab. Could you tell us a tiny bit about stabilisation?

Kelda Gaffney: We have a range of services in the city, and the Thistle is part of our overall alcohol and drug recovery services. That means that access and referral pathways are the same for people who are in contact with our Thistle staff as they are for those who are in touch with any part of our alcohol and drug recovery services. We have clear pathways into all the services—residential crisis services, residential stabilisation and residential rehabilitation services.

We have been very clear about the situation from the outset. There may be a circumstance where somebody has relapsed into injecting behaviours in their drug use, but they may have quite a lot of recovery capital behind them and may be able to access residential rehab quickly—and we would access that and make such referrals. However, the majority of people who come into our service are not at a stage at which they are ready for residential rehab. That would be like comparing apples and pears. It is important to bear in mind that residential rehab is abstinence based, and those people are not at a stage where they could use an abstinence-based residential service, either for their own safety, because they require detox, or for the safety of other people using those services.

In summary, pathways are available, but we must be clear that it is a matter of addressing individuals' needs, rather than suggesting an overview that residential services are suitable for everybody.

Elena Whitham: I see that Saket Priyadarshi wishes to contribute, but I will hand back to the convener now.

The Convener: I will bring you in if there is time towards the end, Saket, but I now call Annie Wells.

Annie Wells (Glasgow) (Con): Thank you, convener, and I apologise for not being with you in person today.

On that last response to Elena Whitham, I understand that the pathway will be totally different for everyone—everyone will have their own recovery pathway—but I have just a quick question. Of the 4,000 episodes that have happened in the Thistle centre, how many of those people have gone on to a recovery or rehabilitation pathway? I get that it will be different for everyone, but I am just asking that specific question, which is for Kelda Gaffney.

Kelda Gaffney: We have not referred anybody directly from the Thistle into an abstinence-based residential rehabilitation service. Again, I return to the point about abstinence-based services; I know that I am overemphasising this, but—and this goes back to one of the committees' earliest questions about whether we have met our expectations—that was never one of the expectations that we set out. It would be the same with any harm reduction

service that an individual might access at whatever point.

Such services are absolutely available, but it is much more likely that we will make a referral to some kind of care and treatment service. Indeed, you will see from the returns that we have made more than 50 such referrals, whether it be to the enhanced drug treatment service, to the community teams or to crisis and/or stabilisation services.

Annie Wells: Thanks very much for that answer, and I get what you are saying. However, when we were discussing the pilot for this facility, we were told that it would be a pathway for people to get into residential rehab, and we are not really seeing that—although I know that the Scottish Government has increased the number of residential rehab places fourfold in the past year.

I know Calton very well—I have family down there, and I went to school there. I appreciate that the facility gives people a place to go to get a shower and all that, but when I backed the pilot, I did so because I thought that it would mean that more people would get the opportunity to go into residential rehab. When I speak to families of people who have lost their lives—my family included—they tell me that the person just wanted help and support, their family to be looked after and to be given the support to go into residential rehab, if that was what they chose. This just seems like a lost opportunity. I will leave it there just now, but I think that we could be doing so much more there.

I have another small question, convener. Does the facility offer transport to people? Is there a transport offer to get people to the Thistle?

The Convener: A very brief answer, if possible.

Kelda Gaffney: I just want to comment very briefly on the member's previous point, because I feel that I have to.

I understand your position, Ms Wells, but I absolutely do not think that this is a lost opportunity, because what we are doing is keeping people alive. The simple fact is that you cannot get people into recovery if they are not alive. I know that that is a very simplistic point, but I think that it needs to be made.

I would also point out that we are only seven months into this, so perhaps when we are a year or 18 months in, we might be seeing more people on a recovery journey. That said, I go back to my previous answer about that journey. Recovery is not about abstinence-based residential rehabilitation; recovery is, for me, about improved health and wellbeing, the use of less harmful drugs or the use of drugs in a less harmful way. It is all about harm reduction to bring people to the point of recovery.

As for your question about transport, my very quick answer is no, we do not normally transport people to the service; we do not have a budget for that. I am aware of discussions in the community engagement forum and/or the service user forum about supporting people to access the service through bus tokens et cetera, but those conversations happen in every part of our service. We do not do anything that is not in line with other services.

Annie Wells: Thank you very much.

Michael Marra (North East Scotland) (Lab): Dr Priyadarshi, I want to take you back to some of your earlier comments about medical emergencies. You mentioned that there was a spike, probably when the nitazenes were in the supply. From the figures that we have, that looks like it would have been in March and April 2025. Would that be correct?

Dr Priyadarshi: That is correct.

Michael Marra: Okay. You also said that you felt there had been a decline in medical emergencies of late, and I think that you referred to the shift into cocaine. Can you set out in a little bit more detail for us why that would be the case?

Dr Priyadarshi: We are vigilant about medical emergencies for every injecting episode—we cannot be complacent about them at all—and the number of medical emergencies in the service seems to be linked to the percentage of heroin in the injecting episodes. Indeed, those individuals who are injecting cocaine do not experience the same medical emergencies. We define those emergencies as respiratory problems: people stop breathing, the oxygen saturation is reduced significantly and people require airway management or at least oxygen.

For people who use cocaine, the toxicity does not present in the same way. We have not seen medical emergencies linked to cocaine use, although we see escalating stimulant effects and toxicity, which translate into behaviours such as people having paranoid or psychotic thoughts. It is then about de-escalating those presentations rather than dealing with a cardiac or respiratory arrest.

Michael Marra: That is very useful, and it tallies with the evidence that I have received from people in Dundee, including clinicians, about an increase in chaotic and sometimes violent behaviour among the drug user community but a potentially declining number of emergencies. Taking that up to a national level, could that shift in the usage be tied to the reduction in the number of deaths?

Dr Priyadarshi: That is a really good question. You are asking me to speculate on the matter. On cocaine stimulant use and violence, I want to make it clear that we see very little really difficult, challenging behaviour that we cannot manage and de-escalate quite quickly in-house. We have had very few, if any, incidents related to those cases that we could not manage.

The change in trends might at least partially explain the change in the drug deaths statistic, but that statistic is multifactorial and will be the result of many issues. Any reductions will have different influences and will be multifactorial as well. For me, the amount of benzodiazepines with opiates was a key driver in the large spikes that we saw from 2015, 2016 and 2017 onwards. In the past few years, the number of cases with heroin and benzodiazepines implicated has reduced, but the number of cases with cocaine implicated in them has risen. Although there was a 10 per cent national reduction, there are still more than 1,000 drug-related deaths.

There have been a whole range of other actions and interventions. In Glasgow, we saw a 25 per cent reduction in drug-related deaths in 2024. Although some of that might have been the result of drug-using trends, we have also implemented a range of responses, such as medication-assisted treatment standards and crisis outreach services. Moreover, naloxone coverage is very high. We get rapid-action drug alerts and response reports now on almost all overdoses that happen in the city, and we can see that people are carrying and using naloxone, without which the death rate would be much higher. Therefore, there are a range of reasons to explain the reductions that we have seen.

Clare Haughey (Rutherglen) (SNP): Good morning to the witnesses. You will be aware that there are calls and, indeed, campaigns for facilities similar to the Thistle to be opened in other parts of the country. I know that you are only nine months in, but I am interested in hearing what lessons you have learned in relation to opening such a facility and what you would do differently.

Dr Priyadarshi: I am sorry that I am doing so much of the talking—

10:00

The Convener: Can you make your responses as brief as possible?

Dr Priyadarshi: Absolutely. We have learned a lot, and we are happy to share our learning. The service has had visits from cities across the United Kingdom.

The first lesson is about community engagement. We need to start community engagement much earlier and explain the potential community benefits to the community instead of having the focus that we started with, which was the business case for harm reduction and recovery for people who use the service. I am sorry to put it as bluntly as that, but, if we were to do it again, our focus would be on what is in it for the community and how we can make it work for them.

Secondly, we get feedback from service users, and one of the barriers that prevent people from using the service to the extent that we want them to use it is the absence of a smoking or inhalation space within the service. We have seen the drug trends that I have described, but some people will smoke and inject in one episode of drug use. If we cannot offer a smoking inhalation space, those people will not come into the service just for the injecting.

The other few barriers are more challenging legally. For example, sharing is an issue for people. People often buy a significant amount of drugs in small groups because pooling their resources allows them to purchase more, and it will last them through the day. An example of that is cocaine injecting. However, we cannot allow that sharing within the facility. If other areas were to come on board, we might want to have a national discussion with legal authorities about that.

We also have a lot of learning about access for women. We have not solved that, but perhaps other areas could do that earlier.

To keep it brief, those are the headlines, but the biggest headline of all is that, to date, we have demonstrated that we are able to deliver what was seen as a high-risk, controversial service within statutory services in a safe and effective manner.

Patrick Harvie (Glasgow) (Green): I thank all the witnesses for their evidence. I am keen to understand a little more about the balance between the benefits for people who might have an adverse reaction or an emergency in a safer environment and the benefit of having reduced drug paraphernalia in the local community, for which there is clear evidence, and the concerns that have been expressed about there being more unknown faces around, whether those are service users or dealers. I could not see anything in the written submissions that tells me whether you collect information about where your service users are travelling from. It might not be easy to get objective data, but do you have a sense of whether people are travelling across the city or even from further afield or whether it is overwhelmingly people who would otherwise be using in another environment in the Calton area?

Dr Priyadarshi: We do collect some data on home postcodes, but that is to do with where

people have used injecting equipment provision in the past, and that data is not accurate, because it might be historical rather than current. It is therefore challenging to answer that question robustly. However, from the evidence that we have collected in the past, we know that the majority of the population that we are talking about are people who are resident in and around the city centre and the east end of the city, either in their own accommodation—temporary furnished accommodation hostels—or in homeless settings.

The key issue is where the drug market is. People buy and consume their drugs very close to where the drug market is, because they do not want to travel with drugs on them. There are people who come into the east end of the city centre to access the drug market and use their drugs close by. That is a historical thing—we have that evidence from doing outreach there for 10 to 15 years. That group is not local, and they are coming not to use the Thistle but primarily for the drug market, to purchase their drugs. If they did not use the Thistle, they would use outdoor spaces.

Paul Sweeney: I am reflecting on opportunities to improve the service. A community syringe redemption programme has been launched in Boston and New York within the past five years. Has that been considered as an evolution of the service, particularly given the significant benefits that have been demonstrated from the small cash incentive to return syringes?

Kelda Gaffney: That programme was reported on at some point. We certainly received an inquiry about it, and the issue was discussed at the community engagement forum, but there was definitely no decision to move that proposal forward. In fact, without going into the detail, we have some concerns about it, and there would be some challenges associated with it.

We are always looking for ways to improve engagement with the community. In fact, people who use the service and our recovery communities are clear that they want to be involved with the environment and the community, without financial remuneration. You will hear people talking about giving back to the community, particularly recovery communities, and that is the model that we are looking at.

Dr Priyadarshi: I know that you were going to allow me one last question, convener, but I want to make a quick comment instead.

As well as thinking about whether we need to expand the provision of injecting bins and the work with our councils around increased frequency of clean-ups, there is a basic point to make about access to services through the Thistle. Our staff are walking a fine line between wanting to give people support to access the whole system of care and not overwhelming people who are already feeling quite worried about using the service. Staff take time to build relationships and work in a very person-centred way. Therefore, you will see that the data that we have around our interventions and referrals reflects not what we think is best for people, but what people are actually asking for.

The Convener: I apologise for having to rush the session, but we have limited time and a lot to cover. Thank you very much for your forbearance and for coming along today. I will briefly suspend the meeting to allow a changeover of witnesses.

10:08

Meeting suspended.

10:09

On resuming—

The Convener: With us for our second panel this morning, we have Maree Todd, Minister for Drugs and Alcohol Policy and Sport. I believe that this is the minister's first appearance before this joint committee, so she is very welcome. We also welcome Maggie Page, unit head of drugs strategy, Scottish Government; and Dr Tara Shivaji, consultant in public health medicine, drugs and alcohol, Public Health Scotland.

I invite the minister to make some opening remarks.

Maree Todd (Minister for Drugs and Alcohol Policy and Sport): Thank you for the opportunity to appear before this joint meeting of the committees today. I look forward to updating you on the vital work that is under way to address the harms and deaths that are caused by alcohol and drugs.

Since the previous joint meeting of the committees, in February, updated statistics have been published by the National Records of Scotland. In 2024, 1,017 drug misuse deaths were registered in Scotland. That is a decrease of 13 per cent compared to 2023. It is also important to note that alcohol-specific deaths statistics showed a 7 per cent decrease in deaths, falling to 1,185, which is the lowest number since 2019.

Let me be absolutely clear that, although it is welcome that both of those statistics show a decline, the figures are still far too high. We know from recent surveillance that there are new threats, and the drug-related harms in Scotland are still high. Every death is a profound tragedy, and every death is one too many. Crucially, every death is preventable, so we must use every tool available to address this crisis.

In that spirit, I very much welcome the work of the committees and the recommendations of the people's panel and Audit Scotland, and those in "Changing Lives", the 2022 Drug Deaths Taskforce report. Collectively, 164 recommendations were offered, and I am reassured by the many common themes and alignment. Our written evidence to the committees details our response to and progress against each recommendation, and how the recommendations have helped to shape our approach to the national mission.

Since launching the national mission in 2021, we have taken a range of actions. We have made £38 million available between eight projects across Scotland to provide additional residential rehabilitation beds; we have invested more than £4 million in widening access to life-saving naloxone; and we have opened the Thistle, the globally recognised safer drug consumption facility in Glasgow, which is the first in the United Kingdom. Since opening, it has overseen more than 4,000 injecting episodes, and has responded to more than 50 on-site overdose incidents. I have absolutely no doubt that lives have been saved. Those achievements were hard won, and I extend my gratitude to those who made them possible, especially individuals with lived experience.

I would like to highlight some of the key progress that has been made since the previous joint meeting.

We are helping to build a skilled and resilient workforce through the publication of new guiding principles and two employability toolkits. We are also seeing good progress in MAT implementation. The June benchmarking report indicated that 91 per cent of MAT standards 1 to 5 were assessed as fully implemented, and that 75 per cent of standards 6 to 10 were assessed as fully implemented. We have also seen progress in residential rehab. In August, we saw the official opening of the new CrossReach facility in Inverness. That is the latest of eight new or extended facilities that have been supported through our funding of £38 million.

I recognise that we need to go further, and I have heard the calls for further and faster action. We are developing a refreshed alcohol and drug strategic plan, in consultation with key stakeholders, including people with lived and living experience.

After five years of emergency response to the drug deaths crisis, it is time to build on our progress, to move to a model of sustainability and to embed long-term change. We are committed to change, driven by the belief that progress is both necessary and possible.

I welcome your questions and look forward to discussing the findings further.

10:15

The Convener: My first question is on the work of the national mission. You spoke about figures on drug deaths, and we know that there was a 13 per cent decrease in drug deaths from 2023 to 2024. However, Police Scotland data shows that there was a 3 per cent increase in the number of suspected drug deaths in the first months of 2025 compared to the same period in 2024. Can you respond in more detail to those figures and what they mean in the context of the work of the national mission?

Maree Todd: Tara Shivaji might want to come in on this, but I will give a first response. All of us will, like me, welcome that substantial decrease—we are very pleased to see it. However, in the earlier evidence session, you heard from other witnesses about the changing market and the differences in the way in which people are taking drugs. That is bringing new threats, which indicates to me that we need to be agile in how we respond to those harms.

When we started the national mission back in 2020, we were largely dealing with the injecting of opioids and heroin. Now, in 2025, we have a significantly increased threat from injecting cocaine, which, as your medical witness described, requires more frequent injecting episodes. There is also a real risk from injection harm. The market is undoubtedly contaminated, so the bulk of what people are buying in Scotland is not what they think that they are buying. There has been a recent spike in harm in Glasgow caused by cocaine contaminated with synthetic cannabinoids, and we have also found heroin contaminated with nitazenes. That is causing real challenges for how we respond to the situation. We have seen a difference in the way in which people are taking drugs. As well as the increase in the number of injecting episodes from cocaine, we are seeing more smoking than we had before, and there are more inhalation routes.

We need to remain agile. It is quite a dynamic situation—things are not static. We have brilliant systems in place to understand what is happening out there, and to learn quickly where the harms are coming from and get good, high-quality information out across the country. However, it is a challenging situation to stay ahead of. Tara Shivaji might want to say more about RADAR.

Dr Tara Shivaji (Public Health Scotland): We welcome the reduction in drug-related deaths. Taking a more long-term view, though, rather than a steady decrease, it appears that figures are plateauing. What we have seen in our most recent

indicators in our RADAR report is that harms are increasing. In addition to the figures that you have mentioned about drug-related deaths, we have seen an increase in ambulance call-outs. We attribute that to the instability and toxicity in the market. In the early part of this year, that played out through quite localised clusters. We do not have the intelligence to understand what was happening in those drug markets, but we know that there are sub-populations of people who were at higher risk. People who were in temporary or unstable accommodation seem to feature quite a lot in those clusters.

In addition to the high toxicity of the new substances that are coming in, a feature of the situation is that dynamic pattern. Although we are focusing on individual substances, the reality is that there are multiple substances occurring together. They may not be taken at exactly the same time, but they have synergistic effects. Contamination is a really big problem in the supply.

Michael Marra: Minister, you mentioned the systems for understanding data. Will you tell us what the current time lag is for a forensic toxicology report?

Maree Todd: No, I could not tell you that off the top of my head.

Michael Marra: Okay. Do any officials know how long it takes between the death and the production of a toxicology report?

Maree Todd: Are you talking specifically about post-mortem toxicology?

Michael Marra: Yes.

Maree Todd: I think that it is significantly faster for that. For example, Dr Priyadarshi described the situation that occurred at the Thistle in which some of the paraphernalia was tested, and that was pretty rapid—they were able to get information almost instantaneously. There is, on occasion, a delay for post-mortem toxicology. I was asked about that last week at the Criminal Justice Committee and I said that I would supply written information afterwards. I will certainly be happy to furnish you with that information if it is specifically post-mortem toxicology that you are asking about.

Michael Marra: Yes, it is.

Dr Shivaji: There are a number of steps that happen following someone's death. By and large, the production of post-mortem toxicology across the country takes about six to eight weeks after the event, but that varies in different places. It is not necessarily available to local areas at that time, because it needs to go back to the pathologist for confirmation of the actual cause of death. There are many factors that need to be considered and there are areas that have issues with the availability of pathologists to provide the service.

In the event of clusters, we have put in place a fast-track process. Colleagues in the forensic laboratories process those samples faster and are able to provide reports for both post-mortem toxicology and police seizures.

Michael Marra: We will see some of that detail in the response from the minister. That is useful—thank you.

Paul Sweeney: Minister, you heard the contributions from members of the previous panel. Will you outline the Government's view, with awareness of the recent metrics, on how the overdose prevention pilot at the Thistle is performing after several months of operation?

Maree Todd: As I said in my opening statement, I am confident that lives have been saved in the unit, which I visited in June. The evidence is anecdotal at the moment but data is being collected and it is being well analysed by excellent academics in Scotland. As time goes on, we will get a better understanding of the work that is going on at the Thistle. The staff who I spoke to were clear with me that people would undoubtedly have died during the cluster of overdose incidents in March and April had they not been using in the Thistle. Across Scotland, other people took similar drugs and died.

There is no doubt that there is concern in the community. I was pleased to hear from the witnesses today that some of those concerns are being allayed as they, along with the people who run the Thistle, are working to tackle the concerns of the community and businesses.

I was pleased to hear about the holistic and person-centred approaches that they are taking to the individuals who come through the door. There is not a set path for those people; they meet them where they are, encourage them in and, for example, help to find them accommodation, which, for many people, can be the very first step on the road to recovery.

Paul Sweeney: Has the minister heard some of the suggestions to enhance the service? There was a discussion in the previous evidence session about a change in the types and frequency of drug injection and the opening hours, and there is also the issue of inhalation, particularly with crack cocaine. I am aware that there is a paper at the integration joint board in Glasgow about an inhalation service. Is your office considering how you might be able to assist in expediting that?

Maree Todd: We work alongside the individuals from the Thistle; Maggie Page might want to come in on that. We also work closely with the organisations that run the Thistle, but it is largely

down to them to work with the Lord Advocate to meet the criteria that she might set to ensure that conditions within the unit can change. It is a long process to get those permissions and to persuade that the legislation that covers the rest of the country can be lifted under certain circumstances.

The Scottish Affairs Committee at Westminster recently reported on the Thistle and made some suggestions for different models. The challenge with that is that we have not been able to persuade the Westminster Government to review the Misuse of Drugs Act 1971 and, because of that, what is happening at the Thistle is a one-off situation. Each time the model is modified, it will have to be agreed locally with the Lord Advocate. That means that it is difficult and that careful steps must be taken to make any changes to the model that operates there. Maggie, do you want to say more?

Maggie Page (Scottish Government): It would be for local areas to work with the Lord Advocate on such decisions, but officials would support Glasgow and any other areas where appropriate.

Paul Sweeney: Do you have any more comments on the Scottish Affairs Committee's recommendations, given that it was referenced by the minister?

Maree Todd: It made a suggestion about mobile units being more cost effective, and I can think of certain areas where that might meet the pattern of need better than a fixed unit. However, the challenges with the 1971 act as it is and the conditions that have been set by the Lord Advocate mean that the model of a safer drug consumption unit is not scalable and not sustainable.

We need the legislation to change, and I think that it is reasonable to ask for it to be reviewed. The legislation is more than 50 years old. It is older than I am, and I am a granny. I do not think that it is fit for modern purposes and for the threats and harms that we face as a population today, so it is reasonable for us to look at modifying it to see whether it can be made more effective and, in particular, enable us to better take a public health harm reduction approach.

Maggie Page: We have responded in writing to the Scottish Affairs Committee on all the conclusions and recommendations in its report, and I think that our response probably arrived today. One of the other key things that was in there was about the provision of crack pipes in response to the rising use of cocaine and the harms associated with that. That is another thing that is restricted under the 1971 act, so the issue is not just about inhalation spaces in the drug consumption facility, but the provision of crack pipes.

Paul Sweeney: Minister, you mentioned that you needed to engage with ministers in other devolved Governments and the UK Government. Have you been able to have those conversations in recent weeks?

Maree Todd: Yes. A couple of weeks ago, we had a four-nations meeting in Edinburgh, and it was very helpful. By the end of that day, it was clear to me that it was helpful to meet my UK counterparts, but it is also clear that we are facing a very different challenge in Scotland. We have a significant number of drug deaths and we need to take action to tackle that. That is not the situation that my counterparts are experiencing in Northern Ireland or in England, and they do not feel the urgency to look at creative solutions to the challenges that they are facing.

That was the week of the Government reshuffle, so all the Home Office ministers had changed and none of them came to Edinburgh. I think that we have written subsequently, or we are writing subsequently, with specific requests. I spoke to the Home Office officials on the day about asking the minister whether they were willing to look at the question of inhalation pipes and harm reduction opportunities in providing paraphernalia to people who are using drugs. If they are not, we will have the clarity that we need to pursue solutions for Scotland alone.

10:30

Elena Whitham: You have already touched on the question that I wanted to ask about the most recent quarterly RADAR report. Can you set out just why RADAR reports are so important? There was information in the most recent report about increases in naloxone administration and A and E attendances; you spoke about why those increases may be happening, in relation to the toxicity of the supply. I anticipate that we might see in the next quarterly report other incidents of that type of increased emergency response.

We get information from WEDINOS, which is the Welsh emerging drugs and identification of novel substances framework, from ASSIST, which is a surveillance study of illicit substance toxicity, from hospital toxicology reports, and so on. Why exactly is RADAR so important for us as a tool?

Maree Todd: RADAR gives us rapid information that can be disseminated out to exactly where it is needed across the country, and it is making a difference to the harms experienced across Scotland.

RADAR is not perfect. My sense, a few months into this job, is that the longer that it takes to produce the data, the more rich and robust it is. We get early data that tells us something, but, often, the longer we wait for the data, the richer it

is. However, we do not have time to wait. We are in a drug deaths crisis and we need fast information, and we need to get that fast information out to the front line—out to the health boards and to the places where people are likely to go to receive treatment for overdose. We need to get it out to the front line so that the paramedics and the alcohol and drug services know what they are dealing with. That is vitally important.

Dr Shivaji: We have three objectives with RADAR. One is identifying and describing trends; the second is identifying new and emergent drugs and being able to provide a bit of description about whether they are important and whether they are ones that we should be concerned about; and the third is about identifying and responding to clusters.

Although the reports are perhaps the most visible part of that work, we have a system that sits behind it, where local areas in particular have built not only the intelligence that comes into us, but those response structures.

Etizolam came on to the market in 2015, but it took us three or four years to understand both that it was a problem and the scale at which it was causing harm. Our focus is on being able to identify what these new substances are and provide quite clear, consistent information about them. We recently issued an alert for nitazenes that we have updated. We are able to give information about where we find it, what it looks like and what the key harm reduction measures are. That is the sort of critical information that staff need.

The trends can be interesting, but they are probably less useful in service planning, although they can give people a heads up to ask whether something unusual is happening. That is particularly important when we are talking about clusters, because we have also developed guidance to allow a public health response to these emergent situations. Rather than retrospectively saying, “We had a peak,” we are now able to say, “We’re in the middle of something quite unusual. Let’s respond much more proactively.”

Elena Whitham: Thank you. Given the toxicity of the supply that is out there, people’s access to crisis and stabilisation services is quite important. Could I get an update on the stabilisation fund and how it has been deployed? Are areas working together to create facilities to address that need, and are those working in the facilities mindful of the increased use of stimulants, and of the benzodiazepines that are being used as well, which means that a different type of stabilisation service is needed?

Maree Todd: Thank you—that is a really excellent question, and I think that Maggie Page will want to come in with a little bit more detail on it.

We think about three strands when we are thinking about the next steps around treatment and access to residential rehab. We focused a lot on providing funded places, and we are on track to reach the 1,000 funded places that we committed to. We also focused on increasing residential rehab capacity, and we have really increased the number of available beds. I think that we will get a report on where we are with that next November, but, again, there has been a substantial increase in provision.

The bit that will probably require a bit more focus in our strategy next year is the pathways around access to residential rehab, which is about access to stabilisation and detox, and how we get things lined up for people. Your previous panel of witnesses talked about access to abstinence-based residential rehab, for which people are required to go through medical detoxification before they can start. It would be ideal if the residential rehab lined up right at the end of the detox, without a gap or a long wait for detox, when somebody is ready for residential rehab and wants to get in. We are working hard on those pathways to improve access into services, because that is an area where we can achieve real improvement.

Maggie Page: I will add a little to that. There is a lot of work still to be done on looking at stabilisation and crisis care more generally in residential and community settings. That is part of the priorities, and it is coming through from our consultation on what happens after 2026 and the national mission. We are also looking to publish a national service specification setting out what the component parts of the treatment system should look like in local areas, although that should be adaptable to the needs of different areas—obviously, what Glasgow or Shetland has must be adaptable to the context. That is another area of work that we are looking at.

Elena Whitham: That is quite helpful for us to know. The £3 million stabilisation fund seems to be difficult to get out of the gates, and having the service specification will perhaps help areas to start to work together to figure out what they need to provide locally. Thank you for the update.

Alexander Stewart: Minister, back in September, you gave a statement in which you spoke about trying to publish the plan for the next phase of the mission and said that you wanted to ensure that there was enough funding to deliver the next phase. It would be good to get a sense of how you see that progressing. Are you ensuring that you do not lose any momentum in managing the national mission work as it progresses?

Maree Todd: The time period that the national mission covers comes to an end in 2026, and, early next year, before the Parliament is dissolved, we are keen to set out the national drug and alcohol strategy, which we see as the next phase. There will be significant changes in there. We will be looking at drugs and alcohol together—they require different approaches, but we will look at them in one strategy for a number of reasons.

On the funding, I hope that there will be some clarity in the budget process this year. I cannot pre-empt the budget process, but it obviously sits alongside the strategy. My personal view is that now is not the time to cut funding to these services, and I am keen to offer assurance that what comes next is unlikely to be smaller.

Sharon Dowey: There are a significant number of reports, strategies and policies in this area—you mentioned a few of them in your opening remarks—but we regularly hear that there is an implementation gap in areas in which there has been a lack of progress. The Auditor General for Scotland raised that with the Public Audit Committee in November last year, for example. Do you agree that there is an issue with implementation? If so, what plans does the Scottish Government have to address that?

Maree Todd: I agree that there is an issue with implementation, which is a challenge that all ministers face in all portfolio areas at all times. We often set out great ideas and produce fantastic policies and great legislation, but that is not how it feels on the ground for the people who access our services. As a minister, one of my challenges is to close that implementation gap, so that the reality meets the ambition.

I am the first to acknowledge that there is a gap. For me, one of the crucial ways in which to close it is through the involvement of people with lived experience. If we have the voices of lived experience at the heart of our policy and legislative development, it keeps us right. It means that we are usually on the right track, because we are listening to the right people.

That also holds our feet to the fire on delivery, which helps us to close the gap. The situation is always evolving. Nobody is saying that we get it 100 per cent right. Lived experience, particularly in this area, where there is a huge amount of passion, does not speak with one voice, but that approach helps us to get it right.

We get lots of data coming in, and lots of monitoring and supervision. In fact, some people feel quite overburdened by the reporting that we request from them, but we are pretty keen to understand what is going on out there. My sense is that we are very much aware of the challenges. We are providing support where we can, so that local areas can rise to those challenges.

Maggie, do you have anything to add?

Maggie Page: There is on-going work around implementation. We continue to support the MAT standards implementation support team—MIST—which is housed in Public Health Scotland. The latest benchmarking report shows progress towards implementation, but that work is continuing. It is about working really closely with partners at national and local levels.

Sharon Dowey: Can you tell us a bit more about the barriers? In your evidence to the Criminal Justice Committee last week, you said that you want things to happen on the ground. You also said that there were implementation gaps. You have great policies and you want things to happen, but they are not happening. Are we holding the officials—the people who should be making sure that things happen—accountable enough? You said earlier that “we have not got time to wait” and that “We are in a drugs death crisis”.

You just talked about your feet being held to the fire, but we already have lots of data. I sigh when I am in a committee meeting and hear that we are going to have another working group to look at something that we already have the answer to. We know what the issues are. What are the barriers to implementation and seeing a difference on the ground?

Maree Todd: There are a number of barriers—that is the challenge with this whole issue. You will be well aware, having been involved for a number of years, just how complex and difficult the subject is. Stigma is a big issue. There are lots of reasons why services are set up in such a way that people struggle to get through the door even just to access them. There is no simple answer to fixing the problem. If there were, we would have done it—all of us would have pushed to have done that. I do not think that there is a simple, straightforward way around it; we just have to work hard to understand what is happening out there and what the barriers and challenges are in each local area. We have heard about some of the challenges that women face in accessing services. We need to understand why certain cohorts find it difficult to access the services that we provide, and we need to make it easier for them to access those services.

The charter of rights will help us to make progress in this area, because stigma is a big part of the problem—every day, it prevents people from accessing help. We have a lot to do, but I do not think that there is a simple answer. If there were, we would have implemented it.

Sharon Dowey: Maggie, do you have anything to add?

Maggie Page: Workforce is always a challenge across health and social care. There has been a lot of work to support and upskill the workforce, and to encourage people with lived experience and who are in recovery to become part of the workforce—they have a vital role to play. There is work going on around that, but it is another significant challenge.

10:45

Patrick Harvie: Good morning. I want to press you a little further on the issues that Paul Sweeney raised about the Thistle and, more generally, about how you see the future of safer drug consumption facilities.

We acknowledge that it is early days for the Thistle, and that a full evaluation is to come, but let us assume that it evaluates well. You pushed back a little on the issues around reserved legislation. For the life of me, I cannot understand why we did not devolve that legislation in 2016, when we addressed other irrational reservations in the Scotland Act 1998 on a consensual, cross-party basis. I wish that we had been able to do that. Let us assume that the Government will be successful in making the case either to change or to devolve the legislation, and that the legal barriers can be removed.

You presumably have some idea in your head already about what level of provision of that type of facility there ought to be in order to address the needs not just of one community but of multiple communities around Scotland. Do you have a sense of how extensive a network of that type of facility a city such as Glasgow ought to have, or that the country ought to have, if those legal barriers were removed and if the evaluation of the early phase proves to be positive?

Maree Todd: That is a really good question. I do not have a sense of where we would be if there were no barriers, but I do have sense of where the need might arise and where local stakeholders are already looking into it. If you look at a map of Scotland, you can see quite easily where there are concentrations of drug deaths, and those would seem sensible places to consider such a facility.

At the moment, work is coming forward from Edinburgh and, at a very early stage, from Dundee, to consider safer drug consumption facilities. Given the number of deaths that occur in both those localities, that is reasonable. Edinburgh is a little more advanced, and the two sites that it has identified seem reasonable. It appears to have matched up the potential sites with where the deaths are occurring. In the past three years, there have been 34 deaths within a 15-minute walk of one of them, and there have been 36 deaths in the past three years within a 15-minute walk of the other site that is being considered. It is important that local areas look at what is happening in their locality.

Earlier this week, I met partners in Inverclyde. Drug use and drug deaths are significantly more scattered in that part of the country, but the area is very high in the national statistics. It is clear that creative thought needs to go into how to rise to and meet that challenge, but a fixed drug consumption room may not be the appropriate solution for that locality, because drug deaths are happening throughout it.

Patrick Harvie: I absolutely take the point about the connection to drug deaths and to places where there is a particular cluster, albeit that those patterns may change over time. Some of the evidence that we heard earlier and that we have read in the written submissions shows that that is not the only benefit of such a facility. It is clear that the reductions in drug paraphernalia in communities and in people being exposed to drug taking in communities and other settings are significant benefits.

There could be the opportunity to achieve those benefits in other parts of communities that may not have the same cluster of deaths at a particular time to justify a fixed facility. I am curious to know whether there is a sense in the Government or in the public health community in Scotland more generally of where this could go if the barriers were removed.

Maree Todd: We have not explored that, because the barriers are not being removed and we have been unsuccessful thus far in removing them.

If I remember rightly, efforts to bring the Thistle to life started in 2015, so that means that it took 10 years until it opened this year. That predates the national mission. Those efforts began at the start of the rise in the number of drug-related deaths, but the reason behind considering whether to have a safer drug consumption facility at that time was to reduce the number of cases of HIV, because there had been an outbreak—a cluster—of HIV in the area, and such a facility was seen as a way of reducing that harm.

You are right that, at the moment, we are in the thick of a drug deaths emergency, and very early data shows that lives have definitely been saved in that unit. Therefore, it is understandable that we recognise that it is a life-saving facility; it definitely prevents deaths. We will do a more thorough evaluation of what happens there and what the benefits and disbenefits are, and we will consider where to go when we have a bit more information.

At the moment, I am not seeing barriers to scalability across Scotland, or even to sustainability, being removed. We had a change of Government in the UK last year, and I thought that there would be an opportunity for a change in approach, but I am not sensing that at all. I have to focus on the here and now and on the emergency that we are in, and find a way forward now.

Patrick Harvie: Have the new UK ministers that you mentioned shown an interest in visiting the facility and seeing for themselves what is happening?

Maree Todd: My equivalent in the UK Government is a Home Office justice minister, and although the public health minister also attended the UK four-nations meeting, she was brand new that week. I do not think that those ministers will have had a chance to visit the Thistle yet, but I would certainly recommend that to them.

I worked in a hospital for 20 years, so I am used to a clinical environment. I worked in a mental health hospital, so I am used to working with people who are often stigmatised and on the edge of society, and I was hugely impressed by the facility. I was impressed by the professionalism of the staff, the warm welcome that they gave and the thoroughness of the work that goes on there. I have absolutely no doubt that the Thistle is life saving.

The Convener: I think that Annie Wells has a very brief supplementary question, and then I will bring in Pauline McNeill.

Annie Wells: I am sorry, convener. My question is not related to that point, so I will wait until the end.

Pauline McNeill: I agree that the Thistle is a very impressive set-up and that it is very professional. One of the things that I noted relates to referral services, which are important. I want to ask you about longer-term approaches. Annie Wells asked whether there have been any referrals to rehabilitation services yet. It is early days, so the focus is on getting the service up and running, but do you hope that, at some point fairly soon, we will begin to see such referrals? Obviously, this is about saving lives, but we need to try to get people off the thing that is putting them at risk in the first place. Are you hopeful that we will see more referrals for rehabilitation?

Maree Todd: We need to be careful about setting expectations around that. The service is life saving, as we have heard. An earlier witness—I think that it might have been Kelda Gaffney—made the point that, if people are not alive, they cannot be rehabilitated. The profound importance of saving lives should not be underestimated.

Then we need to think about the first steps on the recovery journey and how we achieve person-centred, individualised recovery. I am pretty clear that abstinence is not recovery. We should not mistake the two things.

Often, the first step on the recovery journey is stabilising housing and people having a secure roof over their heads. We heard from Tara Shivaji that people who have unstable housing are at a significantly higher risk of death. I am concerned about the narrative that suggests that the high rate of referral for housing might not be a success. I know that that is not what you are saying, Pauline—

Pauline McNeill: It is not at all what I am saying.

Maree Todd: It would concern me if we thought that the only measure of success was referral into treatment. We heard the statistic that more than 50 people have been referred to treatment. That is reasonable if we think about the level of chaos that the people who came through the door in the first six months were experiencing. To have 50 people referred for some form of treatment—not necessarily residential rehab—within six months is a reasonable number.

Pauline McNeill: I did not mean what was suggested. As you may know, early on, I hosted a meeting in 2018 with and supported the Danish lawyer who had been successful with the idea and who brought it to Scotland, so I am fully committed to it.

I am interested in the longer-term policy. It may be appropriate for Tara Shivaji to answer my next question, as she talked about housing. We know that women tend not to access services, but I want to ask about the vulnerabilities in men who are drug users. If we look ahead to the future of the policy agenda, has any thought been given to what we need to do in the longer term to address those vulnerabilities, particularly given that the number of male users is higher? I would be keen to hear anything that you have to say about that.

Dr Shivaji: I am happy to answer. I will frame this answer with the learning that we have taken from the national mission. Public Health Scotland has been conducting an evaluation of the national mission, and a lot of our questions are about what has worked for whom, in what circumstances that has worked and what needs to improve. We have tried to feed that learning in along the way.

One of the challenges that people have described has been in the ability to work across different areas. We have talked about housing, and multidisciplinary teams often do a lot of work that involves housing, justice and social work services working at the local level. However, there is a difficulty in implementing measures or working

at scale, because there are competing priorities in other departments, which limits the ability to do that. Therefore, it is important to recognise that we need wider input beyond the drug and alcohol treatment service.

Housing and justice settings are other areas that are particularly important to consider for men. That is about how we approach people and the quality of care that they get, not just for drug treatment but in relation to addressing underlying mental health issues in those settings—that is another issue that has been mentioned.

We need to further and much more fully develop our approach to prevention more generally—to how we are preventing people from using substances. We need to think about what the universal approaches are that apply to everybody, who is at higher risk and how we address their needs.

We recently published a consensus statement in which a lot of stakeholders were in agreement about what we need to do. We need to work with people in a person-centred and relational way and we need to address some of the underlying factors that contribute to vulnerabilities for using problematic substances, be that alcohol, drugs or tobacco. It is recognised that it is for multiple partners to do that and that there is shared accountability across the different governance structures that are all responsible for the same outcomes.

11:00

Michael Marra: Minister, you have already set out some of the long-term challenges in setting up the Thistle, and we have had exchanges previously on drug-checking centres. Where are you with drug-checking facilities, with particular reference to Dundee? I put it on the record that I was previously the deputy director of the Leverhulme research centre for forensic science at the University of Dundee.

Maree Todd: The Home Office has approved a licence for Glasgow, so people there are working hard to deliver that facility. There are three other proposed facilities—in Aberdeen, Dundee and Edinburgh. Edinburgh is a little behind the other two; it came quite late to the pilot. The proposals for Aberdeen and Dundee are quite developed, but they require a drug-testing facility in Dundee. The national testing and reference laboratory needs to be up and running for those facilities to be able to finalise their application to the Home Office.

I met representatives of the Leverhulme last week. I am confident in the progress, and we are supporting as much as we can the process of getting the national testing and reference laboratory up and running. I know that you have made a request to meet me, and I am happy to meet you some time soon over the next few weeks, so that I can update you fully on where we are. We are on the cusp of progress; I am pretty sure that we are just doing the final touches.

Michael Marra: I appreciate that, and we will have a more detailed conversation during that meeting, but I would like to get something on the record today. This has been a long-term project. I understand the challenges when it comes to licensing across the UK, and it is right that we are getting to the point of completion. I hope that that will make a big difference.

In Dundee, are any particular challenges arising with the university in getting that progress? Is there a sticking point that you would like to be unpicked in the next couple of weeks that would allow there to be an announcement, perhaps even prior to the recess?

Maree Todd: With reference to the national testing laboratory at the Leverhulme centre, the Government as a whole has been working closely with the University of Dundee since last year on the challenges that it has faced, and the Government has been providing a great deal of support, including financial support. We are pretty close to a resolution on the issues that the Leverhulme was facing in getting the national testing laboratory up and running, so I am confident that things are on track. Maggie, do you have more to say about where we are?

Maggie Page: No—that is where we are right now. To reiterate, the point-of-care sites for Aberdeen, Dundee and Glasgow have submitted their licence applications to the Home Office, and they have all had their essential compliance visits. Things are moving and progressing on that front.

Maree Todd: The model in both Aberdeen and Dundee requires the Dundee lab to be a part of it.

Michael Marra: You will understand my concern, given the parallel process—the real crisis—that is going on at the university. However, this is a critical piece of national infrastructure for saving lives, and we want it to be in place. I seek assurance that the university is not holding that process up. I may put some words to the principal in that regard, but I hope to see something in the next couple of weeks.

Maree Todd: It is fair to say that the situation that the university as a whole has faced has probably slowed progress slightly over the past year, but we are motoring now.

Michael Marra: That is great—thank you so much.

Annie Wells: Minister, we heard from a man who has lived in the Calton area for 42 years. He

is a drug addict and has been trying to get off drugs for a long time. He said that the situation in the area—for example, when it comes to drug dealers—is the worst that he has ever seen, and he feels that he has been left behind. What are you doing in that area? What measures are you putting in to make a difference so that drug dealers do not come into the area? Will those efforts make a positive impact on that gentleman's life?

Maree Todd: I would like to hope that those efforts will have a positive impact on that gentleman's life. We heard from the previous witnesses about the outreach work that is going on from the Thistle centre. We heard from the community representatives about the lengths that the staff go to in order to meet people and encourage them to access help and support. I am confident that, if the Thistle is not the place for him, it could help him to access help and support in other places.

We heard from the previous panel that, anecdotally, there are concerns about an increase in the number of people in the area and about faces that are not recognised. It is quite difficult to capture that. As both community representatives on your previous panel said, it is undoubtedly an area where drug consumption was happening anyway. The drug consumption happens close to the market. It is long established that this is an area where people come to buy their drugs, so it is difficult to capture how much change there has been since the Thistle opened its doors in January.

In general, safer drug consumption facilities reduce the levels of crime, drug paraphernalia and street litter in the areas that they are sited in. As well as being a life-saving intervention, part of their purpose is to reduce the harm that is experienced by individuals and by the community because of drug use happening in it.

Annie Wells: I understand where you are coming from, but the gentleman I mentioned said that the situation is the worst that he has seen in the east end of Glasgow in 42 years. Having been a pupil at a school down there—less than 42 years ago—I understand where he is coming from. I also have family who live there.

My main concern is that we have gangs in Glasgow, who have been in the news a lot recently, and they are the people who are selling drugs in the streets. What can we do to make the community safe for those who are trying to abstain from drugs but find a drug dealer on the corner of the street, outside the Thistle or in the surrounding area? I would like to get a wee bit of recognition that that is happening now. What can we do about it?

Maree Todd: It is really important that the community's concerns are listened to. We heard from the previous panel about the forum that is available to hear those concerns.

The drugs market is entirely unregulated. We do not have access to drugs on any legal basis in Scotland. Organised crime is a huge part of the drugs market in Scotland, and a suite of work is going on across the UK to tackle that organised crime activity and disrupt the market. However, it is really challenging.

When we had the four-nations meeting, one of the people who attended from a justice background talked about a £75 million haul of cocaine that was achieved in Glasgow. Although £75 million-worth of cocaine was taken out of the market there, it made not a jot of difference to that market. It gives us some idea of how resilient the market is—and how resilient the supply in some parts of Scotland is—that even removing £75 million-worth of drugs from it does not make a difference to the supply.

With the new synthetics, we are up against different challenges, in that they are very potent drugs. As a paramedic described it to me, what used to be a suitcase is now a matchbox-sized package of synthetic opioids. That means that people are able to get them into the country and, in fact, manufacture them in the country. Some manufacturing of synthetic opioids is happening in the UK—not in Scotland, as far as I know, but certainly in the UK. Disrupting the supply is undoubtedly challenging, but our justice partners are working really hard to stay one step ahead of the criminals who are causing such distress in our communities.

Annie Wells: Thank you, minister. I might write to you on a couple of other points.

The Convener: I have a final question. Earlier, we discussed the recent Scottish Affairs Committee inquiry into the Thistle project, which made recommendations for the UK and Scottish Governments, and you have helpfully sent an outline of the Scottish Government's response to that. I am interested in any further comments that you want to make on the inquiry and its recommendations.

We have spoken quite a bit this morning about the creation of a smoking and inhalation space, for which the Thistle oversight board has recently approved the development of a business case. I am interested in your broad response to the inquiry recommendations and, specifically, your comments on smoking and inhalation.

Maree Todd: As I have said before, I agree with much of what the Scottish Affairs Committee said; it is right to encourage us to look at more cost-efficient models—I agree with all that. The legal

environment in which we are operating is very challenging and, without a wholesale review of the Misuse of Drugs Act 1971, we have challenges with scaling and sustainability for facilities such as the safer drug consumption facility. That is my main takeaway from the inquiry. It is frustrating that, although people agree with us, we still do not have the power to change the situation that we are in.

Will you remind me what the second part of your question was?

The Convener: It was on the specific point of the development of a business case for a smoking and inhalation space.

Maree Todd: The business case will go through its process. The Thistle will need to work with the Lord Advocate on how that interacts with the 1971 act and the statement of prosecution policy that was developed for the safer drug consumption facility. The Lord Advocate will need to give a view on how possible such a space is and what legal exemptions from prosecution would be required to develop the facility in that way.

We have heard clearly from the clinicians who operate the Thistle about the issue of not allowing inhalation. It is about being agile—my frustration is that we need to be able to be agile to the changing pattern of drug use. We have heard loud and clear that one of the barriers to coming in and using drugs in the Thistle is that people like to smoke at the same time as they inject. We need to think carefully about how, in this challenging area of harm reduction, we best meet the needs of the people who would benefit most from coming across the Thistle's threshold. My officials and I will support, in any way that we can, any changes that need to be made.

There is a broader challenge with the 1971 act and harm reduction when it comes to paraphernalia. We have spoken about inhalation pipes, which cannot be supplied. What is happening at the moment, as you have heard in evidence today, is that people are injecting cocaine, and there are real risks because of the frequency of injection. There are real risks of increased levels of blood-borne viruses from sharing needles, and there are significant risks—to the extent of amputation—from injection site reactions; people can run into real difficulty from injecting 10-plus times a day, particularly if they become more intoxicated during the day. Being able to supply alternative, safer and less harmful means of using a drug—such as inhalation pipes—would be a significant step towards harm reduction that we could take but, currently, the 1971 act prevents us from doing that.

I also heard from the people at the Thistle about tourniquets. Even to laypeople, it is obvious that having injection procedures that are as sterile as possible would be a good harm-reduction intervention but, at the moment, the Thistle cannot supply sterile tourniquets for injections, because the 1971 act bars that.

The Convener: In your correspondence to the committees, it felt as though, to a certain extent, there was a common thread of challenge because the 1971 act prevents progress. Would it be safe to say that, should the act be reviewed by the UK Government, that would be very helpful?

Maree Todd: Absolutely. I advocate for that, but I am not sure that it is listening to me.

The Convener: I sincerely hope that it is.

That brings us up to time. Thank you very much for your attendance. That concludes our public evidence session.

11:15

Meeting continued in private until 11:34.

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