The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Thursday 28 November 2013

Session 4

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Scottish Parliament

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[The Presiding Officer *opened the meeting at 11:40*]

General Question Time

Engagements (Aberdeen)

1. Lewis Macdonald (North East Scotland) (Lab): To ask the Scottish Government when it will provide a substantive response to written question S4W-16703 regarding the First Minister's engagements in Aberdeen in June 2013, which received a holding answer from the Cabinet Secretary for Culture and External Affairs on 10 September. (S4O-02642)

The Cabinet Secretary for Culture and External Affairs (Fiona Hyslop): The parliamentary question was answered on 21 November 2013, and the delay was due to an administrative error.

Lewis Macdonald: I am grateful to the cabinet secretary. There is nothing like an oral question to concentrate the mind. I and my MSP colleagues and the MP for Aberdeen South would have been delighted to welcome the Government's contribution to the Pound for Piper Memorial Trust's fund at the time, if the First Minister had seen fit to tell us about it then or, indeed, in any of the weeks after the Aberdeen Donside by-election and before the anniversary of the Piper Alpha disaster. Can the cabinet secretary confirm whether there has been a breach of the "Scottish Ministerial Code 2011" in this instance? If so, will an apology be issued by her or by any other responsible minister?

Fiona Hyslop: There has been no breach. Paragraph 9.20 of the code states:

"Private offices should where possible issue constituency letters".

On the memorial garden in memory of those who died in the Piper Alpha disaster, the date of the anniversary and the location are fixed. In terms of funding, I think that people expect this Parliament to be respectful in remembering and honouring those who died in the Piper Alpha disaster and that the contribution on behalf of the people of Scotland to the memorial garden was very appropriate. I regret that Lewis Macdonald is treating it in this way.

Homelessness

2. Bruce Crawford (Stirling) (SNP): To ask the Scottish Government what progress it is making in tackling homelessness. (S4O-02643)

The Minister for Housing and Welfare (Margaret Burgess): Homelessness continues to fall in Scotland, as is shown by figures published earlier this month. In the first quarter of 2013 we saw an 11 per cent fall in applications to local authorities from the previous year's figure and, crucially, falls in the number of households with children in temporary accommodation. That continues the positive trend of falls in homelessness in Scotland in recent years. Progress has been driven by the achievement of our internationally acclaimed 2012 homelessness target and our focus on prevention, working with local authorities and others, and supported by our investment in new affordable housing.

Bruce Crawford: I did not sit beside the minister to ensure that I got the answer that I wanted.

According to the latest summary from Stirling Council's housing advisory group, the number of applicants to the Stirling Council homelessness list has continued to fall. That is very encouraging news, but obviously there is still much to do. Does the minister hope, as I do, that that trend will continue? What further action can the Scottish Government and Stirling Council take in working together to help to reduce homelessness rates further?

Margaret Burgess: I agree that it is good news that we see homelessness figures continuing to fall. They have fallen in Stirling by 14 per cent, which is higher than the national fall of 11 per cent. The progress is the result of the adoption of the housing options approach to preventing homelessness by local authorities and their partners, rather than a change in the underlying drivers of homelessness.

I attended a national homelessness event this morning that looked at how we can continue to work together on the issue and further develop the regional hubs—Stirling Council is a member of one—to prevent further homelessness. We have made significant progress in tackling homelessness, but independence would allow us to ensure that that would continue because we would have more control over finances and over threats from areas that are currently controlled by the United Kingdom Government, as typified by welfare reform.

Mary Fee (West Scotland) (Lab): What will be done to assist rough sleepers over the winter? What additional assistance will be given to charities that are already carrying out tremendous work with rough sleepers?

Margaret Burgess: The Scottish Government continues to work with charities that support rough sleepers, whose numbers in Scotland are reducing. We will continue to work with charities to

reduce their numbers and the number of homeless people. We have set up a number of funds for welfare reform mitigation and we are encouraging charities to ensure that anyone who is sleeping rough has the access to those funds that they should have. We continue to support them through our voluntary housing action fund, which funds a number of charitable organisations.

Vocational Education and Training (North Ayrshire)

3. Kenneth Gibson (Cunninghame North) (SNP): To ask the Scottish Government how it plans to boost vocational education and training in North Ayrshire. (S4O-02644)

The Minister for Youth Employment (Angela Constance): Consistent with the aims of our reforms, the recently merged Ayrshire College is expanding vocational education opportunities across North Ayrshire. The new college is a considerable boost for North Ayrshire and it will continue to adjust its curriculum to reflect the needs of local employers. Moreover, in the academic years 2012-13 and 2013-14, Ayrshire College has received additional funding of over £3.26 million from the Scottish Further and Higher Education Funding Council to deliver additional places for young people, women and adults returning to education.

Kenneth Gibson: In the year to September, youth unemployment in North Ayrshire fell from 560 to 350, which represents a fall of 37.5 per cent and is the fastest decline in Scotland. Does the minister agree that enhanced vocational education and training will reduce that number still further and will also give older unemployed people the necessary skills to return to work?

Angela Constance: Yes, I do agree. I listened to the figures that Mr Gibson quoted, and I think that I am correct in saying that he is talking about the claimant count figures for 16 to 19-year-olds, which have fallen right across Scotland. Given the particular challenges of North Ayrshire, it is encouraging to hear about that improvement.

Kenneth Gibson might also be interested to know that the claimant count, although it is not a full estimate of youth unemployment, has also fallen across the 16 to 24-year-old cohort, from 11 per cent to 8.1 per cent. He is absolutely right about the importance of vocational education and training. The targeting of specific skills needs in order to meet the needs of local employers will, indeed, boost the employability of learners of all ages, and support growth.

Department for International Development (East Kilbride)

4. Margaret McCulloch (Central Scotland) (Lab): To ask the Scottish Government what impact independence would have on the Department for International Development's office in East Kilbride. (S4O-02645)

The Minister for External Affairs and International Development (Humza Yousaf): In "Scotland's Future: Your Guide to an Independent Scotland", on page 365 and earlier in the document on page 31, we make it clear that international development is one of the areas where the Scottish and Westminster Governments have a mutual interest in working closely together. Our having in Scotland people with the skills to deliver Government priorities is an asset. The Scottish Government will work with the Westminster Government to preserve continuity of employment for all civil servants in Scotland, either by transfer to the Scottish Government or by continued employment with the Westminster Government where their skills will still be required by that Government. That will provide, on independence, for continuity of services and jobs, including those in DFID in East Kilbride, without either Government having to recreate significant infrastructure.

In stark contrast with the Scottish Government, which has a strong record of valuing public service, the Westminster Government is not operating a policy of no compulsory redundancies in the public sector. Recent examinations of DFID's accounts for 2011-12 shows that the UK Government plans to decrease the number of staff in East Kilbride from 2014 onwards.

Margaret McCulloch: I thank the minister for that in-depth answer. We were told that the white paper would answer all our questions, but it does not make things any clearer for staff at DFID—a department that employs more than 500 people in East Kilbride. The Scottish Government cannot seem to decide whether to assure civil servants in East Kilbride that they will seamlessly transfer to the Scottish civil service or to tell them that they will stick with a UK civil service that will run its overseas aid programme out of a foreign country.

Will the minister answer the questions that the white paper did not answer and confirm to DFID staff in East Kilbride what will happen to Abercrombie house in the event of independence? What will happen to the absolutely vital job base there, and why should those workers gamble their future on independence?

Humza Yousaf: Actually, I did answer that question. I told Margaret McCulloch that we would, of course, preserve continuity of employment with the Westminster Government, through negotiation.

Page 49 of the white paper specifically mentions that one of the delivery functions of the international relations and defence department of an independent Scotland would be in East Kilbride.

Maybe Margaret McCulloch should also talk to Michael McCann, the Labour member of Parliament and her colleague, who said about DFID jobs:

"I have ... made it clear that compulsory redundancies should be avoided at all costs and have asked the Minister to keep me updated with any developments. It seems to me that the Government"—

that is, the UK Government—

"isn't doing all it can to protect British jobs."

In addition, I encourage Margaret McCulloch to look in more detail at the international development section in "Scotland's Future". It has been welcomed by NIDOS—the network of international development organisations in Scotland—in particular because of its commitment to spend 0.7 per cent of gross national income on international development, and its commitment to "policy coherence for development".

That said, an independent Scotland would take its commitment to international development very seriously. The priorities, skills and expertise of the people in DFID will be well used in an independent Scotland's international development function. We would not, for example, have a policy through which we would do our development work while also undermining it by selling arms to people like Robert Mugabe, General Suharto, Hosni Mubarak and Saddam Hussein.

Finally, I will not take lectures from anybody in the Labour Party, which in 13 years of Government at a time of boom could not find it in itself to commit once to spending 0.7 per cent, which is our international obligation. It has taken a Conservative Government—a Tory Government that is hell-bent on austerity—to put the Labour Party to shame in that regard.

We have said and continue to say that DFID staff will be absolutely protected; we will preserve their continuity of employment. I have twice asked to meet the relevant DFID minister to discuss those issues. I hope that on the third time of asking she will be able to do that.

The Presiding Officer (Tricia Marwick): If I am going to make progress through the questions, we must have the questions a bit shorter and the answers considerably shorter.

Miscarriage Support

5. Anne McTaggart (Glasgow) (Lab): To ask the Scottish Government what support it provides to people who have experienced miscarriage. (S4O-02646)

The Minister for Public Health (Michael Matheson): Health professionals provide tailored care and support to people who have experienced miscarriage, which may include further investigation or counselling, as appropriate. Additionally, a patient may be referred to an appropriate voluntary organisation. During 2013 the Scottish Government has provided funding to several organisations that work in the field.

Anne McTaggart: I thank the minister for that reply. Organisations such as Scottish Care and Information on Miscarriage have been supporting mothers in my region—Glasgow—since 1992 and have worked to identify and tackle the causes of miscarriage and stillbirth through expert research. Does the Scottish Government have any plans to review their level of funding or to assist them and similar charities in acquiring alternative funding streams?

Michael Matheson: I met SCIM last week to discuss such issues. We provide it with a grant of more than £7,000 a year for the work that it undertakes in the greater Glasgow and Clyde area. We also provide funding to a range of other organisations that work in the field, to help them to support families who experience miscarriage.

I have no doubt that SCIM will choose to apply to the section 16(b) funding stream, which will open before the end of this year. Its application will be considered alongside other applications from organisations that carry out similar work.

Road Safety (A937 Montrose to Laurencekirk)

6. Alex Johnstone (North East Scotland) (Con): To ask the Scottish Government what action it will take to improve safety on the A937 between Montrose and Laurencekirk. (S4O-02647)

The Minister for Transport and Veterans (Keith Brown): The A937 is a local road, so responsibility for it rests with Angus Council and Aberdeenshire Council.

For our part, the Government has provided £100,000 for the access to Laurencekirk study, which is being commissioned by Nestrans in partnership with Aberdeenshire Council and Transport Scotland. The work aims to identify a preferred option at Laurencekirk on the A90.

Alex Johnstone: The minister will be fully aware that recent analyses and figures have indicated that the A937 is, as it has been described,

"the most dangerous ... road in Scotland"

and one of the most dangerous roads in Europe. The pinch point on that road is its crossroads with the A90, which is most definitely a trunk route.

Given recent correspondence, will the minister take this opportunity to retask his civil servants to begin the process of finding ways of improving that junction, rather than finding excuses for not doing it?

Keith Brown: Alex Johnstone should be more careful about how he describes the road. The road that was described as being

"the most dangerous ... in Scotland"

is actually the local road, not the trunk road. The trunk road is a low and medium-risk road. The high-risk road is the local road.

Obviously, we want to work with local authorities and others to improve road safety wherever we can. In relation to the trunk road—which is not the road that is mentioned in Alex Johnstone's original question—we have introduced measures in 2007 and 2008. Since that time, accident stats have reduced and we have conducted a cost-refinement exercise on the junction. As I mentioned, we are taking forward a design proposal with the north-east of Scotland transport partnership to see what the best possible solution for the A90 and access to Laurencekirk could be.

Although that suggests to me that the Government is being very proactive on the matter, we certainly acknowledge local concerns. I have met the campaigners—I talked to one just last week—and we will continue to listen to them and to improve the road where we can.

Nigel Don (Angus North and Mearns) (SNP): I have recently written to Angus Council and Aberdeenshire Council, which are responsible for the section of road, to ask them what they are doing to improve safety on what we know is an extremely dangerous stretch. Is the Government able to do anything to help in that process, given that the road in question adjoins a trunk road? The best brains need to be applied not only to the problem of the Laurencekirk junction, which I know the minister is working on, but to the stretch down to Hillside.

Keith Brown: It is worth my while saying that the Scottish Government has, as a roads authority, no authority to suggest or make improvements to a road for which another roads authority is responsible. However, Nigel Don is quite right to say that we work closely with local authorities, not least on roads maintenance. If the local authorities or the regional transport partnership make such a request we will be more than happy to work with them on the issue.

Carers' Rights Day

7. Fiona McLeod (Strathkelvin and Bearsden) (SNP): To ask the Scottish Government what action it is taking to promote carers' rights day. (S4O-02648)

The Minister for Public Health (Michael Matheson): On carers' rights day and all year round, the Scottish Government supports unpaid carers and young carers by providing valuable care and support to their families, friends and neighbours. With partners, we are developing a carers' rights charter that will set out and consolidate existing rights and which will be widely available next year. Moreover, subject to the outcome of consultation and parliamentary approval, the Scottish Government intends to introduce new legislation to support carers and young carers.

Fiona McLeod: Although the First Minister's announcement of a carers' rights bill at the carers parliament in October was very welcome, can the minister advise on the powers that can be used now to make councils such as East Dunbartonshire Council follow their duty to give carers their assessments?

Michael Matheson: The legislation is clear that where carers request an assessment the local authority must provide it. Local authorities must also notify carers of their entitlement to make such a request. I note that some councils support carers without any assessment, but it is important that councils undertake a good-quality assessment of all carers who request it.

As I have pointed out, we will also consult on carers legislation provisions on, for example, identification of carers, carers assessments and information, advice and support for carers with the aim of having across the country a more consistent approach that supports better outcomes for carers and ensures that those who would benefit from such an assessment are able to obtain one.

Policing (Stop and Search)

8. Kevin Stewart (Aberdeen Central) (SNP): To ask the Scottish Government how many stop and searches Police Scotland has carried out. (S4O-02649)

The Cabinet Secretary for Justice (Kenny MacAskill): The use of stop and search is an operational matter for Police Scotland. Since the organisation's formation in April 2013, there has been approximately one stop and search per police officer per week, which amounts to 12,089 police officers carrying out 454,737 stop and searches. Stop and search is effective not only in taking knives or other weapons off the street before they are used to commit violent crimes but

in recovering drugs or alcohol, which can reduce antisocial behaviour and its blight in our communities.

Kevin Stewart: Since the inception of Police Scotland, stop and searches have increased by 45 per cent in Aberdeen. Given the chief constable's statement that there are no targets for stop and search, will the cabinet secretary give me an assurance that he will keep a close eye on the statistics in order to assure my constituents that the procedure is being used only when there is suspicion of crime or during special operations?

Kenny MacAskill: Yes. Mr Stewart makes a good point; after all, this is a matter of balance. Having discussed the stop and search issue with the chief constable, I can confirm that—as Kevin Stewart said—there are no targets for numbers of searches. Helpfully, however, there are percentage targets for positive searches. I have been reassured that stop and search is an intelligence-led tactic that is used appropriately by Police Scotland to keep people and communities safe, but the Scottish Police Authority and the Scottish Government will, of course, continue to monitor its use.

I also point out that since this Government came to office, crimes of handling offensive weapons have fallen by 60 per cent. That is in no small way down to a visible police presence, tough laws and strict enforcement by our police officers.

First Minister's Question Time

12:00

Engagements

1. Johann Lamont (Glasgow Pollok) (Lab): To ask the First Minister what engagements he has planned for the rest of the day. (S4F-01716)

The First Minister (Alex Salmond): Engagements to take forward the Government's programme for Scotland.

Johann Lamont: Muchas gracias.

Yesterday, the Spanish Prime Minister made it clear that, by leaving the United Kingdom, Scotland would also leave the European Union and would have to reapply as a new member. What part of that statement does the First Minister not understand?

The First Minister: I have here a full transcript of Señor Rajoy's statement. This is how he starts:

"I don't yet know what the White Paper says which was presented by the Scottish President yesterday."

I have to say that promotion is always welcome, but I would like to point out that page 45 of "Scotland's Future" makes it absolutely clear that Her Majesty the Queen will continue as head of state of an independent Scotland.

Johann Lamont: I know that the First Minister likes to quote selectively, but that takes the biscuit. Looking for reaffirmation, where does he find it?

However, let us hear what the Spanish Prime Minister, Señor Rajoy, said.

"I would like that the consequences of that secession be presented with realism to Scots.

Citizens have the right to be well informed and particularly when it's about taking decisions like this one ... I know for sure that a region that would separate from a member state of the European Union"—[*Interruption*.]

The Presiding Officer (Tricia Marwick): Order.

Johann Lamont: I am not sure whether that is the defence that the SNP is going to prosecute. Dearie me.

Señor Rajoy said:

"I know for sure that a region that would separate from a member state of the European Union would remain outside the European Union and that should be known by the Scots".

The Spanish Prime Minister is being straighter with the people of Scotland than the First Minister is. Since, in any negotiation, Señor Rajoy will have a veto, should the First Minister not listen?

The First Minister: I am not a president, I am a First Minister; and Scotland is not a region, it is a nation. [*Applause*.]

The Presiding Officer: Order.

The First Minister: The difference is that Scotland will be negotiating its position from within the European Union. There are three questions about that. Can that happen legally? Would it happen? Can the process be completed within 18 months?

I have here a letter from the head of unit of the European Commission's secretariat-general, which addresses exactly the first question. It says:

"The ongoing democratic process is a matter for the UK and Scottish Governments and the Scottish people, and as you say, it would of course be legally possible to renegotiate the situation of the UK and Scotland within the EU."

I will put the letter in the Scottish Parliament information centre, so that all members can have the benefit of it.

So, it can happen, legally. Would it happen? I cite Sir David Edward, who was the British judge on the European Court of Justice for 12 years and is the person who knows most about these arguments in Scotland. He says:

"In accordance with their obligations ... the EU institutions and all the Member States (including the UK as existing), would be obliged to enter into negotiations before separation took effect, to determine the future relationship within the EU of the separate parts of the former UK and the other Member States."

So, yes, it would happen, because the obligation is to do it.

Thirdly—[*Interruption*.]

The Presiding Officer: Order.

The First Minister: Thirdly, and crucially, having cited Sir David Edward, I will now cite someone whose authority cannot be questioned even by the better together parties: Professor James Crawford, who was appointed and paid by the UK Government to dispense legal advice on this matter. When asked the specific question about the 18-month timetable, he said:

"Well, the Scottish estimate is about 18 months, and that seems realistic."

We have the European Commission, Sir David Edward, formerly of the European Court of Justice, and the person who was appointed by the UK Government, who says that the timetable is realistic. That is reasonably substantial evidence that Scotland as a nation can negotiate its position to full membership of the European Union.

Johann Lamont: I know what a nation is; the problem is that the First Minister does not seem to understand what a veto is. It does not matter who else he quotes, if there are 28 states with a veto they can use it if they choose to do so.

This is the First Minister who said that he had EU legal advice

"in terms of the debate",

which did not exist in terms of reality. The President of the European Commission, Mr Barroso, has said that Scotland would have to reapply to the EU, and now the Spanish Prime Minister agrees with him. However, in Salmond's world they are wrong. Here is negotiation Salmond style. Yesterday, he said that without Scottish electricity England's lights would go off—as though he is Vladimir Putin and the rest of the UK is the Ukraine. What is the First Minister going to turn off in Spain—

Members: Fishing rights!

The Presiding Officer: Order.

Johann Lamont: What is the First Minister going to turn off in Spain if it insists that Scotland is not in the EU? Is he going to threaten to blockade the North Sea again, as he did in June this year?

The First Minister: In terms of—[*Interruption*.]

The Presiding Officer: Order.

The First Minister: I am sure that Johann Lamont would not want to say something that the Spanish Prime Minister did not say. There was no mention of a Spanish veto in anything that Señor Rajoy said yesterday. However, the question has been addressed directly by the Spanish foreign minister, Señor García-Margallo. In response to that exact question, he said:

"If in the UK both parties agree that this is consistent with their constitutional order, written or unwritten, Spain would have nothing to say, just that this does not affect us. No one would object to a consented independence of Scotland."

We have an extraordinary situation in which that is what the Spanish foreign minister says but Johann Lamont has the idea that Scotland is a place that no one else in the European Union would want as a member. This nation, with its huge natural resource base, would be welcome in the European Union. Not to realise and understand that point is not to get to grips with the matter. Scotland is a European nation and we want to be a European nation. The only question about our membership is coming from the Conservative Party, many of whom want to get out of Europe. They are the real risk to our EU membership. Can Johann Lamont not embrace the fact that Scotland will be welcomed as a member of the European Union?

Johann Lamont: I used to say to my children, "What you want is not necessarily what you get." The First Minister needs to understand that it is

not his assertion that matters, but what people are entitled to do. If people cannot agree, they can disagree, or they can agree on conditions, and we do not know what those conditions would be.

The reality is that the white paper—so vaunted, like an Argos catalogue but without the prices—is truly historic: no document has become obsolete quite so quickly. What it says about keeping the pound is just plain wrong. Now we know that what it says about Scotland staying in the European Union is just plain wrong. However, the First Minister thinks that if he asserts things often enough they become true, and that, if he says that it is common sense or as sure as night follows day, his next statement will be believed however unbelievable it is in reality. What does it say about Scotland when Scots have to listen to a foreign Government to find out the truth?

The First Minister: In this exchange, I have cited the head of unit at the European Commission, who says that we could do it legally from within the European Union; I have cited Sir David Edward, a British judge in the European Court of Justice for 12 years, who says that there would be an obligation to have the negotiations; and I have cited Professor James Crawford, the legal adviser paid by the UK Government, who says that the 18-month timetable is realistic. That is a substantial amount of evidence. I have pointed out that the Spanish foreign minister says that

"No one would object to a consented independence of Scotland. "

That was the precise reason for having the Edinburgh agreement in the first place.

I had heard the one about the catalogue before, because Johann Lamont used it last night—just before, I think, she suggested that she would means test nursery education under Labour's plans for Scotland.

The question goes to the heart of whether the unionist parties believe that Scotland would be a welcome member of the European Union. We had a definitive answer on that last night from one of the key members of better together—Alistair Carmichael. Now, listen, I would not recommend that people go and watch the programme, because a referee would have stopped things when Nicola Sturgeon was bruising the bruiser. However, Alistair Carmichael managed to complete a sentence, which I think the rest of his colleagues in better together should look at:

"The question is not whether we would be welcome or not; it would be the terms".

Exactly. I believe that, for example, the terms of Scottish membership of the European Union would not allow €1 billion to be taken away from our rural industries, as the UK Government has done.

Scotland is a European nation. Resource rich Scotland would be welcome. Anyone with an ounce of sense knows that. Can better together not just get off the scaremongering and embrace the idea that this nation is a European nation?

Prime Minister (Meetings)

2. Ruth Davidson (Glasgow) (Con): To ask the First Minister when he will next meet the Prime Minister. (S4F-01713)

The First Minister (Alex Salmond): No plans in the near future.

Ruth Davidson: Before I start, I would like to get the Spanish foreign minister out of the way. José Manuel García-Margallo told the Spanish Senate:

"In the hypothetical case of independence, Scotland would have to join the queue and ask to be admitted, needing the unanimous approval of all member states to obtain the status of a candidate country".

If we are going to quote the Spanish foreign minister, let us do it properly.

On 13 December last year, the Deputy First Minister made a statement to the Parliament on Europe. In that, she told MSPs that she had written to the European Commission President, José Manuel Barroso, to seek early discussions with him on the process by which an independent Scotland would become a member of the EU. She told the Parliament that she would give an update once those discussions had taken place. Can the First Minister tell us why, in the intervening 11 and a half months, we have not had that update?

The First Minister: We would go tomorrow to the European Commission, but it has said that it would need the UK Government—Ruth Davidson's Government—to agree.

I ask Ruth Davidson to get on the phone to the Prime Minister. Unfortunately, he will not be at his St Andrew's day reception tonight because he cannot make it, but, nonetheless, I ask her get on the phone to him and ask him to agree that we go together, as the European Commission has invited us to do, to look at the legal case for Scotland being a member of the European Union. Get on the phone—do it reverse charges—and ask your leader for permission.

Ruth Davidson: There is surprise and indignation from the First Minister, and yet he should not be surprised. [*Interruption*.]

The Presiding Officer: Order.

Ruth Davidson: Anyone who has ever had any dealings with the European Union would know that the head of Commission would speak only to sovereign states on accession issues. The question is—[*Interruption*.]

The Presiding Officer: Order. Can we just settle down please?

Ruth Davidson: The question is: why did the Deputy First Minister not know that when she said it? That shows just what a shower of rank amateurs the Scottish National Party Government is when it comes to international diplomacy. [*Interruption*.]

The Presiding Officer: Order. Let us hear Ms Davidson, please.

Ruth Davidson: SNP ministers say that they are right and everyone else is wrong on Europe. They say that the European Commission President is wrong when he says that Scotland would have to join the same queue as everybody else. They say that the Spanish Prime Minister is wrong when he says that we would have to join the same queue as everybody else. They say that the foreign ministers of Spain, Latvia, Ireland and the Czech Republic are wrong when they say that we would have to join the same queue as everybody else.

The First Minister does not understand that it does not matter if he gets 15, 25, 26 or even 27 member states on board because he needs every single one of the 28 Governments to agree to his demands. Is the First Minister winning friends and influencing people by telling them that they are wrong?

The First Minister: Judging by the response of Ruth Davidson's back benches, this may be her valedictory First Minister's question time.

Ruth Davidson's approach was bad enough but, for goodness' sake, I suggest that she does not get into a debate with Nicola Sturgeon on that topic. The point is quite simple. We have said—it is on public record—that we want to go to the European Commission.

I will provide an interesting update for Ruth Davidson. Yesterday, she said that the European Commission would not talk to us after Scotland voted for independence. The European Commission is prepared to talk to us now but it says that it needs the permission of, and that we must go jointly with, the UK Government. We have asked the UK Government to do that, but the UK Government—which is led by her political party—says that it will not pre-negotiate and therefore it will not go.

It is not the Spanish veto that we must worry about—they do not have one—but the UK Government's veto.

The Presiding Officer: I call David Stewart to ask a constituency question.

David Stewart (Highlands and Islands) (Lab): The First Minister will be aware that Flybe is to close its Inverness base with a loss of 35 jobs, which include local flight crew, engineers and pilots. Those losses are echoed in cuts in Aberdeen and beyond. Does the First Minister share my view that a base closure today could be a route closure tomorrow? Will he meet me to join the fight to save the base and local Highlands and Islands jobs?

The First Minister: I certainly agree to meet the member, and we will do what we can to redress the situation. We have held a number of meetings with Flybe. The member knows that there is a general retraction in Flybe services. I am sure that the member agrees with me that, among the reasons that it has cited, air passenger duty has played a key part in the difficulties that it has on the routes that it serves.

Cabinet (Meetings)

3. Willie Rennie (Mid Scotland and Fife) (LD): To ask the First Minister what issues will be discussed at the next meeting of the Cabinet. (S4F-01714)

The First Minister (Alex Salmond): Issues of importance to the people of Scotland.

Willie Rennie: How many of the people whom he listed to Johann Lamont have more power than Mr Rajoy? None of them. It is the Spanish Prime Minister's word against the First Minister's word, but Mr Rajoy has the veto.

The First Minister does not need most European Union countries to back Scotland; he needs every single one, and they all know that he has nowhere else to go.

At breakfast yesterday, there was little doubt over Scotland's place in the EU; by tea time, there was little certainty. What will the First Minister trade to get the Spanish on board?

The First Minister: Señor Rajoy did not say that he would use the veto—that is the point that I was making. Indeed, the Spanish Prime Minister has explicitly said that Spain would not veto because it would be a consented independence. If the Liberal Democrats want to put words into the Spanish Prime Minister's mouth, that is a matter for them.

Of course, Willie Rennie's colleague said last night—I think that this was repeated by another of his colleagues this morning—that they acknowledge that Scotland would be welcome as a member of the European Union. That is what Alistair Carmichael said last night.

If the better together parties can get at least to that first base—and not have a situation in which the Liberal Democrats believe that Scotland would be welcome, the Labour Party seems to doubt

Scotland's welcome and the Conservative Party seems to doubt the entire European Union—and if we get to a place of acknowledgement that Scotland would be a welcome member, then we will make progress.

Incidentally, I accept that the white paper has been predicated on the basis that Scotland, as a European nation, would be welcomed by other European nations—we have every possible reason to believe that that would be the case. Given that Alistair Carmichael has acknowledged that, surely Willie Rennie can bring himself to support if not me then at least his colleague.

Willie Rennie: The First Minister really should not answer the questions that I did not ask. He is obviously relying on his powers of persuasion with the Spanish Prime Minister. However, all of us in this chamber remember his six red lines on the Scotland Act 2012 and that he sold out on every single one of them. That was negotiating with only one Government, and that is why he has been called the worst negotiator in the northern hemisphere.

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): The Liberal Democrats know all about selling out.

The Presiding Officer: Order.

Willie Rennie: When the Croatian ambassador was in this building, he said that countries have to

"take pretty much what is offered."

Every country has had to trade things away to secure a place in the EU. Will the First Minister sell out our Scottish fishermen for a Spanish vote? [*Interruption*.]

The Presiding Officer: Order.

Willie Rennie: What about the rebate, the Schengen agreement or the euro? We all know that he will say anything to get independence— [*Interruption*.]

The Presiding Officer: Ms Adamson!

Willie Rennie: Who will he sell out to get the vote that he needs?

The First Minister: I remind Willie Rennie that, in negotiations for joining the European Community, as it was then, a civil servant noted bitterly:

"In light of Britain's wider European interests they"—

the Scottish fishermen—

"are expendable".

That is an exact quote. I can tell Willie Rennie that, for this Government, Scottish fishing will never be expendable.

Just in case he thinks that that is too dated a quote, I see his colleague Tavish Scott sitting behind him. Let us remember that he had to resign from Government in the Scottish Parliament because he did not think that it was fighting for Scottish fishermen.

Let us also remember the information published by Richard Lochhead that €1 billion is the cost of British negotiation on, and attitudes to, the common agricultural policy. That is a loss to Scottish farmers, even if we were getting the minimum support across the community.

That evidence on fishing, farming and a range of other issues shows exactly why this European nation should represent itself at the top table in Europe.

Social Care Services

4. Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): To ask the First Minister what action the Scottish Government will take to avert the reported pressures on social care budgets undermining care services for older and vulnerable people. (S4F-01715)

The First Minister (Alex Salmond): Alongside our on-going and absolute commitment to free personal care, the integration of health and social care is needed to ensure that we have effective care services for older and vulnerable people. Earlier this week, our bill to take integration forward passed stage 1. That integration will ensure that the human and financial resources in Scotland's caring services can be used to best effect.

Christine Grahame: I am aware—as we all are—that the cuts to our budgets are having huge impacts across this area. In my constituency and elsewhere, because of pressures in the here and now, carers looking after their elderly and vulnerable clients are increasingly close to breaking point. Will the First Minister and his Cabinet colleagues consider whether, in very pinched budgets, we can find some funding to assist in the here and now?

The First Minister: I draw Christine Grahame's attention to the £120 million integration fund for 2015-16. The final shape of that fund and the nature of the programmes and projects that it will support are currently being determined in partnership with local authorities and the third sector. In addition, the reshaping care fund is making £300 million of change funding available between 2011 and 2014-15 to help to reshape care for older people. Scottish Borders Council and other councils, working with local health boards, have made use of the reshaping care fund. For example, as Christine Grahame knows, Scottish Borders Council has received £2 million

from the change funds this year for projects that focus on preventative care, support at home, care in hospital and care in care homes.

I hope that that answer satisfies Christine Grahame that, even despite the huge pressure, the commitment to free personal care is absolute and that the change fund and integration fund will make sure that we are doing everything possible to ensure that the integration between the health service and local authorities in personal care for the elderly and vulnerable has the best possible passage into effect.

Rhoda Grant (Highlands and Islands) (Lab): The First Minister will be aware of Age Scotland's concerns that some people are receiving care visits that are as short as seven minutes. Will he ensure that care visits are long enough to provide the care and attention that frail and elderly people require to allow them to live in security and dignity? Will he ensure that care visits are not restricted to 15 minutes or less?

The First Minister: I am sure that Rhoda Grant will want to acknowledge that the United Kingdom Homecare Association has conducted a survey that shows that 58 per cent of home care visits in Scotland last longer than 30 minutes, compared with only 27 per cent in England. It also shows that 89 per cent of visits in Scotland are longer than 15 minutes. Although performance in Scotland is not perfect and is capable of improvement—vigilance is always necessary—in a range of areas it is vastly superior to performance elsewhere. On the basis of the figures from the UK Homecare Association, free personal care is very much a reality. I share Rhoda Grant's concern, but she should acknowledge that, in Scotland, the local authorities, in particular, are pursuing a policy that is substantially better than that of their colleagues south of the border.

National Health Service (Winter Pressures)

5. Neil Findlay (Lothian) (Lab): To ask the First Minister whether the Scottish Government considers that there is sufficient capacity in the NHS to deal with demand this winter. (S4F-01719)

The First Minister (Alex Salmond): Neil Findlay will be aware that demand for NHS services—including demand for accident and emergency services—grows year on year. Winter brings additional pressures, not least from norovirus and increased respiratory illness. That is why, earlier this year, we announced that we would be working with the College of Emergency Medicine on a £50 million unscheduled care action plan that would put more key staff, including emergency consultants, in place to tackle unacceptably long waits in accident and emergency.

Neil Findlay should remember that, under this Government, almost 1,000 additional medical consultants have been provided—that includes a doubling of the number of A and E consultants; there has been a 5.5 per cent increase in the number of general practitioners; and more than 1,000 additional qualified nurses have been provided. Winter brings its challenges. We will work with NHS staff and boards to provide the best possible service this coming winter.

Neil Findlay: I am advised that, this week, patients at Edinburgh's Western general receiving unit have languished on trolleys for up to 18 hours. This week, we also found out that nine out of 14 NHS boards failed to meet A and E waiting times targets.

It is only November and the weather is mild, yet our hospitals are struggling despite the immense efforts of NHS staff. Why has the Government failed to heed the warnings of the Royal College of Nursing, the British Medical Association, Unison, patient groups and many others, who have said for months and months that the NHS is not ready for winter?

The First Minister: On the unscheduled care action plan, Jason Long, who is chair of the College of Emergency Medicine Scotland, said:

"This is an important initiative that will improve emergency medicine across Scotland, and we welcome the opportunity to collaborate on this initiative."

The member should look at things from the point of view of where we are. This week, figures have been published that show that, in the third quarter of 2013, performance against the four-hour accident and emergency treatment target was 95.2 per cent. If we look back a few years to 2006, we find that 87.5 per cent of patients waited for less than four hours. I will repeat that: the figure was 95.2 per cent in the most recent quarter compared with 87.5 per cent in April 2006. The then health minister, Andy Kerr, hailed that performance. He said:

"This is the first time we have had comprehensive data ... The data shows that the vast majority of A & E departments are meeting the four hour target ... Investment and reform ... is paying off".

All that I would say, as gently as possible, is that every one of us would like to see the figure of 95.2 per cent going up to 100 per cent—of course we would—but the Labour Party must explain why it hailed a figure of 87.5 per cent in 2006, yet a figure of 95.2 per cent is now apparently not good enough. Let us look at the reality and the figures and let us recognise the improvements that have been made and the commitment to cope—as far as we possibly can, in good will and good judgment—with the coming winter and the pressure on our A and E units. Let us also remember the people who serve in those units and

serve the public, who are doing their best for the health of Scotland.

Barnett Formula

6. Kenneth Gibson (Cunninghame North) (SNP): To ask the First Minster what the Scottish Government's position is on the recent comments by the Secretary of State for Scotland regarding the future of the Barnett formula once the economy has "stabilised". (S4F-01720)

The First Minister (Alex Salmond): I should pass on my best wishes to the Secretary of State for Scotland as he recovers from last night's debate.

As the member will have seen, that aspect came up in last night's debate. On Monday, the report from the all-party parliamentary group on taxation, which includes MPs from the Conservative, Liberal and Labour parties, said that

"the Barnett Formula must be replaced as a priority"

and that we should go over to the proposals of the Holtham commission. We know that the Holtham commission, which was commissioned by the First Minister of Wales, who was lauded by the better together parties when he came to Scotland just last week, forecast a £4 billion cut in spending. That was its assessment. All three of the better together parties are signed up to a £4 billion cut in Scotland's finances or—to put it in terms that the Tory party understands—a cut of £1,600 for every taxpayer in Scotland.

Kenneth Gibson: The secretary of state's gaffe in saying last Sunday that the United Kingdom economy remains unstable was compounded when he implied that the Barnett formula's days are numbered. Does the First Minister agree that, as politicians south of the border from all three UK parties are now pressing for substantial cuts to Scotland's budget—in addition to those that have been endured in recent years—the only way for Scotland to avoid the cuts is for Scotland to vote yes in next year's independence referendum?

The First Minister: This is where we come to it. I could cite quote after quote from members of all three unionist parties—from the Labour Party, the Conservatives and the Liberal Democrats—who say, "Scrap the Barnett formula." Their all-party group has now said what it wants the formula to be replaced with. The academics who were concerned with the Holtham commission told us in the *Financial Times* that they estimate that the Holtham proposal would mean a £4 billion cut in Scotland's finances.

That is why we published the white paper—the enormous amount of detail in "Scotland's Future"—which is our prospectus for an independent Scotland. Let us see from the unionist parties the reality of what their colleagues plan—a £4 billion cut in Scottish finances.

Drew Smith (Glasgow) (Lab): The Barnett formula is an arrangement for redistributing resources around the United Kingdom. The person who is campaigning hardest for the end of Barnett is the First Minister. Does the First Minister understand that if you are not in it, you will not get it?

The First Minister: I will answer with two statistics. We get 9.3 per cent of the spending, but we raise 9.9 per cent of the revenue; 9.9 per cent is greater than 9.3 per cent. [*Interruption*.]

The Presiding Officer: Order. Mr Johnstone.

The First Minister: That happens to be greater by about £4 billion. It would therefore be a good idea if we got control of the revenue as well as the spending.

Drew Smith's colleagues have in mind cutting the 9.3 per cent to about 8.3 per cent, which would be £4 billion less. *[The First Minister has corrected this contribution. See end of report.]* I will put that in the simplest terms that I can for Labour back benchers. If we had raised our own revenue and taxation in the past year, we would have £4 billion more. Under the plans of the better together parties, we will have £4 billion less. Does that complete the calculation?

World Prematurity Day 2013 and Neonatal Care

The Deputy Presiding Officer (Elaine Smith): The next item of business is a members' business debate on motion S4M-08110, in the name of Rhoda Grant, on world prematurity day 2013 and world-class neonatal care in Scotland. The debate will be concluded without any question being put.

Motion debated,

That the Parliament celebrates World Prematurity Day on 17 November 2013 and understands that 8,000 babies are born sick or premature each year in Scotland; welcomes *Neonatal Care in Scotland: A Quality Framework*, which creates new standards for neonatal care that aim to help ensure improvements to the care of premature and sick babies, ensuring that they receive the world-class treatment that they and their families deserve; commends Bliss Scotland and the health professionals involved in drawing up the new standards, which include increasing the number of staff in units, involving parents in the care of their baby and offering proper support and facilities to families, and looks forward to the implementation of these standards.

12:33

Rhoda Grant (Highlands and Islands) (Lab): I am pleased to open the debate to mark world prematurity day, which fell on 17 November.

I vividly remember visiting my great-nephew just over a year ago in a special care baby unit. He was only a few days old and just out of an incubator. My niece told me that we could see him but we were not allowed to lift or cuddle him. When we were peering into his cot, a nurse told us that we could pick him up and hold him. That was a special moment. Needless to say, he is now doing well and getting up to mischief, and those days seem far away.

Other babies are not as lucky. In the United Kingdom, one in 300 babies dies within four weeks of birth. In Scotland, one in seven babies are admitted to neonatal care every year because of early birth, being small or being too sick. Therefore the quality framework for neonatal care is welcome, and I pay tribute to the work of the professionals and parents who have been involved in drawing it up, as well as to Bliss Scotland and Sands—the Stillbirth and Neonatal Death Society.

Bliss Scotland drew our attention to the problems that are faced in neonatal care in its "A chance for change Bliss Baby Report and Manifesto: Scotland 2011". It tells us that there is a significant shortage of nurses for sick babies in at least three level 3 units, and four neonatal units reported having problems with recruiting doctors and consultants. There is a lack of counselling services for parents who need emotional support and a lack of accommodation for them when their babies are in facilities that are away from their homes.

The British Association of Perinatal Medicine has outlined staffing guidelines. There should be a nurse ratio of 1:1 for babies who need neonatal intensive care, and the nurse should have a post-registration certificate in neonatal intensive care. The BAPM also recommends a nurse ratio of 1:2 for babies who require high-dependency care and that the nurse should have had training in neonatal care, and that there should be a nurse ratio of 1:4 for babies who require special care.

Three out of the eight neonatal units that responded to Bliss Scotland gave information on nursing levels and occupancy rates that did not meet those standards, and units are not meeting the minimum standards for nurse training. The Royal College of Nursing standards say that 70 per cent of nurses who work in neonatal intensive care units should have a qualification in specialised neonatal care, but half of the level 3 units that responded to Bliss Scotland did not meet that standard. They reported that it is difficult to release nurses for training.

Neonatal units are also having problems with recruiting consultant-level doctors. One nurse said that posts cannot be filled because of a lack of applicants and funding. Because of that, neonatal units have to close their doors to babies who need that specialist care.

In June 2010, fewer than half of the units provided parents with access to counselling. Counselling is crucial because parents who have gone through the trauma of having a child in neonatal care are at higher risk of developing depression or anxiety. We can all imagine the stress that is caused by a seriously ill loved one, but the illness of a tiny baby causes untold stress, so counselling and support are crucial for those parents.

Bliss Scotland also found out that there is a need for 38 more overnight rooms to accommodate parents. Babies and families have to travel far from home to access care because there are only 16 neonatal care units in Scotland. That has emotional and financial implications for the families who need to be close to their child. Access to overnight rooms that allow parents to be close to the unit is crucial for them and their baby.

We also need to make sure that adequate specialist transport is available. My region covers the majority of Scottish islands, and listening to parents whose child has been airlifted to a neonatal care unit while they have been left behind on an island is heart-rending. It is difficult enough to be separated but somehow having sea between the parents and the baby makes it worse. Fathers also often have to face making an awful

decision about where they should be if their baby's mother is also seriously ill. Those parents need practical and emotional support. It is right that specialist staff who care for babies in transit are given priority on flights and in ambulances, but we need to find ways of allowing parents to travel if they are fit and able to do so.

We also need to make sure that there are sufficient allied health professionals to support families and children. Physiotherapy, nutritional support and indeed speech therapy might be needed to help young babies with swallowing, as that is often an issue for babies who need intensive care. We also need palliative care support for parents; that is one of the most difficult areas and it is essential that parents are supported through it.

The quality framework deals with many of those important issues, but it requires to be implemented quickly. World prematurity day takes place every November. It allows us to focus on issues, gives us the opportunity to gauge the improvements that have been made during the year, and allows us to renew our efforts to ensure that we offer a world-class service to premature babies and their families.

12:39

Mark McDonald (Aberdeen Donside) (SNP): I congratulate Rhoda Grant on bringing this important debate to the chamber. It has a personal note for me, as many of the children in my family spent time in neonatal care because of premature birth.

In March this year, I attended the launch by the Friends of the Special Nursery at Aberdeen neonatal unit of the miracles and memories scrapbooks project, which aims to bring together pictures and stories from people and families who have experienced the care and support of the Aberdeen special nursery.

One of the mothers, Julia Ann Roberts, commented to me that the neonatal care has led to a community spirit among the parents who have experienced prematurity and the care of the neonatal unit. Many of them are now dedicated fundraisers who work extremely hard to raise money to support the work of the special nursery.

One of my constituents, Donna Scott, petitioned the Parliament on the subject of donor breast milk and the establishment of a donor milk bank to cover all of Scotland. I am delighted that she was successful in achieving that aim with the support of the Scottish Government and the national health service. We now have a system in which, regardless of geography, premature babies can access donor breast milk, which as we know is vital for many premature babies.

Donna Scott and other parents who have been in contact with me have made a point about the number of beds that are available in units, particularly in Aberdeen. One point that has been brought to me frequently is about the number of mothers who have to be relocated to Ninewells in Dundee. They could not fault the care that they received there but, as Rhoda Grant highlighted, the geographical displacement causes obvious difficulties, particularly for the wider family, who want to visit and support the mother and child during what is a difficult time.

Another interesting point is about parental leave, although I realise that that is not devolved to the Parliament. Many fathers have only two weeks of statutory leave, but if a child is in a neonatal unit for a number of weeks, that leave can often be eaten up during time when the child is not at home. The mother's maternity leave is also eaten into by the time that the child spends in the neonatal unit.

One of my constituents, Wendy Eastell, told me that, when her daughter was born prematurely at 27 weeks, she had 24 weeks of maternity leave. One week of that was spent in labour and 11 weeks were spent while her daughter was in the neonatal unit, which meant that she had only 12 weeks at home with her daughter before she had to return to work. At that point, her daughter was only term plus 11 weeks and weighed only five pounds. There can also be difficulties for mothers with breastfeeding and attachment if they do not have that vital time with their baby because it is spent largely in the neonatal unit.

Presiding Officer, I have a couple of other constituent examples that I would like to raise, so I ask you to be a little flexible with my time so that I can at least put them on the record. A number of people have contacted me. I will not be able to raise all their points, but I have told them that I will send their comments to the minister after the debate.

One example is my constituent Alison Martin, whose daughter Sawyer was born six weeks prematurely. Alison said that the staff at the neonatal unit in Aberdeen allowed her to be as hands-on as possible with the care of her daughter and that she cannot fault the care that the unit provided.

One of the more harrowing cases that I have come across is that of my constituent Dani Rose Mackay, who was pregnant with twins and was taken in at 21 weeks with pre-term premature rupture of membranes, or PPROM. One of her twins had no water, but one did. A week later, the other twin had no water either. Both babies had heartbeats right up to labour at 25 weeks, but one of them, Lucy, had stopped growing. Her cord flow

was bad and she did not cope with the labour, and her heartbeat stopped during it.

Dani had been moved to Dundee at 24 weeks because Aberdeen had no room—a point that I raised earlier—but labour was stalled with steroids, magnesium and a contraction-stopping drug. At 25 weeks, she was found to be fully dilated, with her daughter Amie's foot visible, and was induced. That failed, and 17 hours later Amie was born after surgery, although not a section. However, Dani's cervix closed, so Lucy was induced and was stillborn, with waters intact, another seven hours later. Her waters had not ruptured, but had diminished due to placental issues.

Dani felt that there was a disparity between the service that she was offered in Aberdeen and that in Dundee. Obviously, that predates the guidance that has been implemented, so I hope that it will perhaps change some of that. She said that she would love to see discharge packs being given to mothers when they leave the neonatal unit and more appointments being offered, which would enable mothers to chart the progress of their children. Perhaps having a dedicated outpatient department as the first port of call for mothers who have spent time in the neonatal unit could be looked at.

I hope that I have been able to put some thoughts in the minister's head. I thank Rhoda Grant for bringing the debate to the chamber.

12:45

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I thank Rhoda Grant for lodging the motion, which reminds us that 8,000 babies are born prematurely in Scotland each year. That is 8,000 families, all of whom have the right to the highest possible quality of care, and 8,000 reasons why we should all join Rhoda Grant today in welcoming the new quality framework for neonatal care and commend our healthcare professionals, in partnership with Bliss Scotland, for producing it.

When put in place, the framework will offer new guidance to the NHS and offer support in the delivery of safe and effective person-centred care.

In this field of study, the impact of premature birth on adult development is at present still relatively unknown. The Bliss campaign, however, has engaged with the EPICure study at University College London over the past 18 years and has contributed to a longitudinal study of the effects of premature birth. The next phase in that study was announced on Sunday 17 November.

The purpose of the study is to ensure that the interventions made at an early stage are based on well-informed evidence. With so much riding on the success of the framework, it is vital that we establish a better picture of which interventions are most effective. That can be determined only by looking at the long-term development of premature babies as they grow into adulthood.

In its response to NHS Scotland's 2007 publication, "Better Health, Better Care: A Discussion Document", Bliss outlined the importance of getting it right for premature babies and their parents. At the time of the consultation, the main issue that was identified to be working against the shift towards better-quality neonatal care was a shortage of nurses to deliver the specialist support. As Bliss stated at the time,

"While the care that neonatal nurses, doctors and other health professionals provide for sick and premature babies is excellent, the service is compromised by nursing shortages. While demand for neonatal services is increasing, the numbers of neonatal nurses employed is remaining almost static."

That was in 2007. It is therefore encouraging to see that the new quality framework aims to improve safety through ensuring that duty rotas always have the appropriate level of staff on hand to meet the neonatal unit's needs, with a high baby to nurse ratio.

Rhoda Grant quoted the British Association of Perinatal Medicine recommendations on that, which are: one nurse to one baby in neonatal intensive care; one nurse to two babies in neonatal high dependency care; and one nurse to four babies in neonatal special care. Until recently that was not the case in Scottish units, so Bliss was right in its contribution to the development of the framework to make the case for a greater number of nurses. Perhaps the minister will update us on that in his wind-up speech.

All parents going through the pregnancy and birth process hope for a positive experience and the chance to bond with their newborn baby. Wherever possible, that should not be compromised by the baby being premature.

Anyone who has experienced the birth of a baby as a mother or father will know what a moving and indescribably special time it is. Quality neonatal care does not simply mean creating a safe clinical environment; it also means providing a nurturing and understanding place for parents and their new babies at that crucial point. "Neonatal Care in Scotland: A Quality Framework" seems to recognise the importance of that point. I have no doubt that Bliss was in part responsible for the immense progress made in changing the quality of care accordingly.

It is great to see that steps are being taken to provide better person-centred care and a chance for parents to have greater involvement in the

decision-making process. That includes clinicians collaborating with parents in the production of a care plan, including time spent with the baby as and when it suits the parents.

Today we recognise the incredible work done by healthcare practitioners, campaigners and parents themselves, who in times of great difficulty can show such fortitude when given the right support. We also acknowledge, as I have done several times in my contribution, the vital role played by Bliss.

I commend Rhoda Grant for bringing forward the motion and give it my full support.

12:49

Nanette Milne (North East Scotland) (Con): I, too, commend Rhoda Grant for securing this debate on the very important—but not widely discussed—topic of premature birth and care of babies who are born too early, too sick or too small.

Rhoda Grant, the minister, other members and I have been active in the chamber this week on a variety of health-related issues. On Tuesday, we discussed a bill at stage 1 that will set the scene to enable integration of adult health and social care across Scotland. It is aimed at improving the wellbeing of many people who are at the upper end of the age spectrum.

Today, we are discussing the other extreme of life. There are many fewer patients at that extreme, but first-class care can set tiny babies on the path to a normal, healthy childhood and the lifestyle and lifespan to which most of us aspire.

My first encounter with prematurity was when a colleague anaesthetist with a special interest in neonatal and paediatric care became the father of a baby who weighed about 1.5 pounds. I remember seeing that tiny scrap of humanity in an incubator and wondering how on earth she could possibly survive. Mercifully, she became one of the tiniest babies to make it in those days, and I am delighted to say that she grew into and through childhood and is now a very successful and healthy adult. She must be in her mid-40s by now.

My memories of that tiny baby were rekindled yesterday when I received an email from a North East Scotland constituent, who asked me to take part in this debate. He told me of his experience, which he is happy for me to share with members. I will quote from his email, because it highlights the importance of what the debate seeks to achieve. He said:

"In September 2007 my daughter was born 3 months early and weighed 1lb, which is the same as a baby of 22 weeks gestation. My wife and I were fortunate to stay in a city which has an excellent neonatal care unit. Without this, the care and attention provided by the doctors and nurses there, and the support provided by BLISS, ... there is a very real chance that my daughter would not have survived. Happily she did, and in August this year she commenced primary school with the rest of her friends. Please continue to support neonatal care, as the service provided saves lives each and every day."

That uplifting story is about just one of the 8,000 babies who are admitted to neonatal care every year in Scotland either because they are born prematurely or because they are seriously ill. However, not everyone in Scotland has such a good experience as my constituent had. A report by Bliss Scotland in 2011 revealed a significant shortage of neonatal nurses in special high-dependency or intensive care units, and the need in 2009 to close more than half of Scotland's neonatal units to new admissions at some point during the year.

The report also revealed a lack of support for parents, including a shortage of overnight accommodation for parents who have to travel far from home to receive appropriate care for their babies. Having had the experience of staying for five weeks with a son who had to go to Birmingham for transplant surgery, I know how important it is to have accommodation close to the hospital, with other people around who are undergoing and understand the fears and strong emotions that close relatives experience at such stressful times.

I therefore commend the activity of Bliss Scotland, which works hard to get the best possible care and support for all premature and sick babies and their families, and I welcome its contribution to the new standards for neonatal care in "Neonatal Care in Scotland: A Quality Framework", which was published in March this year. Those standards deal with areas such as the nurse-to-baby ratio and the appropriate training levels that are needed to deliver safe, effective and patient-centred care; the co-ordination of care between units; and the facilities and support that should be available for all families. If they are properly implemented, they should result in the gold standard for neonatal care that has been agreed by the British Association of Perinatal Medicine.

It is important that Scotland's health boards now set out detailed plans for implementation of the new standards within a 10-year timeframe. I hope that the minister will assure us that the Scottish Government will hold health boards to account via regular reviews and open discussion on their progress towards ensuring that all babies who are born prematurely or sick get the best possible care. I look forward to his response at the end of the debate.

12:53

Cara Hilton (Dunfermline) (Lab): I thank Rhoda Grant for bringing this important debate to the chamber to mark world prematurity day.

As we have heard from Malcolm Chisholm, in Scotland 8,000 babies a year are born too soon, too small or too sick. The care that premature babies receive during their first few minutes, hours, days, weeks or months impacts on the rest of their lives. For mums, dads and grandparents, that time can be one of the hardest and most anxious times that they will go through.

I speak from experience: my youngest son, Luca, was born at 33 weeks and weighed just 3.5 pounds. Like many mums, I had absolutely no warning that he would be premature. On the day he was born, we had driven back from holiday, arrived home at about 6.30 and sat down for tea. All of a sudden, I felt a pain that I knew was not a good sign. We rushed straight to the hospital in Kirkcaldy in time for Luca to be born just after eight o'clock. We saw him very briefly before he was whisked away. I was left in shock, holding a photograph of my new baby that the midwife had given me. That was me until the next morning, when I was able to visit Luca for the very first time in the neonatal high-dependency unit.

That was the start of a very long and stressful three weeks. All I wanted to do was hold my new baby and take him home, but there he was in an incubator, all wired up and being fed through tubes. Doctors and nurses were now his primary carers; as parents, we felt that we were watching from the sidelines. The care that Luca received from all the staff at Forth Park hospital in Kirkcaldy during that time was first class, but there is no doubt that, as a family, it was one of the most scary and stressful periods of our lives.

Thanks to our fantastic national health service in Scotland, Luca is now an extremely healthy and vibrant three-year-old. However, I never forget how lucky we are that he was born here in Scotland, because around the world every year 15 million babies are born too soon and 1 million of those babies die: premature birth kills one baby every 30 seconds somewhere in the world. That is a shocking statistic that is all the more shocking because 75 per cent of those deaths could be easily prevented by keeping babies clean, warm and close to their mum and by breastfeeding—proven low-cost interventions that can and do save little lives.

I am really pleased that here in Scotland we now have a comprehensive set of new standards for care of premature babies. It is vital now that we work to ensure that they are fully implemented. Central to that must be parental involvement and engagement. Parents whose babies are in special care are faced with multiple worries—not only about the immediate health of their baby, but about whether their baby will face long-term health problems. They also have worries about leaving their baby behind in hospital, about how they are going to manage looking after their other children, about how they can afford the petrol for the constant trips back and forward to hospital, about how their partner will manage to get time off work after their two-week paternity leave is over and, for some, about whether their little one will ever make it home.

Families deserve better support in neonatal units than they have at present. As other members have said, lack of accommodation means that it is very difficult for parents to spend time bonding with their baby in the early days. Lack of crèche facilities in hospitals means that it is very difficult for parents who have other young children to manage. We know how important breastfeeding is, but breastfeeding can be extremely difficult for parents of premature babies when they are kept apart from their baby and have to travel back and forward to their home from a hospital that might be quite far away.

When my son was in special care, I remember being shown a corner of the ward where mothers could express milk behind a curtain. However, there was hardly any privacy, so it did not surprise me that that facility was rarely used. If neonatal services are to be family friendly, mums and dads need to be fully involved in shaping them. When your baby is in a neonatal unit, it is very easy to feel that you are a bystander. That situation needs to change. Parents need to be at the centre of the care. The new standards will go a long way towards helping to deliver the family-centred approach that we need. I hope that the Scottish Government will make the standards a reality as soon as possible in order to ensure that premature and sick babies have the best possible care and quality of life.

12:58

The Minister for Public Health (Michael Matheson): I congratulate Rhoda Grant on securing time for the debate on an area of extremely specialist healthcare provision in NHS Scotland. I welcome Cara Hilton to the chamber, as this is the first debate in which I have had the opportunity to hear her speak. I thank her for sharing her experience, which has given us a personal insight into the matter.

I take this opportunity to acknowledge the support that is provided across the country by organisations such as Bliss Scotland to parents of sick and premature babies. They do a tremendous amount of work to raise awareness of premature birth matters.

The Scottish Government is committed to ensuring that sick and premature babies receive the highest possible quality of care by the most appropriate professional at all times. We recognise the vital role of our neonatal units in providing intensive and specialist care for sick and premature babies. Only on Monday this week, I was in the Victoria hospital in Kirkcaldy visiting the neonatal unit, which I am sure is a significant improvement on the previous facilities there. The level of neonatal care from the staff is first class. I also had the opportunity to see a BabySam system in operation there: a small camera is located above the incubator so that a mother can observe her baby on a tablet device from her hospital bed at any time. Parents have found that facility to be tremendously useful.

I am pleased that Rhoda Grant's motion welcomes "Neonatal Care in Scotland: A Quality Framework". We are extremely fortunate in Scotland to have a high level of expertise available to us, which was provided in the form of the neonatal expert advisory group that we established to develop the framework. The group included key experts from the health professions and other services, and stakeholders from across the country including support groups Bliss and Sands. The expert group also played a vital role in engaging with the managed clinical networks that were established in 2010 to ensure that we had agreed pathways of care and protocols for maternity and neonatal surgical services, and that services, staff and facilities meet the predicted demand from the population.

The framework outlines NHS Scotland's commitment to providing the highest possible quality of neonatal care for babies. It aims to be a dynamic framework that supports staff in order to allow them to improve services at local level. The framework has been regularly reviewed by neonatal staff throughout its development.

I believe that the framework is ambitious. It needs to be, in order to secure the best form of care for premature and sick babies. We know that implementation of the framework will take time. I acknowledge that Cara Hilton and others are anxious to see things happen as quickly as possible, but I am also sure that members appreciate the complexity and the specialist nature of some of these matters, and understand that health boards need time to implement the framework effectively. We will make sure that that happens.

We have heard mention of workforce issues. Those issues are not unique to neonatal care, despite the specialist nature of the work, but the framework offers boards opportunities to move to a much more modern and stratified service that focuses on the provision of safe care and ensures that the sickest babies are cared for by the right staff with the right skills at the right time and in the right place. A neonatal nursing workload and workforce planning tool that identifies the nursing needs of sick and premature babies has been implemented across NHS Scotland through our neonatal units, so we are making progress. The tool takes into account the staffing recommendations of the British Association of Perinatal Medicine, which Rhoda Grant and Nanette Milne mentioned, and it captures actual nursing workload in real time so that we can see clearly the level of work that is being undertaken.

Many of the requirements that are set out in the framework to deliver high-quality, safe and person-centred neonatal care are already in place at units across the country. The framework makes it clear, however, that boards must put in place plans or pathways to repatriate babies to the unit that is closest to their home as soon as is clinically appropriate for the level of care that they require, and parents should be supported to help them to understand the situation and the choices that they face.

Mark McDonald mentioned the challenges that exist when babies are transferred and parents have to transfer to other units. That is why we need to ensure that boards are working in a co-ordinated way so that we have the right staff in the right place to provide the right care to parents at that point, and then to allow babies to return to more local units, when possible.

We are also working to provide more information to parents. We are undertaking a patient leaflet programme in partnership with Bliss to support and inform parents of what the framework means for them, and what they should expect.

In drawing my remarks to a close, I reassure members that, where any service change is considered as an option to meet the high standards that the experts set out in the framework, boards should work in consultation and in partnership with their local communities. Scottish Government officials are reviewing the implementation plans that have been received from NHS boards and we will meet the three managed clinical networks to go over them in more detail. Facilities for parents, workforce issues and other points that have been raised in today's debate will be highlighted and discussed at that meeting, as will potential funding opportunities.

I hope that I have reassured members that we are determined to ensure that the framework is implemented across the country so that babies who require such specialist care receive it at the right time.

13:05

Meeting suspended.

14:30

On resuming—

Scottish Parliamentary Corporate Body Question Time

Room Allocation

1. Nigel Don (Angus North and Mearns) (SNP): To ask the Scottish Parliamentary Corporate Body how it allocates room resources between MSP events and SPCB events. (S4O-02655)

Liam McArthur (Scottish Parliamentary Corporate Body): There are approximately 380 events a year at the Scottish Parliament. Of those, approximately 340 are member-sponsored events with the remaining being sponsored by Scotland's Futures Forum and the SPCB. SPCB events do not take precedence, but as major events can impact on a number of venues within the Parliament, they are agreed and planned up to a year in advance with resources allocated accordingly.

Most major events take place on Mondays and Fridays and occasionally, in the case of receptions, on a Wednesday evening. As such, they should have minimal impact on member-sponsored events. However, if a room that is booked for an SPCB event is needed for a member-sponsored event, parliamentary officials will work with members' offices to try to find a suitable alternative room or date for their event.

Nigel Don: I thank Liam McArthur for those helpful comments. His answer makes the point that the SPCB tries to keep out of the way of MSPs, but that is not how it feels. When we go looking for a room many months in advance, it is not unusual to be told that the SPCB has booked it for some reason or other.

I am conscious that Christine Grahame will also ask a question about rooms, but we seem to have had a number of substantial events—I do not want to criticise them—that seem to have taken place during term time when perhaps they could just as well have been held for the public's benefit during holiday time, if I can put it that way. I wonder whether we might just reallocate our time.

Liam McArthur: I hear what Nigel Don says. Room reservations are made in advance for member-sponsored events so that if a member wishes to hold an event to engage with external organisations or members of the public, they are able to do so.

As I said earlier, we try to consider the larger-scale events a year in advance simply because of the logistical questions that need to be resolved. If

Mr Don wishes to bring a specific case to the SPCB's attention, we will be happy to look at it. However, as a general principle, we set great store by and value the openness and accessibility of the building and all members tend to subscribe to the notion that we need to safeguard that. The major events play their part in allowing a wide range of people from across Scotland access to the building and to members of the Scottish Parliament. If Nigel Don has specific concerns about his own attempts to hold events in the Parliament, we are more than happy to look at those.

Sustainable Travel

2. Patrick Harvie (Glasgow) (Green): To ask the Scottish Parliamentary Corporate Body what progress it has made on promoting sustainable travel and reducing reliance on aviation and the use of private cars. (S4O-02652)

Mary Scanlon (Scottish Parliamentary Corporate Body): As we say in our environmental policy, the SPCB is committed to promoting sustainable travel for business and commuting. We are also committed to reducing our carbon footprint by 42 per cent by 2020 and, by the end of March 2013, emissions had been reduced by 25 per cent.

Emissions from business travel have reduced by 21 per cent since 2005. Aviation emissions have reduced from a high of 280 tonnes of carbon dioxide equivalent in 2010 to 131 tonnes during the last financial year.

Patrick Harvie: By happy coincidence, I ask my question on the day on which Transform Scotland has published a report on the public sector's sustainable transport practices, in which it finds a pretty poor performance overall. If the Scottish Parliament intends to show leadership on this issue within the wider public sector, is it really acceptable that every single committee visit to Brussels has used aviation as the default method of travel and has not even produced an environmental impact assessment considering rail as an option when Brussels is so easily reached by rail?

Mary Scanlon: The member makes some good points. I am sure that he will understand that I do not have the Transform Scotland document, but it is worth reading and the corporate body could discuss the issue. The point is a constructive one, and we could of course always do better.

The SPCB strongly encourages staff not to fly to destinations that can be reached by other forms of transport in a reasonable timescale. In 2010, the SPCB conducted a travel-to-work survey, which revealed that 80 per cent of respondents travelled to work in a sustainable manner. As I said, we can always do better. I give Patrick Harvie my commitment that we will look at the document that he mentions and consider the areas in which we can improve our progress.

Exhibitions (Use of Committee Rooms)

3. Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): To ask the Scottish Parliamentary Corporate Body whether it plans to use committee rooms for exhibitions on a regular basis. (S4O-02656)

Linda Fabiani (Scottish Parliamentary Corporate Body): There are no current plans to use committee rooms on a regular basis for exhibitions.

Christine Grahame: I am delighted to hear that, because the key remit of the corporate body and its staff is to ensure that the Scottish Parliament can operative effectively and that members can carry out their duties. However, recently, the Justice Committee was relegated to the chamber to take key evidence. I sat on the Labour benches, committee members sat where corporate body members are sitting now and the witnesses sat where Jackson Carlaw is sitting. We had great difficulty while a committee room was allocated for an exhibition. It appears to me that the key priority was the exhibition.

In case I am considered to be particularly grumpy or a spoilsport, I point out that it crossed my mind that the chamber would make an excellent venue for Cirque du Soleil—just a suggestion—and that that might even determine the safety of the beams.

Linda Fabiani: It would never cross my mind to describe Christine Grahame as particularly grumpy.

I believe strongly that another remit of the Parliament is its openness and accessibility to the public. The exhibition that we are talking about was the Andy Warhol: pop, power and politics exhibition, which was announced in April this year. There are many reasons why it was held in committee room 1. As we were the first Parliament in the world to host the exhibition, we should be very proud of it. No committee meetings were cancelled because of the exhibition. More than 22,500 people visited it during the 30 days and more than 500 people participated in screen printing workshops, which I believe is a great triumph for the Parliament. My SPCB colleagues and I will stand by our belief that the exhibition was excellent and was a good example of our Parliament being accessible and encouraging to the public.

Christine Grahame: I agree that the exhibition was excellent, but that is not the question in point. The question in point is that the key priority is to

allow MSPs to carry out their duties effectively. By deposing the Justice Committee from a committee room and placing us in the chamber, those priorities were changed. Frankly, I do not want it to happen again.

Linda Fabiani: As I said, there are no current plans to use committee rooms on a regular basis. I repeat that no committee was prevented from meeting because of the exhibition. I would have thought that the chamber would be an excellent place to meet, as it reflects the importance of our committees.

Building Maintenance

4. John Wilson (Central Scotland) (SNP): To ask the Scottish Parliamentary Corporate Body how much it has spent on cyclical and reactive building maintenance in each year since 2010. (S4O-02654)

Linda Fabiani (Scottish Parliamentary Corporate Body): I have the figures on that and I can certainly pass them to Mr Wilson after question time. We include cyclical maintenance in our planned maintenance figure, which was £1.52 million in 2012-13, the same in 2011-12 and £1.56 million in 2010-11. Reactive maintenance was £233,000 in 2010-11, £158,000 in 2011-12 and £179,000 in 2012-13.

John Wilson: I am almost tempted to ask when the koi carp will be installed in the water feature on the garden lobby roof—as we all know, there is a great deal of surface water lying on the roof at present. However, the question that I want to ask is, are any major works planned in the foreseeable future, similar to the security screening facility, which might require planning permission?

Linda Fabiani: No. Nothing like that is planned. As has been reported to the Parliament already, the security screening facility is now complete and it came in on cost and on time. We are pleased by that. The facility is being seen as a welcome addition to our Parliament.

On-going, planned cyclical maintenance and reactive maintenance go on day to day, week to week and year to year. I do not have in front of me the plans for the next few years, but no major capital items that would require planning permission are planned at the moment.

Disabled Parking

5. Dennis Robertson (Aberdeenshire West) (SNP): To ask the Scottish Parliamentary Corporate Body how many parking spaces for disabled people there are in the car park and whether their use is monitored. (S4O-02653)

Linda Fabiani (Scottish Parliamentary Corporate Body): The Scottish Parliamentary Corporate Body has six parking spaces for disabled people and those are booked and monitored through the facilities management help desk.

There is also of course a disabled parking space out on the street across the road from the Parliament entrance, which can be used by visitors.

Dennis Robertson: As the member might know, I am taking forward a member's bill on the blue badge scheme. I hope that this Parliament can be an exemplar in terms of ensuring that disabled parking spaces are used only by appropriate blue badge holders. I request that the use of the spaces continues to be monitored so that we can be such an exemplar.

Linda Fabiani: Dennis Robertson is quite right: we would like this Parliament to be an exemplar.

A recent example is that one of our members was hosting a group that had quite a few disabled persons in it and we were able to arrange for them to use the spaces in the Parliament car park.

If the six disabled persons parking bays in the car park are not booked by noon, they are sometimes released for general booking for the following day. I stress that that is, and will continue to be, monitored very carefully.

This is such an important issue and Dennis Robertson is right to bring it up, especially in the light of his member's bill. We should always be held as an example.

Independent Expert Review of Opioid Replacement Therapies

The Deputy Presiding Officer (John Scott): The next item of business is a debate on motion S4M-08422, in the name of Roseanna Cunningham, on the independent expert review of opioid replacement therapies in Scotland. I invite members who wish to speak in the debate to press their request-to-speak buttons now, or as soon as possible, and to locate their microphones effectively, remembering that they are directional microphones. I call the minister—when she is ready—to speak to and move the motion in her name. You have 14 minutes, minister—as soon as you are ready to proceed.

14:43

The Minister for Community Safety and Legal Affairs (Roseanna Cunningham): It would be useful to remind the chamber of the background to this afternoon's debate. In August last year, it was reported in national statistics that, in 2011, drug-related deaths reached the highest level recorded. Some 584 people in Scotland lost their lives to drugs and, for the first time ever, methadone was implicated in more deaths than heroin. Those deaths affected, and continue to affect, friends, families and communities.

That background is why I asked the chief medical officer, Sir Harry Burns, to commission an independent expert group on opioid replacement therapies. The expert group published its report "Delivering Recovery—Opioid Replacement Therapies in Scotland" in August. My thanks go to Sir Harry Burns, Dr Brian Kidd, who was the chair of the group, and Doctors Charles Lind and Kennedy Roberts, who undertook the research, for their drive and determination in producing the report. I also extend my thanks to everyone who contributed to the process, including members of this Parliament.

The report provides recommendations on the delivery of opioid replacement therapies in Scotland and on the wider delivery landscape, and looks at themes such as social exclusion and health inequalities; recovery; governance and accountability; information, research and evaluation; and the improvement approach that is needed to drive change. Today, the Minister for Public Health and I will provide a cross-Government response to the report.

Since the report was published, the Government has held two events to provide those who work in alcohol and drug partnerships and primary and secondary care with an opportunity to reflect on it. As members are aware, some of the report's recommendations refer to the national health service. I will touch on some of those recommendations, but Mr Matheson will provide more detail later about how we are responding to them.

First, I want to ensure that everyone is aware of the headline finding in the report. Last year's drug-related death figures resulted in media coverage that questioned the use of methadone. However, the expert group concluded that opioid replacement therapies have

"a strong evidence base ... and should be retained in Scottish services"

and

"should be delivered as part of a coherent person centred recovery plan".

The report is clear that methadone, like other treatments such as residential rehabilitation, community detoxification or psychiatric support, has a place only in the context of recovery. In practice, recovery is best realised through the development of

"recovery oriented systems of care",

which is a term that is used frequently in the report. It means systems that enable people to progress at their own pace with a planned and integrated care pathway from their first entry into services to their return to non-specialist services.

With that in mind, the Government has been developing an alcohol and drug quality improvement framework, which will ensure quality in the provision of care, treatment and recovery services as well as in the data that will evidence the outcomes that people are achieving. The framework is aligned with the themes that are outlined in the report. Following collaboration with service users, people in recovery and delivery partners, we are about to consult Scotland's 30 ADPs on the development of quality principles, embedded in a human rights approach, for drug and alcohol services.

We have achieved huge success in reducing waiting times—the latest statistics show that 96 per cent of people started treatment for their drug problem within three weeks or less; in 2007, people could wait for over a year for an appointment—but securing quick access to treatment is the least that we can do. The quality principles to which I referred will set out what someone who accesses a service can expect to achieve, and will be measurable at service, local and national levels. They include high-quality, evidence-based interventions; workers who are appropriately trained and supervised; full strengths-based assessments and person-centred recovery plans that are agreed and regularly reviewed; and, if it is helpful to the individual, the opportunity for their family to be involved. We

know that some areas are taking that approach already, and examples of good practice are highlighted in the report.

Delivering quality also depends on the availability of robust information that is capable of demonstrating recovery outcomes. Access to meaningful and reliable information is essential if ADPs and local services are to monitor their progress in delivering recovery. We are currently working with the Information Services Division of the NHS in Scotland and ADPs to scope out the development of an integrated drug and alcohol information system. The proposed system will integrate the existing waiting times database and the drug misuse database, and gather information on alcohol treatment and recovery indicators. We are also working with members of the expert group via the independent Drugs Strategy Delivery Commission to explore the feasibility of agreeing key priorities for research on substance use in Scotland.

The Scottish Government created ADPs with NHS Scotland and the Convention of Scottish Local Authorities four years ago. The report tells us that there are real concerns around the lack of progress on delivering recovery that has been found in many ADPs. We must not be complacent, and we must ensure that governance and accountability are robust within those structures. The Government is committed to working with current expert advisory structures on drugs to review their impact, performance and lines of accountability.

We have already taken steps to improve the accountability of ADPs. Planning and reporting mechanisms have been developed and agreed, and in order to drive performance locally, I have set ministerial priorities for all ADPs to report on in their annual reports.

Those include the delivery of the health improvement, efficiency and governance, access and treatment standard to maintain fast access to treatment; increasing levels of compliance with the Scottish drug misuse database; sustaining the quality of data in the national drug and alcohol treatment waiting times database; and increasing the number of take-home naloxone kits supplied to those at risk of opiate overdose. Those pieces of information must be supplied on an annual basis. ADPs have taken those priorities seriously and have committed to taking forward the areas identified for improvement. For example, over the past six months the number of take-home naloxone supplies that have been distributed has increased.

Our focus on improvement is crucial. I met ADP chairs last month and urged them to set an improvement goal that sets out specifically how they will respond to the independent report. For example, West Lothian ADP has stated that, by December 2016, 100 per cent of people who receive substitute prescribing will have had a review and will have a recovery plan in place, and Edinburgh ADP will, in 2014-15, increase by 30 per cent the proportion of people who are linked, rather than just referred, to recovery communities and/or mutual aid groups following a planned discharge from specialist treatment. Those examples demonstrate that a real change is taking place as a result of the Government's alcohol and drug quality improvement programme and the expert group report, on which we have already begun to act.

However, it is important to remember that people affected by drugs are extremely vulnerable and often experience other significant health conditions, including the effects of ageing. The evidence also tells us that stigma is a significant barrier to delivering recovery. The CMO recognised that in his foreword to the expert group's report, in which he highlighted that

"Overcoming the stigma and further increasing the numbers of people in recovery will be challenging—but achievable."

In line with Government priorities, the report emphasises the importance of workforce development, not only in upskilling but in addressing stigma and attitudes towards drug use and recovery, which are present even within the wider workforces that deal with people who use drugs. The attitudes of many professionals themselves must therefore be challenged.

Scottish training on drugs and alcohol—STRADA—our nationally commissioned workforce development agency, is working with ADPs to support them to identify training needs around the development of recovery-oriented systems of care. In addition, the Scottish recovery consortium delivers recovery workshops for treatment providers, giving workers opportunities to connect with people's own experiences of recovery as well as to learn about recovery tools and practices that are used elsewhere in Scotland. I am delighted that, by taking that work across the country, the recovery consortium will work with all addictions staff in NHS Ayrshire and Arran in the coming months.

The report makes recommendations on the quality, consistency and availability of drug treatment services within Scotland's health service. Inconsistency was reported to be driven by the opt-in nature of the general practitioner contracting process for substance use treatment. To increase consistency, the report calls for discussions within primary care and pharmacy about the delivery of drug treatment services and suggests the development of national standards for primary care and community pharmacy.

The Government has increased the number of GPs in Scotland and we now have more GPs per head of population than the rest of the UK. We are leading the way with the world's first patient safety programme for primary care and we invested more than £757 million to deliver primary care services last year, which is an increase of more than 17 per cent since 2004.

John Finnie (Highlands and Islands) (Ind): Does the minister acknowledge that there needs to be uniformity of services and that there cannot be any areas in which there is an opt-out due to public perceptions of treatment for people in drug programmes?

Roseanna Cunningham: It is always going to be a challenge to deliver uniformity of services, particularly across a wide range of services, many of which are designed to be responsive to local needs and conditions and involve a variety of professional groups and professional interests. We need to work very hard to overcome that challenge.

However, we must remember that patient care is provided by the whole clinical team and not just by GPs. They use their professional judgment to work with patients to agree the best and most appropriate care to support individuals' general health, including their recovery from drug use. In delivering care, GPs should take account of all aspects that affect a patient's care and, where necessary, actively link with specialist services to deliver the care that is required.

The report does not make light of the role of pharmacists in delivering recovery. Since the publication of the expert group's report, the Government published "Prescription for Excellence" in September. That document is our 10-year vision and action plan for pharmaceutical care in Scotland. It gives a firm commitment to work with pharmacists and other healthcare professionals to develop and implement new NHS standard specifications for drug and alcohol services. The expert group's report will build on work that is already taking place in NHS boards and inform the development of that work.

At the event with healthcare professionals that was held just this month, both the Minister for Public Health and I made individual commitments on how we can better engage with the NHS. I committed to bringing together relevant healthcare professionals each year to ensure that people with drug problems are supported in their recovery, and the Minister for Public Health committed to identifying an accountable officer from every NHS board to be responsible for the delivery of opioid replacement therapies in local areas. Mr Matheson will provide more information on that later.

I also take this opportunity to reassure the Parliament that recovery is alive across Scotland. Last year, I announced the development of a recovery initiative fund, and since then almost £100,000 has been distributed to individuals and recovery communities. Examples of successful applicants include the unity recovery football club, which is a Glaswegian football group consisting of people in recovery and their families, and hectic life in Edinburgh, which is a social enterprise that aims to provide training and permanent work for individuals in recovery from addiction through furniture building, restoration and recycling. Meaningful work and activity are extremely important when we are talking about recovery.

I have also had the privilege of attending five-year anniversary events for "The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem", at which we discussed not only what still needs to be done but the achievements that have been made since the introduction of that strategy in 2008. I think that all members have been sent a copy of "The Story So Far: A collective summary of reflections on Scotland's road to recovery since 2008", which reflects on how things have changed in Scotland in the past five years.

While we must not be complacent about the improvements that still need to be made, I would like to finish with a quote from "The Story So Far" that I think summarises where we are today:

"Momentum is building and I hope that in 5 years time we will have reached a tipping point that washes all the unhelpful stigma and moral rhetoric away. I appreciate that sometimes we can be seen as naive optimists and know that living can be tough whoever you are, whatever demographic, social, economic situation you're in ... But it is right to pursue recovery in this way, at this time, in an inclusive and hopeful way ... and it is working."

I move,

That the Parliament notes the August 2013 publication of the report and findings of the independent expert group on opioid replacement therapies commissioned by the Chief Medical Officer and led by the independent Drugs Strategy Delivery Commission; endorses the expert group's conclusion that opiate replacement therapies have a strong evidence base, should be retained in Scottish services and should be delivered as part of a coherent person-centred recovery plan; agrees with the six priority themes identified in the report and calls on members to endorse an improvement approach, as enshrined in the "three-step improvement framework for Scotland's public services", at national and local level to address health and social inequalities for people affected by drug problems in Scotland, address variability in service provision to ensure that high quality recovery-oriented systems of care are in place across Scotland that recognise the contribution of primary and secondary care, continue to improve the governance and accountability of the delivery system and further develop information, research and evaluation systems on substance misuse at a national level; recognises the role and contribution of the workforce in delivering a recovery-oriented system of care in Scotland,

and supports the continued development of all those working to make recovery from problem drug use a reality.

14:57

Elaine Murray (Dumfriesshire) (Lab): I welcome the opportunity to debate the findings of the independent report on opioid replacement therapies, although it feels as if it has been a long time coming. It was announced in October last year, and at that time the recommendations were supposed to be produced by the spring. Nevertheless, I am pleased that we are, at last, discussing the important and often contentious issues around the treatment of people who suffer from heroin addiction.

Labour members welcome the acknowledgement in the Government's motion of the concerns that are contained in the report, which raises many important issues about how services are delivered across Scotland. I do not argue that all those issues fall at the feet of Government, but in using 11 of the recommendations to form the basis of what it terms an "immediate improvement process", the report places the responsibility on Government to provide leadership. We feel that more urgency is required than is displayed in the Government's motion.

Importantly, the report identifies that opioid replacement therapy is an "essential" service with a "strong evidence base". I repeat that, as the minister said, that has been verified through research in a number of countries around the world. Among the actions recommended by the report are that there should be a more co-ordinated approach from all service providers to tackle the effects of health inequality and stigma; that ORT should be offered in the context of a flexible and mixed treatment system; and that therapy should be part of a person-centred recovery programme with both the care pathway and the progress of individuals able to be objectively determined.

There was clear and significant concern about the performance of alcohol and drug partnerships across the country. There is an argument that their functions need to be reviewed, as some have displayed little evidence of a real impetus towards recovery and a lack of progress towards recovery-oriented systems of care, or ROSCs, and quality assurance.

The report notes that there is an urgent need to address

"the lack of institutional memory"

in planning, delivery and governance, which I imagine is some form of management speak for a failure to learn from past mistakes or instances of good practice. There is also a lack of accountability, including lines of accountability to the Scottish Government, and there is a need for an approach that has a track record of delivering change. Indeed, there is a lack of outcome measurement at the moment, and even the very modest SMR-25b follow-up forms are not completed for the majority of clients. Research and academic inquiry is also noted to have been poorly developed in Scotland.

Our amendment focuses on the need to make real progress on the issues identified in the report, and to demonstrate commitment to that by determining a timetable for action on the required improvements that have been identified.

The report notes that the average age of heroin users is increasing. Heroin does not seem to be the drug of choice of younger people—it is not seen as cool. That is good, but it may be due to the easy availability of so-called legal highs, which of course bring many dangers such as extreme psychosis and which need to be the subject of scrutiny. Perhaps we need a separate debate on that.

However, the increasing age of heroin users brings with it problems, as prolonged use leads to more complex and severe physical and mental health problems, and we should not assume that current unpopularity of heroin among younger people indicates that it will eventually fall out of use. I am advised that drug popularity is cyclical and that future generations may not eschew heroin to the extent that young people do today.

Heroin users do not engender much in the way of sympathy from the general public. The report noted that the UK Drug Policy Commission found

"high levels of blame and intolerance"

among the Scottish population and that

"the fear of and the need to exclude people with drug problems were higher in Scotland than the rest of the UK"—

a finding that the report describes as "sobering".

Attitudes towards medication-assisted recovery are also more negative in Scotland, and Scotland has higher rates of harm and premature death than other European Union countries have. Those rates have not fallen in the way that they have in other countries, so we have a challenge here in Scotland.

In addition to stigma, the debate around drug treatments is often ill informed, with a lack of information regarding available treatments and what is meant by recovery. The lack of a shared definition of recovery is noted in the report. Although there is a definition in the "Road to Recovery" that recognises that recovery is about voluntarily moving on from problem drug use, and there is the UKDPC consensus statement on

recovery, those definitions do not seem to be universally understood or accepted, and there is a perception that recovery equates to having achieved abstinence.

Of course, that is the goal for many heroin users and their families, as indeed it should be: where it is possible for a user to become drug free that should be the aim, and efforts and support should be directed towards that aim, but for some it will not be possible to totally cease opioid replacement treatment, because some people are too ill ever to be able to come off medication. Before people criticise that and ask why the NHS is paying for it, I point out that we pay for the consequences of obesity, smoking and other choices that people make. This is the same issue.

Jim Eadie (Edinburgh Southern) (SNP): Dr Murray was right to highlight stigma. Does she agree that the attitude that people make a lifestyle choice when they choose to misuse drugs neglects the fact that such people are often in the poorest and most deprived parts of the country, and that therefore that lifestyle choice is not the choice that people say it is?

Elaine Murray: I acknowledge that; indeed, I will come to that issue in my speech.

The standard opioid replacement is methadone, although buprenorphine, which is also known as Suboxone or Subutox, is becoming a more common alternative. In most ADP areas only one patient in 20 is prescribed buprenorphine, although in two of our ADP areas it is one in three. Clearly, that is a clinical decision—I hope that it is not based on the fact that buprenorphine is three times as expensive. It takes longer to supervise and is easier to conceal, as it is a tablet, which can be concealed under the tongue. It is harsher on the user as he or she remains totally sober and therefore has to be psychologically and physically robust enough to tolerate its use.

However, there must be something to be learned about its use from the two ADP areas that prescribe it so much more frequently. It is important that users who want to progress into recovery—and, I hope, abstinence—are offered the road most suitable for them, whether that be methadone, buprenorphine or abstinence.

I want to touch on a couple of other issues in the report. The first is the HEAT target that anyone with a drug problem should wait no more than three weeks for treatment. We believe that that target needs to be refined, as it does not monitor recovery. The Scottish morbidity database reviews all clients at three months and then annually or upon discharge but, in 12 ADP areas, reviews were not followed up in more than 50 per cent of cases because data collection is not mandatory. The HEAT target should be person centred and based on recovery rather than just access to treatment.

The report also pointed out that fewer than half of Scotland's health boards can offer any access to specialist addiction psychology services. Given the problems that we have in Scotland with addiction, whether it be alcohol, smoking, gambling, eating disorders or drug abuse, I find that situation very worrying and hope that it does not indicate that a too low priority is being accorded to mental health services.

An estimated £36 million is spent annually on substance misuse services in Scotland. However, the independent expert group estimates that when all the services and agencies such as justice, child protection, social services and so on are taken into account the total cost of drug addiction to the public sector in Scotland could be almost 100 times that amount, or £3.5 billion. When we are talking about a sum of public money of such magnitude, we need to get our act together to develop a more effective response to drug abuse.

We must also use early intervention to support vulnerable individuals and prevent them from getting on the road to substance abuse in the first place. As Jim Eadie mentioned in his intervention, drug users have often experienced trauma, sometimes in childhood through parental drug or alcohol abuse, family breakdown, a parent in prison, the death of a key family member or sexual and domestic abuse, or poor engagement with education and social services. Many have had problematic relationships with alcohol in their early teens before moving on to misusing other substances. Indeed, some, including many of those who have left the armed forces, have experienced trauma later in life. As a result, identification of and support for people at risk of self-medicating with alcohol and drugs would save them and their families a lot of misery as well as saving the public sector significant costs across a range of services. Indeed, that is why our amendment states that the strategy should include preventing drug use from starting by identifying and supporting those who are vulnerable to its attractions. That is very important.

Finally, our amendment changes the final phrase of the Government's motion. It might be the way I read it but it appears to recognise the contribution and role of the health service workforce alone and does not include everyone outside with NHS, many in the voluntary sector, who also make a vital contribution to support for and the recovery of drug users. I am thinking, for example, of the Scottish Drugs Forum, First Base in my constituency and a whole load of people in the third sector who make an extremely important contribution in a variety of ways.

I hope, therefore, that members will be persuaded to support our amendment, which, as I have said, adds to the Government's motion.

I move amendment S4M-08422.1, to leave out from "the workforce" to end and insert:

"everyone in delivering a recovery-oriented system of care in Scotland; supports the continued development of all those working to make recovery from problem drug use a reality; considers that the ultimate aims of the Scottish Government's strategy should be both prevention and providing people with routes to overcome their addiction, and calls on the Scottish Government to determine a timetable to enact the improvements contained in the report."

15:07

Mary Scanlon (Highlands and Islands) (Con): I am delighted to speak in this debate but will start by suggesting to the minister in the most constructive way that I would have found it very helpful to have received the Government's response prior to the debate. Perhaps she was not sure that I was speaking this afternoon; indeed, I have not been in recent times.

Having been a member of parliamentary health committees for many years, as well as a member of cross-party groups on drugs and alcohol as far back as 1999, I must say that I, like my colleague Annabel Goldie, fully supported "The Road to Recovery". On that basis, I very much welcome the minister's remarks about the emphasis on outcomes, the quality principles for ADPs, what a person can expect to achieve, family involvement and naloxone. In fact, there was very little that the minister said that I do not welcome, and I find that very positive.

I acknowledge that there is not an exact overlap between "The Road to Recovery" and the report from the independent expert group that we are debating this afternoon. After all, the former looked at recovery, delivery and prevention, while our focus today is on opioid replacement therapy. However, I have to say that, five and a half years after "The Road to Recovery", the progress that we all expected and which everyone on all sides of the chamber supported has been, to say the least, disappointing. Even more disappointing is that many of the themes and recommendations that we are debating this afternoon were put forward in 2008.

As a result, although I welcome what has been said, I would like more regular updates on the progress of the actions that have been taken. More information on the response to treatment would allow treatment services to be benchmarked and make the effectiveness of interventions that are supplied to patients more transparent.

For example, does everyone who is on the methadone script get a monthly test to determine the presence of illegal drugs? I am not sure. Government statistics for the quarter to June this year state that 96 per cent of people attended an appointment for drug treatment within three weeks. I welcome that, but it is what happens after those three weeks that is important. I welcome what the minister said today, but that is the target that we have just now. I commend the focus on the outcomes, which we heard about today, rather than on the three-week period before the first appointment.

There is much good practice in the country. One example is the North, East and South Ayrshire alcohol and drug partnership, which piloted a methadone cessation programme that was aimed at supporting long-term methadone users over a period of six months. Given the information that we have, that is an example of a programme that has, undoubtedly, seen some notable success.

I have submitted various parliamentary questions on the issue. One such question, from 2001, was answered by Iain Gray, who was then the Deputy Minister for Health and Community Care. He said that drug users often claim that methadone is harder to come off than heroin. I am not sure that that is always understood. We need to listen to those who are addicted to drugs, those who are in recovery and those who are having difficulties addressing their drug usage. I would also welcome the inclusion of families.

The review says that

"there are still huge inconsistencies across the country in terms of ... availability of treatment ... or the range or quality of care"

and that little evidence was presented by some ADPs regarding a real impetus towards recovery.

That was raised by Audit Scotland in its report on drug and alcohol services in 2009. It was also the conclusion of a 2009 report by the Health and Sport Committee, of which Michael Matheson and I were members. Further, "The Road to Recovery", which was published five and a half years ago, states that

"there were serious shortcomings in a number of ADATs".

That was in 2008, so what we have today is not new.

I welcome the commitment and the focus, but I do not want to see the same problems coming up again in another five and a half years.

One of the themes in the report is health inequalities. "The Road to Recovery" talked about

"An appropriate range of drug treatment and rehabilitation services to promote recovery"

and

"Better integration of medical treatment with ... mental health".

That is what we have heard today. We knew that that was a problem five and a half years ago.

Another theme in the report is

"a lack of institutional memory (at all levels) regarding an agreed understanding of the key issues and the plans".

It says that, without that understanding,

"systems are destined to continue repeating mistakes".

"The Road to Recovery" states:

"agreed understanding and collaboration is a central theme".

Theme 5 in the report talks about

"an urgent need to develop meaningful information systems".

That was also in "The Road to Recovery".

"The Road to Recovery" also contained 10 actions to support the setting up of

"a new national drug strategy website to bring together all policy and research in one place for academics, practitioners, key experts, service users and the public."

We have heard the same thing today.

I welcome what the minister has come forward with today. I welcome the focus on outcomes. However, I ask whether she will work with us, because she has support from across the chamber, and I ask for regular updates on progress.

15:14

Jim Eadie (Edinburgh Southern) (SNP): The issue of substance misuse is a complex one, but we must always have at the forefront of our discussions the fact that this is about people's lives—the lives of those who are recovering from substance misuse, of their families and of the people in the communities in which they live.

The causes of substance misuse are multifaceted. Therefore, tackling the issue requires a strategic approach, with all the relevant Government departments, agencies and organisations working together to achieve what I believe are the shared objectives of recovery, harm reduction and prevention.

We must ensure that all that necessary activity and service provision is underpinned by high-quality, evidence-based practice. Opioid replacement therapies have a strong evidence base, as was recognised by the independent expert review. Dr Brian Kidd, the chair of the Drugs Strategy Delivery Commission, stated:

"We have concluded that ORT with methadone is an effective treatment and must remain a significant element of the treatment options available for those struggling with opiate dependency in Scotland. However, ORT must be one of a comprehensive range of treatment options in every area."

The expert review highlights the fact that

"Systematic reviews have ... concluded that ORT is associated with improved retention in treatment, reduced illicit opioid/heroin use and reduced HIV and blood borne virus risk behaviours - related to injecting."

The review's conclusion is clear: ORT should be retained in Scottish services and

"should be delivered as part of a coherent person centred recovery plan".

Another requirement in tackling these issues is national leadership. I pay tribute to the work of the Minister for Community Safety and Legal Affairs and the Minister for Public Health for the constructive and inclusive way in which they have taken matters forward.

The context for the debate, as Mary Scanlon reminded us, is the national drug strategy "The Road to Recovery". The strategy was published in 2008 by the Scottish Government, but it has been endorsed by the Parliament and commands widespread support across all the relevant agencies and organisations that deliver services as the right approach for addressing Scotland's legacy of drug misuse. It states:

"Central to the strategy is a new approach to tackling problem drug use based firmly on the concept of recovery. Recovery is a process through which an individual is enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society."

The key phrase is "towards a drug-free life". There must be an acceptance and understanding of the fact that someone who has a history of drug misuse will, in many if not the majority of cases, simply not be able to become drug free overnight even if becoming drug free is the ultimate objective.

The dichotomy with which we are sometimes presented, with abstinence on the one hand and harm reduction on the other, is a false one. That point was made effectively by the United Nations Office on Drugs and Crime in its report in 2009.

Mary Scanlon: Does the member acknowledge that the problem is often that there is an underlying mental health problem and that a dual diagnosis and psychological support are required, not just detox and rehab?

Jim Eadie: I agree absolutely with the point that the member makes. I will discuss mental health in a moment.

One of the barriers to accessing services and achieving recovery is the stigma that exists for current and former drug users and their families. That point has been highlighted by the expert review and, this afternoon, by the minister and

Elaine Murray. The review goes on to make the sobering observation that such stigma is endemic at all levels in society. Let us pause for a moment to consider what that means. It means that some of the most vulnerable people are not accessing services although they may be more at risk of premature death, which is a sobering thought indeed.

There has been a transformation in attitudes towards people with mental health problems in our society. Would it not be equally satisfying if we were to see similar changes in public attitudes towards people who are recovering from drug misuse? If stigma is endemic in our society, it would be naive to believe that negative attitudes do not exist on the part of some professionals who are involved in providing addiction services. I was told by someone who has significant experience in the field that one service user told him, "I go to services as an addict and I get punished as an addict." There is a clear challenge for the NHS and other agencies to ensure that there is appropriate training and continuing professional development for all staff who work in services that are designed to assist people on their recovery journey.

The evidence tells us that recovery is achieved most effectively when service users' needs and aspirations are placed at the centre of their care and treatment. The role of community pharmacy featured prominently in the review and was endorsed as making a vital contribution to the provision of high-quality care for substance misuse patients. A number of recommendations in the review will improve the provision of services in that area. I pay tribute to the Scottish Drugs Forum for the work that it undertakes to harness the talents, experience and skills of service users to improve the quality of services, promote employability and support individual recovery.

There are a number of challenges in the report that we must tackle if we are to bring about improvements in the provision of services covering a range of areas. The aim must be to minimise what people need to recover from and to maximise what they can recover to.

In conclusion, the review provides yet further supporting evidence to underpin the important role of ORT in tackling drug misuse, identifies areas where further improvement must be made and provides a valuable platform that will allow many more people with substance misuse problems to achieve good outcomes. That is something around which all of us in the Parliament should unite to support.

15:20

Anne McTaggart (Glasgow) (Lab): I am keen to contribute to this important debate on the review of opioid replacement therapies in Scotland.

In my region of Glasgow, the issue is of particular importance, as it affects thousands of families who are struggling with addiction and substance dependency issues. I am confident that members across the chamber will agree that opioid replacements such as methadone can, in particular circumstances, help to stabilise drug users and direct them away from the most harmful of illegal drugs.

However, I am also confident that we could do much more to help addicts to dispose of their drug habit altogether through greater use of community recovery resources. I believe that, as a short-term solution, methadone can act as an effective intervention that removes the individual from dependency on other substances and the lifestyle associated with acquiring that. However, a longer-term strategy will need to address the social, economic and medical reasons behind the process of addiction to drugs such as ecstasy, cocaine and heroin.

The most effective strategy will not just be medical but will reflect on the reasons why people become addicted and provide individuals with a route out of their addiction altogether. Fundamentally, that will mean tackling effectively problems such as poverty, unemployment, homelessness and crime. The harsh reality is that there is no one solution that will comprehensively eradicate the harm caused by drug addiction. Serious investment is required in a number of areas if we are to have a greater impact on the lives of those most affected.

I welcome the findings of the review into opioid replacement therapies, which recommends that we attempt to prioritise recovery from addiction and aim to work more consistently with grass-roots agencies across the country. However, I would still like to see from the Scottish Government a timetable outlining the action being taken to provide clear and effective routes from addiction to recovery. Those who depend on the support of key agencies and services are not only the drug users themselves but their families and the wider community, all of whom are affected by the criminal behaviour that facilitates the traffic of drugs into Scotland.

Having worked within the field of addiction for the past 20 years in various roles and projects, including latterly as a social work professional for Glasgow City Council, I know that drug treatment and testing orders can play an important role in helping to deal with drug-related crime—a point that is also highlighted in the report. However, my

experience has taught me that we need to use DTTOs better as part of a joined-up system that supports addicts to overcome their addiction. Very often, drug treatment and testing orders are too little, too late and are handed down to individuals who are already well acquainted with a life of hard drugs and the criminal behaviour required to pay for them.

We need to be smarter about when we intervene with drug users. In my view, intervention should be as early as possible. Our agencies should be working within local communities where drug dependency is known to be high, and they should be carrying out preventive work with young people in schools and youth centres. For established users, our systems need to be effective at helping those who combine a number of drugs as well as those who misuse alcohol on top of drugs. It is a mistake to oversimplify the problem by isolating substances and neglecting the pattern of abuse that, for too long, has ruined lives and families.

We know that the number of drug deaths in Scotland is too high. I will work with the Scottish Government to tackle that tragic reality, and I commend the basic principles of the report on ORT. I urge the Government to look more widely at the issues that we face and to place an emphasis on the kind of preventive work that will result in Scotland becoming a cleaner and safer place to live for future generations.

15:24

Sandra White (Glasgow Kelvin) (SNP): We are all aware of the effects of substance abuse on the individual, those close to them and the wider community. Indeed, many members have visited such individuals and the families and the groups that look after them and perhaps even those peoples' families, as Anne McTaggart mentioned. We should all pay tribute to their hard work in looking after and supporting families and those who suffer from substance misuse, particularly as they often do so voluntarily. I hope that members also agree that people who suffer from substance misuse need understanding and support, and that they endorse the expert group's conclusions and recommendations while we continue to improve that support.

Scotland's 30 alcohol and drug partnerships are vital in delivering those aims, and I welcome the minister's announced consultation with the ADPs on the development of quality principles and, importantly, a strong commitment to human rights.

It is true that concerns have been expressed that, as Mary Scanlon mentioned, ADPs have not been as transparent as they could be. It is therefore encouraging to see new planning and reporting mechanisms agreed. However, it is also important that they are given the flexibility to develop local strategies as the level of substance misuse and underlying reasons differ widely across Scotland. Indeed, I am sure that members have many different stories to tell about what happens in their constituencies and regions.

David Liddell, director of the Scottish Drugs Forum, when commenting on the report highlighted the fact that

"significant income and health inequalities ... underpin much of Scotland's drug problem."

Anne McTaggart also mentioned that matter in her speech.

In Glasgow, the prevalence of drug misuse is still considerably higher than the national average, which is in part due to the inequalities that exist in that great city and the constituency that I represent. Although tackling the issue may fall outwith the remit of the report, it is important to remember those underlying reasons. I therefore welcome the minister's comments on health inequalities and the public health minister's involvement in the work. I encourage joint working, if at all possible, with other Scottish Government departments to tackle inequality at all levels.

The minister mentioned the recovery initiative fund and the unity recovery football club. That is a great example of a local initiative that not only supports recovery, but offers other healthy avenues that give people a new interest and focus. The fact that it also fosters a sense of community among those participating is, to my mind, an important aspect of such projects.

There are many other projects in Glasgow that take a holistic approach to treatment rather than adopting more mainstream methods. Just like us, which is based in Milton in Glasgow, is another great example. It offers a structured 10-week spiritual-based skills programme that focuses on empowering individuals to take control of their lives in a meaningful way and reduce their reliance on prescribed medication. There are plenty more examples of such an approach not just in Glasgow, but throughout the country. They are important to our overall perception and treatment of substance misuse. Perhaps the minister would look at including that approach in the Government's future drugs strategy.

Another important aspect of support and prevention must be to help people coming out of prison to ensure that they do not simply fall back into substance misuse. Unfortunately, the transition from prison life back into society has seen a number of people go back to past habits, reoffend and be sent back to prison. As a member of the Justice Committee, I know only too well from prisoners' experiences and the evidence that

we have heard that substance misuse is part of the revolving door back to prison. It is very much a vicious cycle that must be ended if we are to avoid further drug misuse.

The Scottish Government's public social partnerships have been used in Low Moss prison to tackle that issue and offer the necessary support to individuals after they leave prison. I have an example to share. One user of the partnership said:

"There are so many wee things that you need to sort out. Housing, benefits, meds, and add all these wee things together and it feels like an uphill struggle from the start."

After leaving prison, he went to his doctor's but he had been deregistered and was told that he would not get what he called his "subbie" or, in other words, his prescription, as they had not received a fax from the prison about it. Faced with that, it would have been easy for him to slip back into substance misuse. However, in his case, the PSP spoke to the prison doctor and got the matter sorted out. That is not an isolated incident but, with the support of the PSP, it was much easier for him not to offend again. PSPs have been shown to work. Would the minister consider rolling the model out across Scotland?

I welcome the independent expert review of opioid replacement therapies in Scotland and the fact that, at its heart, it promotes person-centred recovery. The review also highlights the desire further to develop information, research and evaluation systems at a national level. I encourage the minister to include in that research the use of holistic approaches to drugs misuse and the use of public social partnerships in achieving the aims of the Government's drugs strategy.

15:30

Willie Rennie (Mid Scotland and Fife) (LD): The change in the debate on this subject compared with last year is remarkable and I welcome the fact that we have got back to more of a consensus on drugs misuse. The issue was probably all sparked off, to David Clegg's great delight, by the *Daily Record*, which targeted what it called the methadone millionaires.

I met Mr Houlihan who was a so-called methadone millionaire. He is a pharmacist who has built up his business and works in some of the hardest communities in the west of Scotland. I have never seen a pharmacist more engaged in the interests of the people whom he serves. He wants to change their lives, and I was inspired by his commitment to his community, so I did not recognise him as a methadone millionaire. I think that the profit and the turnover were mixed up on that. He was not, as he was characterised in the *Daily Record*, somebody who did not care about the people whom he served.

The report was also inspired by the concern that methadone was triggering a number of deaths from drugs. It should be recognised that many commentators said that it was really about a heroin drought that, in that period, was forcing drug users to experiment with different types of drugs. When people experiment, sometimes things go wrong. Methadone itself was not the problem; there were wider issues at play as well.

We were also dealing with a group of people who dropped in and out of services and had chaotic lives. I will not say that it is natural for such events to happen to such people, but we could understand the reasons why they happened, which is why a superficial look at the figures was not helpful.

I am glad that we have got to the bottom of why the number of deaths was increasing, because I am clear that methadone is part of the solution, not part of the problem. If we compare Russia, which does not have a similar needle-exchange and methadone programme, with the United Kingdom and Scotland, we see that the blood-borne virus problems there are far greater than they are here. We should recognise the differences that we have made over time, and I am glad that the Kidd report endorsed the point of view that methadone is part of the solution, not part of the problem.

I was recently at the Phoenix Futures graduation ceremony in Glasgow. I was a wee bit daunted by going into the Woodside halls in Glasgow, I have to say. There were a lot of people who—how can I put it?—have seen the hard end of life. Many of them had tattoos on their knuckles and had various other marks. However, when I went in, it struck me that they were all hugging one another. They were hard people and had seen difficult bits of their communities, but they were hugging one another.

That was a mark of the success of Phoenix Futures. The organisation has created recovery communities—people who look after the emotional side of one another's needs. It was a tremendous recommendation. Those people were delighted to have graduated out of drugs misuse, and that is the kind of project that we should celebrate.

I also attended a project in Kirkcaldy not long ago and met a young man who said that he was more frightened of recovery than he was of drugs misuse. He was recovering but he said that, having come off drugs, he now saw the world and had to face up to all his demons, from which he had managed to hide in the past. He said that it was getting more difficult being in recovery. Members can understand why people dip in and

out of recovery over time and that it is not easy to progress naturally from methadone to abstinence.

Yesterday's Scottish Drugs Forum conference was an excellent event that focused on trauma. Jim Eadie is right that poverty and deprivation are major contributory factors to drug misuse, but traumatic events in people's lives—regardless of the background that they come from; people from wealthy backgrounds as well as people from poor backgrounds are affected—are significant, too. The SDF's event focused on the effect of trauma—not just the trauma of one-off events, but longer-term trauma.

Elaine Murray is right that there is still a bit of debate about what recovery is. I think that there is a general understanding that recovery means improvement and that it is different for everyone. Some people in the sector view recovery as complete abstinence, although I would not say that they are the majority. I think that that is a healthy debate. When I was at the Phoenix Futures event, someone said that they condemned methadone—they did not like touching it one bit—but the majority of people I meet in the drug misuse community recognise that it has a role to play.

The issue is not just about medicine; it is also about the mind and the wider factors in life. Another consideration is the degree of compulsion that should be involved. To what extent should we encourage drug users to undergo treatment? People would never be compelled to undergo treatment, but how far along the track from encouragement to compulsion should we go? That is critical. There is also a lively debate about residential treatment versus community treatment.

I think that the biggest shake-up that is needed is in the NHS. We need to try to get the NHS in the wider sense to engage properly. Drug abuse affects a range of services from housing to health to justice. Justice takes the lead, but the NHS needs to take a lead, too. That is why it is important that the medical director should be the lead person when it comes to opioid replacement. We need a person in the NHS to take a much more comprehensive lead on such matters.

Dennis Robertson (Aberdeenshire West) (SNP): Does the member agree that the integration of social care and health might be a pathway to relieving some of his anxieties?

The Deputy Presiding Officer: You should be drawing to a close, please, Mr Rennie.

Willie Rennie: Perhaps, but we should not look only to structural changes to change minds. We need to get leading people in the NHS to fully embrace drug misuse instead of just leaving it to someone else. The issue goes beyond the simple one of recovery. We need to sort out issues of housing, work and family. Another issue that I have noticed to an increasing extent is that of boredom: people who are drug misusers are just bored.

The Deputy Presiding Officer: And finally—

Willie Rennie: A bit of good news is the fact that the number of younger drug users is dropping. We should welcome that, because it means that we are moving in the right direction. We still have a lot of work to do, but we are moving in the right direction.

15:38

Christian Allard (North East Scotland) (SNP): I congratulate Willie Rennie on saying that we are moving in the right direction.

Like many of my generation, I have lost too many friends and family members to drug use. I am not surprised by the finding that there are more individuals with a drug use problem in the 35 to 64 age group than there are in the 15 to 34 group. My generation failed to recognise the danger of drug use and, today, the same generation is failing to recover from it. More to the point, many of my generation still consider drug use to be a recreational habit and still claim that they should have the freedom to choose to use drugs. They ignore the cost to society and the human cost—more than 500 lives a year are lost to drug use in Scotland.

I am delighted to have the opportunity to speak on the independent expert review of opioid replacement therapies that was commissioned by the chief medical officer and led by the independent Drugs Strategy Delivery Commission. Some members have already told stories about what is happening today. Because the biggest problem is among the older generation, I would like to share with the chamber a story about one of my friends back in France before I came to Scotland.

This person was normal—he could have been somebody's neighbour. He was a young plumber of 18 years old. He looked after his flat and his little car very well, and he was careful about what he ate. However, he loved recreational drugs, which he took all the time. He told me all the time, "Christian, you should share this with me. You should try it." I always said that it was not for me and I argued that it would lead to the use of harder drugs. He always dismissed me. He had a regular life and a regular girlfriend, who was his sweetheart. When I left France, he was one of the friends whom I really missed.

Two or three years later, I heard that my friend had died. I did not understand why, so I inquired and I discovered that he had died of a drug overdose. What happened was a silly thing—his

sweetheart left him and one thing led to another. He did not die with tattoos or doing anything illegal; he just died of an overdose.

That story shows that, although everyone could be led to believe that using drugs is a personal choice, addiction is extremely difficult to recover from. In those days, people did not have the same opportunities as are available today. I wish that my friend Pascal had had the opportunities that opioid replacement therapies offer people in Scotland today.

In my area—in Aberdeen city and Aberdeenshire—the statistics show that the number of drug-related deaths fell between 2011 and 2012. In my region—North East Scotland—recovery communities have been set up. Aberdeen in recovery was formed by a small group of people in recovery in 2012, with support from Aberdeen city alcohol and drugs partnership, to help to reduce stigma and raise the profile of recovery from addiction to drugs and alcohol. Fraserburgh in recovery has received £1,000 of grant funding. It offers peer mentoring and alternative therapies and it showcases recovery journeys.

"The Road to Recovery" is the only way to tackle the problem of drug use, but I am delighted that the expert group recognised that it can be delivered only as part of a coherent person-centred recovery plan.

The rate of drug taking in the population is falling, and drug-death statistics show an ageing cohort of drug users. The number of drug deaths among under-25s is falling and is at its lowest level since records began. Many of those who are lost to us are older drug users who have become increasingly unwell over the years. Drug-death statistics reflect wider sources of data that show a decrease in drug use among the population and show that far fewer young people are using drugs than before.

My generation has a huge responsibility for the number of people who are affected by the problem of drug use. Too many people of my age still choose to ignore the danger of drug use, despite the number of friends and family members whom we have lost to it over the years.

I can see that, through the education programme that is in place for Scottish schoolchildren, younger generations have a different attitude to drug use. I know that my daughters have that and I hope that my grandchildren will have the same kind of attitude. That is borne out in the statistics, which show that the rate of drug taking among young people is the lowest in a decade.

The position is encouraging. I thank everyone who is involved in delivering the Scottish Government's strategy, which is keeping people alive. I know how important it is for families of different backgrounds across Scotland. Opioid replacement therapy—methadone—is keeping a member of my family alive and I am thankful for that.

15:44

Jamie Hepburn (Cumbernauld and Kilsyth) (SNP): I thank Christian Allard for his thoughtful and heartfelt speech. The debate very much benefits from such contributions.

I welcome the debate, which follows a debate we had last year. The issue is important.

The Deputy Presiding Officer (Elaine Smith): Mr Hepburn, I am having difficulty in hearing you. Will you move your microphone slightly?

Jamie Hepburn: Okay.

The Deputy Presiding Officer: Thank you.

Jamie Hepburn: I will try to talk louder, Presiding Officer, and see whether it helps. People do not usually have difficulty hearing me.

Few of our constituents have a dependency issue, so I will use some of the statistics that are available for the NHS Lanarkshire area that covers my constituency. Those statistics set out the situation in some detail, but there is a serious impact on an individual who has such a dependency. Such people often suffer from complex multiple problems and they can be very vulnerable, as Elaine Murray said.

There is, of course, an impact on the person's family. Who among us would hope for their child to have a drug addiction?

Then, of course, there is the impact of dependency on our wider society and our communities. We know that many people get involved with criminal activity to feed their habit. It is therefore absolutely right that we are having this debate and I welcome the expert group's report.

This has been a historic week and this is an important debate. It might not be as historic as some of the other debates that we have had this week, but it gives the lie to the suggestion that some in the Parliament have made that Scotland is on pause. Today's debate is a vivid demonstration of the Scottish Government taking action and getting on with the business of Government by working to improve support for and treatment of those who have an addiction.

The Government has a good record in that regard. It established and published the national drug strategy, "The Road to Recovery", in 2008. Last November we had a debate to follow the commissioning of the independent group whose

report we debate today. That is a significant effort towards improving support for those who have an addiction.

As I said earlier, I will talk about the situation in my area. Mary Scanlon said that she is concerned about the rate of progress. We should all be concerned about that and do everything that we can. However, there is broadly a good record in the NHS Lanarkshire area, which covers my Cumbernauld and Kilsyth constituency.

In this year, the Scottish Government has allocated almost £6 million, up from £4.3 million in 2008-09, for drug and alcohol treatment, and that has made a real contribution to starting to tackle the problem of drug taking in the NHS Lanarkshire area. Drug taking across the general population has fallen from 12.6 per cent in 2006 to 9.1 per cent of 16 to 59-year-old self-reporting drug users in 2010-11. Again, among young people, the figure in 2010 was the lowest it had been for a decade. It dropped from 23 per cent to 11 per cent of 15-year-olds reporting drugs use in the past month.

In the NHS Lanarkshire area, 98.8 per cent of people are treated for drugs and alcohol addiction within three weeks, as opposed to the Scotland-wide figure of 96 per cent. No one is waiting more than six weeks for treatment in NHS Lanarkshire.

Lest I be accused of painting an entirely rosy picture, I recognise that, in the past four years, there has been an increase in the number of drug-related deaths in the Lanarkshire area. I am not saying that everything is perfect. There is obviously still more to be done, but the overall picture is one of progress and that is to be welcomed.

I very much welcome the report of the independent expert group. It has to be seen as a contribution to and building on progress. Dr Brian Kidd, who chaired the group, set that out when he said that the review has identified a range of areas in which progress is required. Looking at how people have responded to the report, we see that David Liddell, the director of the Scottish Drugs Forum, has welcomed the expert group's report, which is very important given the fact that the forum works with people on the ground who are affected by addiction and campaigns for greater awareness and change in the area. It obviously supports the report.

Willie Rennie made a good speech, and his point about the work of pharmacists was well made. They buy into the report, too. Community Pharmacy Scotland made a number of important points in its briefing to members. It points out that community pharmacists are the health professionals who have the most interaction with patients who receive opioid replacement therapies and that pharmacists are probably the healthcare professionals that people who live in the areas of greatest deprivation will see most often. We are aware of the correlation—it is not a hard and fast rule—between poverty and addiction, and community pharmacists have an important role in rising to the challenge.

It is clear that the report has been welcomed. I very much welcome it and I look forward to seeing further work from the Government on the issue.

The Deputy Presiding Officer: I apologise for interrupting your speech, Mr Hepburn. We seem to be having slight problems with the sound levels and I have asked for them to be checked. Other members have told me that they are having difficulty hearing, so it is not just me. As you pointed out, we usually can hear you quite well.

15:51

Graeme Pearson (South Scotland) (Lab): We should remember that we have faced 35 years of challenge in relation to drugs misuse as it affects Scotland. As many members have said, in that time, much has been achieved by those who are employed by the Government and those in the third sector through the various elements of work that they do to combat the threats, dangers and health risks that are presented by drugs misuse.

In that light, I welcome the presentation of Dr Brian Kidd's report and the work done by the team who assisted him. Jim Eadie rightly identified that the strategic approach that underlies some of the lessons that Dr Kidd outlines is one of the most important messages. Willie Rennie mentioned that he has visited some groups. Like him, I have visited many groups. However, I do not fully agree with his assessment of how we arrived at the current situation. It is fair to say that, when the review was initiated, there was a growing clamour and criticism in the Parliament—I was one of those who offered criticisms—and a campaign by the *Daily Record*. The review took place on the back of those developments. No matter what brought the review to pass, it is most welcome.

In my view, there was never a presentation that suggested that there should be an end to opioid replacement therapies. To argue that there was is either a misunderstanding of the case or a misrepresentation of what people were trying to achieve. The problem that we were trying to address, which we now understand more clearly, is the number of people in Scotland who are accessing treatment therapies, particularly methadone. That is in excess of 20,000 people, with the cost of the service that is being provided estimated to be about £36 million, or £100,000 a day. The number of drugs deaths has risen to a record high and, last year, 41 per cent of those deaths involved methadone. Unfortunately, the

United Nations Office on Drugs and Crime places Scotland in the unenviable position of leading the league tables on opioid abuse, which is not something that any of us would wish to be the case.

There has rightly been cross-party support for successive Government and Administration policies. However, that support should not be given without a commitment and without the ability for us to offer observations and criticisms. It is important that the new review has focused firmly on recovery-oriented systems of care. I welcome that impetus and focus on delivery of outcomes that involve recovery, which can mean many things to many people.

I hope that the minister will say at the end of the debate that steps will be taken to deal with the lack of evidence presented by some ADPs regarding a real impetus towards recovery, that the real concerns around the lack of progress found in many ADP areas on the delivery of recovery-orientated systems of care will be dealt with and that he will monitor the outcomes.

The third point made in the report is that a lack of institutional memory has led to repeated mistakes, false trails and a failure to capitalise on success. As was said earlier, the report refers to improving local information systems to better identify people on ORT so that we know what works.

There will not be a member—I include those in this chamber and those who have not attended the debate—who does not want the Government to succeed; we all want success in this area. However, we need to measure what we are doing. We need to know that what is being done in our name through the policy of "The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem" is effective and is giving everyone who is involved in treatment the opportunity to succeed on their terms.

It has been said that some people will not recover and that they will require to be maintained through methadone or some other means. We need to accept that, but we need also to have an ambition for every patient who enters our care, to give them a chance to be all they can be in their lives and to allow them to play a full part in their family, their community and Scotland's future. In that context, we urge the ministers to apply the lessons from the review with some energy and to come back to the chamber regularly to tell us what has been achieved and what benefits we have gained from applying the pressures as suggested.

I support the amendment in the name of Elaine Murray. Thank you for the opportunity to speak in the debate.

15:57

Stewart Stevenson (Banffshire and Buchan Coast) (SNP): I am very glad that Graeme Pearson has had the opportunity to contribute to the debate. When I was a member of the former Justice 1 Committee, which Pauline McNeill convened, I first met Graeme Pearson over dinner in Glasgow to discuss drug problems. The dinner was excellent, but the message was compellingly disturbing.

I recall that on that occasion Graeme Pearson told us of a drug dealer in Glasgow who had gone into a showroom with cash and bought a brand new Bentley. He told us that that same individual had bought a fleet of cars for his private hire taxi company. He told us that this is a social problem as well as an economic problem, costing perhaps 1.5 to 5 per cent of our gross domestic product. If we were to look at it just in economic terms, that is a loss of tax take of between £0.5 billion and £1.5 billion for Scotland alone.

The reality is that the finance is not really the issue. I first spoke in the Parliament in a drugs debate on 27 October 2004. At that point I said:

"Addiction is a feature of human behaviour and, realistically, it cannot be eliminated."—[*Official Report*, 27 October 2004; c 11150.]

In "A Counter-blaste to Tobacco", which was written 400 years ago, James VI said that the smoker

"by custome is piece and piece allured."

The whole issue of addiction is very far from new.

It is perhaps worth saying that in the 1890s, Sears and Roebuck, a well-known American retailer, had in the catalogue that it distributed to millions of homes across the United States a syringe and cocaine that could be bought for $1.50.

Attitudes have changed and the impact of addiction has changed. However, it was recognised 100 years ago that it was a major issue. The first international drug control treaty was the international opium convention of 1912, which came out of a conference that was held in Shanghai.

From the 1950s, of course, we started to see a relatively small group of morphine addicts being looked after by general practitioners. My father, who was a GP, looked after a tiny handful. Even then, the impact of criminality could be seen. In 1951, a single drug addict broke into a dispensary on the outskirts of London; a decade later, it was discovered that, from that single criminal act, 60 addicts had been created, who suffered problems. It is all too easy for little acts to have huge consequences in the area.

In the 1960s, it was, of course, thought that there were relatively few addicts. In fact, in 1964, the Home Office reported that there were 753 addicts in the UK as a whole. I think that that was questioned at the time; it was also questionable. It certainly led, with greater understanding, to the dangerous drugs legislation. However, it was thought at that time that the problem was so limited in Scotland that no provision whatsoever was made for Scotland. By the late 1970s, boy we knew that we had a problem.

We now have an excellent report that shows what we are doing to deal with that problem. We certainly cannot undo our position simply by reversing the actions that got us here. We must be proactive.

Originally, we sought simply to support the addicts and deal with their addiction medically. Now, of course, addiction has a huge reach into criminality. It is also a public health and infection issue that has to be dealt with.

Let us not forget, either, that opioid addiction, which is the subject of the debate, is part of a whole series of addictions. We have in our society alcohol, gambling and nicotine addictions. A member of staff who worked for me—among the hundreds who did so—was even addicted to a proprietary nasal spray. He consumed 20 bottles of it a day, although it did not seem to affect his life.

The illegal drugs that we are talking about and the issues with which we have to deal in that context are in part related to the free cigarettes that were dispensed to servicemen during the second world war. That desensitised us to the idea that addiction should be avoided.

In closing, it is worth welcoming very much the consensual nature of this debate. It has brought together different points of view, experiences and inputs, but they all point in the same direction. I think that Willie Rennie referred to that.

Two examples of how things can be mishandled are perhaps worth going back to.

Derek Hatton, who was the Labour deputy leader of Liverpool City Council, wanted to attack Margaret Thatcher. I might be up for that, but he did so by designating Liverpool as “smack city”. We are still living on the back of that.

In my constituency, a now-deceased GP, Sandy Wisely, quite unnecessarily and unjustifiably talked up a drug problem in Fraserburgh. We are still dealing with that today in reputational terms.

We have had a good, balanced debate. Let us hope that that continues.

I very much support the essence of what Labour’s amendment says, but very much support the Government’s motion.

16:03

John Pentland (Motherwell and Wishaw) (Lab): Methadone maintenance treatment is not a solution to drug addiction; it replaces one form of addiction with another. However, it can enable an addict to stabilise their addiction and begin to rebuild their life. As well as making their addiction more manageable, methadone treatment is safer than taking drugs of unknown origin and strength, which may also involve sharing syringes and needles, with the risk of contracting hepatitis and HIV.

Methadone treatment is sometimes criticised by the media or by members of the public who think that more should be done to cure addiction through abstinence. I understand that that alternative is used in some countries, including Russia—Willie Rennie mentioned that—but for many users, withdrawal is easier said than done. There may be adverse physiological and psychological consequences; that is the nature of addiction. For that reason, opiate replacement therapies have long been essential harm-reduction measures; that role was endorsed five years ago by the road to recovery strategy.

However, despite the apparent consensus, the evidence is not clear-cut. The expert review recognises that there are issues with the evidence that is available and quotes the 2012 UK drug policy commission:

> “Drug policy is currently a mix of cautious politics and limited evidence and analysis. This is coupled with strident and contested interpretations, both of the causes of problems and the effects of policies. In fact, for as long as there has been a drug policy, there have been gaps in the evidence as well as uncertainty about how to understand and act on the evidence that we do have.”

In that context, I am pleased that the review not only dealt with the many people who are involved in delivering and receiving a variety of treatments, but accorded their views and experiences equal status with those of local and national bodies. If we are to develop an effective person-centred approach to opioid addiction, it is essential that such evidence is a significant part of our consideration of what will be the best way forward.

One aspect that has been made clear by such stakeholder input is that some alcohol and drug partnerships perform poorly when it comes to recovery. The report notes:

> “There was little evidence presented by some ADPs regarding a real impetus towards recovery. Stakeholder reports supported this view.”

The review highlights that basic information was not often accessible, and that

"Clear strategic plans and objective reports of improvement were rare ... Elements of recovery orientated services were often absent."

It also stated that

"There was not a strong sense of accountability ... systems are destined to continue repeating mistakes or failing to capitalise on successes."

Those views add up to quite a damning indictment.

Addicts who are motivated to stop are unlikely to succeed without the right help and support—not only for the initial period of withdrawal, but for the longer term. However, that help must address the circumstances that contribute to drug addiction and the relationship between drug taking and criminal behaviour. I welcome the review's consideration of those issues and its findings, which seek a more consistent approach that focuses on recovery as a primary aim.

The review recommends that a full range of care services be available in every area, including community rehabilitation services such as detoxification, residential rehabilitation, and services that deal with employability and housing. It also recommends development of better ways to link action on health inequalities with action to address problem substance misuse. One key measure would be to ensure that local inequalities strategies refer to plans to address the risks that are associated with substance misuse.

Drug treatment and testing orders have an important role to play in respect of drug-related crime. We need to use them better, as part of a joined-up system that supports addicts to overcome their addiction. The debate has focused on opioids, but we should bear it in mind that many addicts have multiple addictions. Systems need to take account of patterns of drug use that encompass combinations of alcohol, opiates and other substances.

I note the recommendations on pharmacy services; the role of pharmacies has evolved and has become important, so given how that role has changed, we need to examine its operation in order to ensure that it is working to best effect, as part of the overall strategy. I support the recommendation that there should be a national specification to ensure consistent high-quality care across the country, and that the system that is used to reimburse pharmacists for dispensing methadone should be reviewed.

The Deputy Presiding Officer: You must conclude.

John Pentland: We have heard how many deaths result from substance misuse, but any such death is one death too many. We need to ensure that we have a system that provides appropriate treatment options for everyone who wants to escape the dangers of addiction.

16:10

Gil Paterson (Clydebank and Milngavie) (SNP): I am pleased to be speaking in the debate. Although it is primarily a justice debate, I will take a little of my time to raise issues to do with health inequalities by touching on what I have learned during my time on the Health and Sport Committee. I will come to that in a moment or two.

When we debate the impact of drug use, we must acknowledge the devastating impact that it has on communities, families and individuals. That is just as important when we debate how best to treat people who have a history of drug abuse and are trying to get clean. Due to their past problems, some lose friends, become lepers in their community and find that they are shunned by family members, yet those groups of people are the resource that is needed to ensure that those who seek treatment are given encouragement to continue with it, and support when challenges emerge—as they surely will. It is at those times that local agencies must come to the fore to offer their support. Without them, there is a danger that people will not complete their treatment and will fall back into drug misuse.

In my constituency, an organisation called Alternatives West Dunbartonshire Community Drug Services offers support to people who suffer from drug abuse. Since February 2000, it has been working in the Clydebank area to offer alternatives to drug use through a range of services to individuals and families who are, or who have been, affected by drugs. The organisation carries out a great deal of work and is proactive in its attempts to bring people out of drug abuse. Its outreach programme is an umbrella term for a style of work that means it literally reaches to where people are at. Alternatives WD does not wait for people to seek help once they see themselves as having a drug or health problem, but seeks them out with the aim of providing education and services directly in the community.

Although the motion acknowledges that opioid replacement therapies have a strong evidence base, it is important to look at other avenues for treating people who suffer from drug misuse. The Alternatives WD group is one such avenue, and I commend it for the hard work that its members and volunteers carry out in the community. More important is that it should—given the impact of its work on individuals and families—be encouraged by all.

I have contributed to a number of health debates in Parliament in which the main theme has been the need to move to person-centred treatment and recovery, and this afternoon's debate is no different. I am pleased that the Scottish Government has accepted the expert group's conclusions and that it is committed to delivering on the recommendations as part of a coherent person-centred recovery plan. All services, be they local or national, must be focused on the individual's needs. I support the calls for better information systems to identify people who are on opioid replacement treatments and ensure that they are making progress with their recovery.

There is little point in offering the treatment if it is not part of a plan with SMART—specific, measurable, achievable, realistic and timeous—goals. In order to ensure that there is progress in treatment and recovery, there must be constant monitoring to ensure that recovery is taking place to a satisfactory level.

It is difficult to look at the different systems that are in place, or that should be strengthened or established, with the level of inequality that exists. Some people argue that inequality in access to health contributes to, and is the main cause of, drug abuse, but that misses the bigger picture. Health inequality, social inequality and inequality across the board can be summed up in one word: poverty. It will come as no surprise to anyone that people who live in poorer areas are more likely to suffer from the effects of drug abuse—either personally or in their family. Regardless of how much money is thrown at health inequality, it can be a waste if we do not bring people out of poverty. If someone grows up in a family or an area where they are written off or have been told time and again that they are useless or worthless, it will make no difference to them if resources are ploughed into their area. There are people in bad circumstances who, because of the stigma of poverty and perpetual messages of hopelessness, adopt a fatalistic attitude that for them amounts to, "This is as good as it gets for people like me. This is my lot." Therefore, in order to tackle the cause we need to break the cycle of poverty.

If we make people's lives meaningful with well-paid employment, which would give them the confidence to believe in a better life, I promise that health inequalities will narrow as people are lifted out of poverty.

The Deputy Presiding Officer: You must conclude.

Gil Paterson: The Scottish Government has well and truly got that message. This Parliament needs full powers if it is to change the lives of people and make a difference in terms of both inequality and drug misuse. I commend the motion to Parliament.

The Deputy Presiding Officer: Thank you. We are now running rather short of time, so I ask the next three members to keep to their six minutes, please.

16:17

John Finnie (Highlands and Islands) (Ind): I, too, welcome the broad consensus that we have heard, and which I hope will continue. I was delighted to hear the minister talk about the human-rights based approach that will be taken.

I want to comment on some research by the Scottish Drugs Forum, which looked at the life stories of 55 people: people, not statistics. The main aim of that research was to record and understand the life stories of problem drug users; we have heard many examples of what came out of that. It is compelling that the interviewers were SDF volunteers who were addicts in recovery. I commend that approach, which was also used in SDF's naloxone peer-educator initiative.

I was delighted that the research covered urban and rural Scotland, because the problem is not limited to the central belt—it covers the entire nation, unfortunately. It will come as no surprise to anyone that most problem drug users are from disadvantaged neighbourhoods and are personally disadvantaged. There is no doubt in my mind that antipoverty policies and the promotion of equality, in terms of income disparity, have the potential to make a significant impact.

We heard from members that an association between problem drug use and deprivation is worsened by stigmatisation. I find such stigmatisation to be particularly galling when it comes from people who systematically abuse alcohol, as it often does. There is almost a strange snobbery associated with that.

Many of the 55 people talked about significant childhood problems, including anxiety and attention deficit, hyperactivity and conduct disorders. I hope that the getting it right for every child approach will catch that. Anne McTaggart's comments about education were very important, and I certainly commend the patient-journey approach, which looks at where interventions could have made a difference.

We heard in the research that using alcohol and drugs relatively heavily from a relatively young age happens usually in the context of socialising and having fun. In a previous debate I mentioned to the health minister the cynical targeting by social media that is taking place, which is a significant problem; alcohol promotion—whether peer

promotion or global promotion—is something that we need to address.

We hear of the multiagency approach to everything, which is fine; however, local authorities and housing associations face challenges in having to deal with competing issues including provision of housing to people who have drug addiction issues and the disruption that can sometimes result. We need to address that and we need to address GPs refusing access to people because of their addictions.

Of course, many addicts are not bothered or concerned about the implications of what they do and will experiment with so-called legal highs because they feel that they have nothing to live for. We also have to remember that many of them are victims of the violence that is associated with the street drugs trade.

I am particularly concerned about the problem of estrangement from families and about difficulties with care and custody of, and access to, children. We should work very hard to keep family units together and social work departments—rightly—take a child-centred approach to such matters.

I, too, support methadone as an important part of the process. It is regarded as an essential aid on the road to recovery, offering the possibility of improvement, increased stability and—significantly for me—a reduced need for street drugs. Interestingly, the SDF research also highlighted difficulties in getting and keeping a methadone prescription. In my earlier intervention on the minister, I asked about the patchwork of services and I certainly think that there should not be any no-go areas—including Argyll in my region, where thus far ignorance has prevailed. However, I think that NHS Highland is going to ensure that the full range of services that should be available to all citizens will be available.

I want to raise with the minister an issue that has previously been raised by my colleague Patrick Harvie about diamorphine, which as we know is a controlled drug but can be prescribed for treatment of drug misuse and addiction. In the response to Mr Harvie's written parliamentary question, the cabinet secretary Alex Neil said:

"Such decisions should be based on individual patient need and are a matter for the clinical judgement of the patient's doctor".—[*Official Report*, *Written Answers*, 18 November 2013; S4W-17911.]

The fact that no licensing requests have been made might be connected with an understanding that such a move would be a departure from Government policy, but I want nothing to be ruled out in terms of assisting people who have drug issues, including the prescribing of heroin on a harm-reduction basis. Of course, that would need to be assessed, but I would welcome either minister's comments on the matter. Of course, the same goes for the very challenging approach of supervised injection, which also has a role in harm reduction, and street-drug analysis. There is no doubt that our harm reduction people often deal with very challenging individuals and disruptive lifestyles, so anything that can be done to help is worth trying. I therefore ask ministers to consider such initiatives.

A very compelling phrase in the SDF research was about

"maximising what people can recover to."

People must have something to aspire to; with compassion, understanding and care, we can make things better for them.

16:23

Dennis Robertson (Aberdeenshire West) (SNP): In what has been a very positive and consensual debate, most members have, I think, referred to the person-centred approach. I have to say that this sort of thing is not new. I am sure that, with her social work background, Anne McTaggart will testify to the fact that it has been used for many years and, given his previous life as an occupational therapist in the health service, the minister, Michael Matheson, will be well aware of the approach.

I feel that we are looking on the person-centred approach as the magic pathway or whatever when it is, in fact, not. When we talk about a person-centred approach, we must ensure that we are being inclusive. People generally live their lives not in isolation but in a community, if not in a family, and if we do not involve the family or the community, these people might, as Gil Paterson suggested, question their sense of worth. Before they move on to the road to recovery, a person has to identify where they are at and where, perhaps, they would like to be. Sometimes that will require someone else—say, a professional—giving them appropriate guidance and the sense that they are being listened to and that they are very important.

I accept Gil Paterson's comments about poverty and health inequality—those issues create problems. However, I say to the chamber that I have seen drug addiction in the affluent areas of the north-east. I have seen it happen in situations in which money is no object. I have seen it affecting families who, to some extent, are unaware that it is happening, because it has not impacted on their family life, in so far as the mortgage and bills are still getting paid. However, the misuse is still going on.

We have moved on a great deal in the area of stigma around drug addiction. One of the areas in

which we have moved on to a greater extent than people give us credit for is in the community pharmacy service. That service has been embraced by communities, and I commend the work that community pharmacists are doing across Scotland. In Grampian, there are 131 community pharmacy practices. I believe that 127 are engaged in the area that we are discussing. That is to be commended.

People in the community pharmacy can see the bigger picture. They see the individual coming in to get their prescription for methadone, but they can also see the wife, the father, the mother or the brother coming in to get a prescription for something that might perhaps help them to cope with the addiction of one of their loved ones.

We have a long way to go, but we have made significant progress.

I congratulate my friend and colleague Christian Allard for sharing a very personal story with the chamber. Many of us can look at our personal circumstances and reflect on where we and our families are. When I worked in social work, I came across many examples of despair and absolute tragedy—the parent asking, "Why? Why did my daughter die? Why did it happen? What did I do wrong?" They carry guilt for the rest of their lives, believing that they should have done something. However, in reality, they probably did all that they could. It is when we turn our back on people requiring our help—when we turn our back on people in our community and our society because we do not approve of them—that we should feel guilty.

I believe that, in this chamber, we have a consensus to move things forward. I appreciate what Mary Scanlon said. Perhaps the process is not moving quickly enough. However, I think that it is moving at a pace at which we can evaluate it and that will ensure that the evidence is there, because we need that evidence base if we are to move forward in a way that might prevent deaths in t future.

We will never get to the bottom of this. As ever, Stewart Stevenson brought history back to the chamber. Addiction has been with us for centuries and will probably remain with us for centuries.

On a positive note, however, we have consensus and I believe that we have a pathway to success.

16:28

Mark McDonald (Aberdeen Donside) (SNP): This is an important debate. Like Willie Rennie, I have noted the change of tone since last year's debate. It is a welcome change. It is always better when we work consensually on sensitive issues such as this one, rather than seeing individuals or parties making a cheap bid for headlines, which can often derail progress that is being made. It is welcome that that has not been prevalent today.

I take on board the points that have been made about the fact that those who are at the sharp end of poverty and disadvantage often find themselves at the sharp end of drug misuse—that is absolutely correlated by figures—but, as Dennis Robertson said, the north-east has a particular problem around affluent drug use. Those people would not classify themselves as problem drug users but would probably consider themselves to be recreational drug users.

We must also remember that there are circumstances that affect an individual beyond their income, such as abuse of a sexual or domestic nature, which does not confine itself to those in the lowest income brackets. We should not define how drug misuse can affect an individual solely by their income. Christian Allard gave an extremely powerful personal testimony and, in last year's debate, I made the point that I could point to individuals in my school yearbook who had fallen into addiction—individuals who, to all intents and purposes, could be said to have had the same life chances that I had. We do not know what may have gone on in their private lives to affect the trajectory that their lives took.

There is much to be welcomed. Other members have commented on the treatment statistics. In Aberdeen city, 99.5 per cent of people with drug and alcohol problems are being treated within three weeks, and nobody in Aberdeen is waiting more than six weeks for treatment. Those are extremely welcome statistics. Obviously, we want 100 per cent of those people to be treated within three weeks; nonetheless, having 100 per cent treated within six weeks is extremely positive.

Although the number of drug deaths is a lot higher than we would want it to be, the number of drug deaths in the under-25 bracket is at its lowest level since records began. In Aberdeen, the number of drug deaths has reduced from 31 in 2010 to 16 in 2012, which is welcome progress.

In addition, drug taking in the general population has fallen from 12.9 per cent in 2008 to 9.1 per cent in 2011 among 16 to 59-year-olds who self-report their drug use. Among young people, drug taking is at its lowest level in a decade, down from 23 per cent in 2002 to 11 per cent in 2010 according to the statistics that were published by ISD Scotland in December 2011.

There are around 3,200 drug users in Aberdeen, and Drugs Action tells me that around 2,000 of them are currently accessing drug treatment. That means, however, that there are 1,200 drug users out there whom we need to reach and encourage

to seek treatment. I imagine that some of them will fall into the category that I mentioned earlier. Drugs Action offers a range of services across the city, including a counselling service that is available to drug users, ex-users and family members. The point has been made that involving the family in an individual's treatment is vital because they have a role to play in assisting that individual's recovery. Specialist counselling is also available for people who are affected by HIV, people who have hepatitis B or C, female drug users, young people, the parents or other relatives of drug users and people who are drug free but who are affected by drug misuse through their extended family or friends.

Drugs Action also offers city outreach services, with weekly drop-in advice, information and needle exchange sessions in my constituency at Mastrick, Northfield, Woodside and Middlefield. The Woodside outreach service has a dedicated worker for the Woodside area who operates two days a week at the Printfield Community Project and the Woodside Fountain centre. The outreach drugs worker offers individual counselling, support, advice and training to drug users, families, community groups and professionals in the Woodside area. There is a whole-community approach to recovery, which is important.

There is also the Aberdeen recovery community, which is a partnership between Drugs Action and Aberdeen Foyer. It not only seeks to ensure that individuals recover but identifies skills and interests and tries to ensure that, when the individual has been treated, they have the opportunity to reintegrate into society through employment and the opportunities that arise from that.

If the system receives an individual on the basis of their drug use but does not deal with the other factors affecting that individual, it can be said that the addiction has been treated but the person has not. We need to get to the stage at which the person is treated along with the factors that affect them. That is the concept of wraparound treatment that the Government is emphasising.

I welcome the report and the progress that is being made. I also very much welcome the consensus that has arisen during the debate. If that consensus holds, we can continue to make extremely positive progress in the area.

The Deputy Presiding Officer: That brings us to the closing speeches.

16:35

Jackson Carlaw (West Scotland) (Con): I will start with Christian Allard's speech, which I thought an arresting contribution to the debate. As well as to his experiences in France—which I, of course, regard as a model for nothing at all—he referred several times to the experiences of his generation. I do not know what age Christian Allard is, but the concept of generation struck me because, I have to say, when I was growing up in the 1960s, drug taking was presented as a highly glamorous thing. Drugs were the food of film stars, of Hollywood, of fashion, of racy society in London, of smart parties. If people died of drug addiction, it was due not to "an overdose" but to "an attack of the vapours" or to their having "a fragile constitution". Nothing bleak really was portrayed in that language. As we went through later into the 1960s, drug taking was the way that people escaped the realities of Vietnam and LSD was the creative food underpinning the pop movement of the time.

Yet, in her opening speech, Roseanna Cunningham, in a completely unadorned and factual way, got us right back to the fact that in the second decade of the 21st century the reality is that we had the highest number of deaths in Scotland through drugs. Those were not people at smart society parties or film stars or people who were part of the creative process; in all too many cases—though some, perhaps, might have had too much money—they were, as has been said through the course of today's debate, people who through circumstances of poverty and inequality had been led to that situation.

An important point underpinning the reason why we are considering the report is that, for the first time, a majority of those drug deaths were as a result of methadone. The fact that a majority of those on methadone who died were not on a methadone prescription led to the need for the recommendations that we have been considering. Another depressing fact is that, even within that, the death rate in Lothian was twice as high as the rate in Greater Glasgow and Clyde, although they are similar demographic areas. There are all sorts of underpinning trends in there that require to be addressed.

That is why it is important that there must be a real equality and a standard in the way that community pharmacies dispense methadone and in the services that they deliver. Those who have been dying of methadone not on a prescription have sourced that from somewhere. Unfortunately, it has probably come from those who were being prescribed methadone, so that standard is very important. In saying that, I do not take anything away from the tribute that Dennis Robertson paid to the commitment of community pharmacies. I have visited community pharmacies as well and I have seen that, and I understand that their commitment is very real.

Underpinning many of the recommendations is not just a legislative will. The reason why

Roseanna Cunningham could be so unadorned and frank in her speech is that there is appreciation in the Parliament that the subject should be approached on a cross-party consensual basis and that there is no mileage to be gained in exploiting bad news where bad news exists and requires to be dealt with. Underpinning many of the recommendations is not some legislation but a tremendous effort and commitment by human capital going forward in what is not a glamorous task. That represents a huge task, which we should appreciate.

Sandra White introduced the issue of prisons. Information that came to me that I found depressing suggests that, in Saughton prison, some 400 of the 800 inmates are on methadone. They rarely detoxify. There are only two full-time addiction nurses, who have a case load of 200 people each compared with, say, a case load of 30 to 50 in the wider community. That depressing fact is another example of the huge challenge that we need to tackle.

On a lighter note, Presiding Officer, when you said that you were unable to hear Jamie Hepburn, I was going to offer to swap seats with you. Of course, Mr Hepburn makes a profession of gently admonishing me in debates, so let me return the compliment by saying that today his contribution was a model, if not a triumph, of improvisation.

Willie Rennie told us about Phoenix Futures and how everyone was hugging each other as they came through the door. As a father with children, I would do much the same at the sight of a Liberal Democrat—particularly on "Scotland Tonight", I should say.

We heard from Stewart Stevenson about his personal experience in the reign of King James VI, while Jim Eadie and other members mentioned the need to tackle the stigma that substance misusers face.

I pay tribute to the work of the Scottish Drugs Forum and the addiction worker training project. I know that the minister has visited that project because on the wall there was a photo of her along with many of those there.

Without exciting the temper of the debate, I note that one thing that would most help women to recover would be greater childcare. I hope that we can resist making the obvious point in that regard in the context of this week. Anne McTaggart focused on the trauma that affects families and the circumstances that led to that trauma. Those families want to see a greater understanding, appreciation and projection of that into recovery and, as Willie Rennie said, recovery is an improving situation if we define it as such.

Elaine Murray and Graeme Pearson argued the Labour Party's amendment in constructive terms, and we are happy to support it. Fundamentally, the minister should know that she has the support of this party in the work that she and her colleague are doing.

16:41

Rhoda Grant (Highlands and Islands) (Lab): We welcome the review and its findings, which we hope will give a more consistent and rounded approach that has recovery as the main aim. We, too, want to see a clear commitment from the Scottish Government to improve the routes to recovery from drug addiction. That is why we are asking it to produce a timetable for action.

Many members, including Elaine Murray and John Pentland, have stated the obvious: we must have a person-centred approach. People's recovery is different because the causes and types of addictions are different, so if we do not have person-centred treatment available, the approach will not work.

People cannot be put into boxes; they need to be at the centre of and directing the care. Mary Scanlon made the point that, when we are looking to introduce a strategy, we must listen to drug users and recovered addicts because they are the experts. In summing up that concept, Graeme Pearson was right in saying that we need to be ambitious for people, do the best for them and allow them to enjoy their lives and their lives with their families. Those must be the aims of our approach.

We must realise that we are dealing with human beings who have issues that we must help them with. Families are also very much part of that—Christian Allard's speech about the impact of drug addiction on family and friends was not only moving but helpful to the debate. I recently met Scottish Families Affected by Alcohol and Drugs, and it pressed home that point. Sometimes it is the families who know what the causes are and are best placed to help with the recovery. They should be given the tools and the information that they need, made part of the process and allowed to fulfil that role, so that they are much better able to intervene when the time is right and to help people towards recovery, which was a point made by Gil Paterson.

A number of members talked about the age profile of people who have been addicted to heroin. It means those people's families, especially their parents, who are often the people looking after their children, are aging and are perhaps becoming disabled themselves due to old age.

There is an issue related to young carers that we must deal with clearly. They have a fear not just about being taken into care but about

accessing the available support because they need it for a parent's addiction. We need to look at a child-centred approach.

I remember walking into a chemist one day and seeing a young lad who was probably about 10 years old. As he saw me coming, he had on his face not embarrassment but absolute shame as he stood beside his mother who was being handed her methadone by the pharmacist. He was in dread of me being a part of that.

The experience brought home to me the impact of stigma—that young lad was aware of the stigma and what he thought my reaction would be. I felt that, as a society, we were really letting him down. He obviously did not have the support that he needed; he was living with stigma every day.

Jim Eadie and many other members talked about stigma. The United Kingdom Drug Policy Commission did a report that discussed the feelings of shame and worthlessness that are engendered through stigmatisation. Those families have an impact on people's self-worth. We cannot help people through the experience unless we build their self-worth. Families also describe being too afraid to reach out for help because they are too ashamed to speak to anybody about what is happening. If we do not deal with the stigma of drug abuse, we hamper recovery and prevent people from seeking help and, therefore, stop their journeys towards recovery.

As our amendment makes clear, we need not only to help people towards recovery but to tackle the causes of addiction. Many people talked about that. Gil Paterson talked about inequality, and he was right to do so, but there are also deeper causes, such as trauma and mental health problems, which Mary Scanlon mentioned. None of those is income related, but they are also causes of addiction, so we need to consider them all in the round and tackle them.

We need to tackle those issues for the people who suffer from addiction. As Willie Rennie said, the fear of recovery is great because, once people stop using the drugs that helped them to deal with the problems that caused their addiction, they have to go back and deal with those problems, which were insurmountable before and continue to be so unless they get the help that they need to deal with them.

The debate is really about opioid replacements. They have their place, as everyone has agreed. Of course, we need to make sure that the prescription is right. I represent many rural and remote areas where it is not possible for people to attend a pharmacy or access such treatments, and we need to consider different drug treatments.

That is especially the case for people who take prescriptions home with them and who share a home with children or to whose home children have access. Methadone causes respiratory depression, and if a child gets a hold of it by accident—that can happen, because children get everywhere—it can have a real impact on them.

We need to ensure that not only the people who need the prescriptions but the people who live with them are thought of in prescribing. We need to consider that as a matter of harm reduction to help stabilise people and to put in the necessary help and support. It is a question of dealing with the whole person and the causes of their addiction and considering how we can help them to come to terms with that.

Many speakers mentioned the area drug partnerships. As Graeme Pearson said, the Government needs to monitor the improvement in the area drug partnerships, because it is not fair that people do not have a quality of service. People need their issues to be dealt with. There must be national standards and—yes—local strategies, but they should be the same for everybody. People should not be involved in a postcode lottery that means that their addiction is dealt with differently and, indeed, their recovery is less because of where they live.

Many speakers mentioned pharmacies. We need to have a joined-up approach among social work, health, pharmacies and everyone else who deals with the issue. To go back to my point about the young lad, there must be dignity in the provision. There was no privacy for him or his mother, and that had an impact on their reaction to stigmatisation.

I could talk about many other issues and I could go on for ages, but I will not. We hope to see a timetable for the improvements that are outlined in the review, and I hope that that will give people real hope for their futures.

16:49

The Minister for Public Health (Michael Matheson): As some members have already said, this has been a largely consensual debate. Over my years in the Parliament, debates on drugs policy have been largely consensual, although last year's was not quite as consensual. It is good that there has been much more of a consensus this time.

Out of the people who I recognise have been engaged in the drugs debate in the Parliament over the past 14 years, a few notable individuals have not been able to participate in today's debate. One such person is Brian Adam, who is no longer with us; he would often participate in drugs debates. Another is Richard Simpson, who is unwell. Annabel Goldie has participated in drugs debates over the years; I suspect that she is

prepping for a visit to my constituency this evening.

The debate has been helpful in setting the drugs policy issue in the wider context of inequality in our society. Jackson Carlaw showed his age a little when he reflected on how, over the past generation almost, there has been a change in the way in which individuals have got into drug use. Some of the personal experiences that we heard about from members such as Christian Allard and Mark McDonald demonstrated that.

Over the years, I have lost a number of good friends as a direct result of drug use or through illness or violence associated with drug use. Some of them were my best friends at school; sadly, they are no longer with us. Many members have been touched by the damage that drug misuse can cause.

The report helpfully underlines that "The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem", which we published five years ago, is the right approach. It confirms that we are moving in the right direction, while highlighting some areas in which we face challenges and in which we need to take further action.

I want to pick up on a couple of issues. Mention has been made of the alcohol and drug partnerships and the health aspect. In particular, it has been identified that there can be inconsistencies among the 30 ADPs and in the way in which health boards deal with such matters.

Roseanna Cunningham and I are determined to do as much as we can to achieve a level of consistency, where possible. However, there is only so much that we can do. It is worth bearing in mind that ADPs are partnerships—they are partnerships that have been formed by local authorities, health boards and others in an effort to reflect most effectively what is needed in the local community. A top-down approach to prescribing everything that they must do on the ground is not necessarily the best approach, as it will not allow the necessary level of flexibility.

That said, as my colleague Roseanna Cunningham highlighted, ministers set a range of priorities that they expect ADPs to report on annually. That includes information on the health improvement, efficiency and governance, access and treatment—HEAT—standard, the Scottish drug misuse database, quality data in the national drug and alcohol treatment waiting time database and an increasing number of naloxone kits being made available. Some of those aspects can be measured, but it is worth bearing in mind that ADPs are partnerships and that we must allow a level of flexibility to reflect local need.

Willie Rennie: From what the minister sees in the NHS, does he think that enough senior people in the health service are committed to the job in hand? It is a huge job that crosses many departments and responsibilities in Government. Does he think that the NHS is pulling its weight?

Michael Matheson: I was going to come on to that in the next part of my speech, which is on health.

I think that, on the health aspect, we can get greater consistency because of the nature of the way in which we configure health services in Scotland. As Roseanna Cunningham did, I have set out that I am clear that I want to see much greater leadership on this issue in the NHS.

When I met primary and secondary healthcare teams a few weeks ago to discuss an aspect of the report, I made it clear that I expected all the boards to have an accountable officer at a decision-making level who could take responsibility and show leadership in this area of policy. That work is now taking place, and we expect all boards to demonstrate that they are doing that and to select the right individual.

We can do more, and I am determined to ensure that we do more and that someone is accountable for ensuring that the work happens. I do not want to prescribe whether that should be a director of public health or a medical director, but the person must be sufficiently senior to bring about the change that is necessary.

I will pick up on an area where we can get greater improvement. Elaine Murray talked about access to psychological services, which can be challenging at times and has been so for many years. That is why we are bringing in a HEAT target on psychological services. It will come into force from December next year, and it will ensure that we have a clear timeline for those who are referred for access to those services.

The availability of psychological therapies has increased across the country and work is on-going to support more of that. That is an example of where we can get more consistency across the country by setting a clear national standard.

A key part of dealing with the health challenges that the expert group's report highlights is ensuring that GPs are properly engaged in the process. Primary care is central to how we deliver aspects of the drug recovery model, but there are challenges in doing that, because GPs are independent contractors. We must look at how we can build the approach into their contract, but it is not in the Government's gift just to say that that will happen. We must negotiate with the profession and look at taking the issue forward.

Given what I have said, and although I am keen to have a consensus in the debate, we cannot accept the Labour amendment. That is not because of its main content but because of its final element, which is on setting a timeframe. I am not in a position to set a timeframe for getting a national agreement with GPs; I wish that I was, but the reality is that I am not. It would be false of me to indicate that I could do that, but I can say that the issue is on our agenda and is part of the discussions that we are having. We wish to strike a consensus, but it is a fact that we cannot set a timeframe.

John Finnie: I recognise what the minister says about GPs. Does he acknowledge that a ministerial lead would be needed? He would have to initiate measures such as prescribing heroin, supervised injection and testing for street drugs.

Michael Matheson: Taking forward such issues with GPs as part of the general medical services contract involves negotiation. We would have to explore the questions. As I said, the issues are very much on the Government's agenda, and we have to work with colleagues to take them forward.

I turn to prescribing through our community pharmacy services. Willie Rennie and Jackson Carlaw made the point that community pharmacies play an extremely important part in the jigsaw of the recovery model. Some of the publicity and language last year about the methadone programme through our community pharmacy provision was unfortunate. Thankfully, we have moved beyond that.

In September, we published "Prescription for Excellence", of which a key part is developing and implementing NHS standard specifications on alcohol and drug services and, in particular, pharmaceutical services, which will help us to drive forward improvements in standards. We all recognise that community pharmacies have a role to play in delivering an effective recovery model under drugs policy in Scotland.

Mary Scanlon asked whether individuals who are on the methadone programme are tested monthly for compliance. I appreciate the logic of that suggestion, but the recovery model is such that people often slip back. The suggested approach of testing every month is recognised as not being valuable and can undermine the recovery model. It is resource intensive and it does not demonstrate much in the way of outcomes. However, I appreciate Mary Scanlon's point that we must ensure that the system has proper checks.

That brings me to my final point, which is the need to make sure that we measure what we are getting from the system. Graeme Pearson is right that we need to be sure that we are clear about what we get from the drugs policy that we are pursuing. The improvement methodology that we are setting out as part of our response on this particular policy will help us to achieve that.

I believe that the report helps us to build on the good progress with drugs policy that has been made in recent years. The consensus that has been struck today gives me strength in knowing that a joint effort is being made across all parties to make sure that we build on the progress. I hope that we have demonstrated to members that Roseanna Cunningham and I are committed to making sure that we take the joint working across Government to build on the good progress that we have been making.

Point of Order

17:00

Johann Lamont (Glasgow Pollok) (Lab): On a point of order, Presiding Officer. Today at First Minister's question time, the First Minister said that he had a letter from the European Commission's secretariat-general that implies that an independent Scotland could apply for European Union membership from within. He omitted to say a number of other things about that letter. He omitted to say that it goes on to undermine entirely the points that the First Minister made. He omitted to say that it was not a response from the EC to the Scottish Government. As the First Minister's official spokesman confirmed this lunch time, the First Minister omitted to say that he does not know who the letter was sent to or what that person asked, and that they had found this random letter through a trawl of the internet.

Presiding Officer, I believe that the First Minister's use of that letter was an attempt to deceive the Scottish Parliament and the Scottish people. Can the Presiding Officer tell me whether government by Google is in order?

The Presiding Officer (Tricia Marwick): As the member is aware, and as I have said again and again, as recently as yesterday, the Presiding Officer has never been, is not, and cannot be responsible for the contents of members' speeches in the chamber.

Decision Time

17:02

The Presiding Officer (Tricia Marwick): There are two questions to be put as a result of today's business. The first question is, that amendment S4M-08422.1, in the name of Elaine Murray, which seeks to amend motion S4M-08422, in the name of Roseanna Cunningham, on the independent expert review of opioid replacement therapies in Scotland, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Hilton, Cara (Dunfermline) (Lab)
Kelly, James (Rutherglen) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Urquhart, Jean (Highlands and Islands) (Ind)

Against

Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)

Campbell, Aileen (Clydesdale) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hume, Jim (South Scotland) (LD)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Johnstone, Alison (Lothian) (Green)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McDonald, Mark (Aberdeen Donside) (SNP)
McInnes, Alison (North East Scotland) (LD)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Rennie, Willie (Mid Scotland and Fife) (LD)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Salmond, Alex (Aberdeenshire East) (SNP)
Scott, Tavish (Shetland Islands) (LD)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Presiding Officer: The result of the division is: For 43, Against 65, Abstentions 0.

Amendment disagreed to.

The Presiding Officer: The next question is, that motion S4M-08422, in the name of Roseanna Cunningham, on the independent expert review of opioid replacement therapies in Scotland, be agreed to.

Motion agreed to,

That the Parliament notes the August 2013 publication of the report and findings of the independent expert group on opioid replacement therapies commissioned by the Chief Medical Officer and led by the independent Drugs Strategy Delivery Commission; endorses the expert group's conclusion that opiate replacement therapies have a strong evidence base, should be retained in Scottish services and should be delivered as part of a coherent person-centred recovery plan; agrees with the six priority themes identified in the report and calls on members to endorse an improvement approach, as enshrined in the "three-step improvement framework for Scotland's public services", at national and local level to address health and social inequalities for people affected by drug problems in Scotland, address variability in service provision to ensure that high quality recovery-oriented systems of care are in place across Scotland that recognise the contribution of primary and secondary care, continue to improve the governance and accountability of the delivery system and further develop information, research and evaluation systems on substance misuse at a national level; recognises the role and contribution of the workforce in delivering a recovery-oriented system of care in Scotland, and supports the continued development of all those working to make recovery from problem drug use a reality.

Meeting closed at 17:03.

Correction

The First Minister has identified an error in his contribution and provided the following correction.

The First Minister:

At column 25054, paragraph 5—

Original text—

Drew Smith's colleagues have in mind cutting the 9.3 per cent to about 8.3 per cent, which would be £4 billion less.

Corrected text—

Drew Smith's colleagues have in mind cutting the 9.3 per cent to about 8.7 per cent, which would be £4 billion less.

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e-format first available
ISBN 978-1-78392-201-7

Revised e-format available
ISBN 978-1-78392-215-4

Printed in Scotland by APS Group Scotland