OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

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

Thursday 14 November 2024

The Scottish Parliament
Pàrlamaid na h-Alba

Session 6

Thursday 14 November 2024

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35th Meeting 2024, Session 6

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CONVENER

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

DEPUTY CONVENER

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

COMMITTEE MEMBERS

*Jeremy Balfour (Lothian) (Con)
Katy Clark (West Scotland) (Lab)
*Sharon Dowey (South Scotland) (Con)
Joe FitzPatrick (Dundee City West) (SNP)
Sandesh Gulhane (Glasgow) (Con)
Emma Harper (South Scotland) (SNP)
Fulton MacGregor (Coatbridge and Chryston) (SNP)
Gillian Mackay (Central Scotland) (Green)
Rona Mackay (Strathkelvin and Bearsden) (SNP)
Ben Macpherson (Edinburgh Northern and Leith) (SNP)
*Marie McNair (Clydebank and Milngavie) (SNP)
*Pauline McNeill (Glasgow) (Lab)
Carol Mochan (South Scotland) (Lab)
*Paul O'Kane (West Scotland) (Lab)
Liz Smith (Mid Scotland and Fife) (Con)
David Torrance (Kirkcaldy) (SNP)
Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Richard Foggo (Scottish Government)
Neil Gray (Cabinet Secretary for Health and Social Care)
Maggie Page (Scottish Government)
Annie Wells (Glasgow) (Con) (Committee Substitute)

CLERK TO THE COMMITTEE

Bruce Alex
Stephen Imrie
Claire Menzies

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Criminal Justice Committee

Thursday 14 November 2024

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Audrey Nicoll): A very good morning, and welcome to the second joint meeting in 2024 of members of the Criminal Justice Committee, the Health, Social Care and Sport Committee and the Social Justice and Social Security Committee to consider the progress being made in implementing the recommendations of the Scottish Drug Deaths Taskforce.

Our first item of business is to decide whether to take in private items 3 and 4, which are to review today's evidence and to receive an update on the work of the people's panel. Are we agreed to take those items in private?

Members *indicated agreement.*

Tackling Drug Deaths and Drug Harm

09:30

The Convener: Our main item of business is an evidence-taking session on tackling drug deaths and drug harm. I am very pleased to welcome Neil Gray, Cabinet Secretary for Health and Social Care, and from the Scottish Government, Mr Richard Foggo, director of population health, and Ms Maggie Page, unit head, drug strategy unit. I refer members to papers 1 and 2.

I am grateful to the cabinet secretary for providing some written evidence in advance and invite him to make some brief opening remarks.

The Cabinet Secretary for Health and Social Care (Neil Gray): Thank you very much, convener, and good morning, colleagues. I really appreciate the opportunity to answer your questions today.

I want to begin by wishing Christina McKelvie all the very best in her treatment. We look forward to her return as Minister for Drugs and Alcohol Policy.

We launched the national mission to reduce drug-related deaths in 2021. Since then, the Scottish Government and our partners have worked tirelessly to bring innovative, structural change to that complex emergency, and we remain fully committed to reducing drug deaths and harms. Backed by £2 million of investment from the Scottish Government, a safer drug consumption facility, the first in the United Kingdom, will open soon in Glasgow. That landmark evidence-based service, which was co-designed with local people using substances, will help protect those who are most vulnerable from overdose and reduce harm.

It is, however, just one of the programmes of work that we have been taking forward. I would like to use this opportunity to outline the wider action that we are taking to reduce harm and to improve the lives of people and communities that are impacted by drugs and alcohol.

On 31 October, Audit Scotland published a report on drug and alcohol services, which acknowledged that we have "improved national leadership" and have made significant progress in tackling Scotland's long-standing issues with drugs and alcohol, notably through significant investment and innovative action in our national mission. That action includes widening access to life-saving Naloxone, expanding treatment capacity and increasing access to residential rehabilitation.

However, despite all the progress, there is more to be done. The report specifically draws attention to work on local accountability, so we are stepping up our work with local leaders to strengthen accountability against national and local outcomes. It also highlighted the need for a "whole-systems approach" and "more preventative" action, and I assure colleagues of the Government's commitment in that area.

Our response to the Scottish Drug Deaths Taskforce's recommendations has delivered progress, for example, the publication this September of the mental health and substance use protocol and our work to implement the "Drugs and Alcohol Workforce Action Plan 2023-2026", which was published in December 2023. Our whole-systems approach to prevention aligns with our wider vision for health and social care—that of a Scotland where people, including those with drug and alcohol dependencies, live longer, healthier and fulfilling lives.

There is, however, clearly still more to be done. The first years of the national mission were about laying the foundations; we are now committed to building on those foundations while responding to new threats and challenges, such as the emergence of novel, stronger synthetic drugs, which pose increased risks to our communities.

Scotland's drug and alcohol deaths remain too high—I am absolutely clear on that point. Each death is a tragedy—a life lost too soon—and it will be felt dearest by the families concerned. However, we are driven by a steadfast belief in the necessity and possibility of change, and we remain fully committed to delivering on our commitments.

I look forward to the opportunity to provide fuller updates during the meeting.

The Convener: Thank you, cabinet secretary. I put on record the committee's warm wishes to Christina McKelvie.

Cabinet secretary, I want to open the questioning by asking for an update on the drug checking pilot project, which we have looked at in the past during the joint committee's evidence sessions. We are aware of a number of projects that are under way across Scotland, and I would be interested in receiving an update on the expected timescales for decisions on the Home Office licence application process and the subsequent establishment of drug checking facilities in each of the pilot areas. In that respect, I draw the cabinet secretary's attention to comments from Kirsten Horsburgh of the Scottish Drugs Forum, who, at our last meeting, welcomed the pilot, but was keen for progress to be made, particularly on the timescales for its establishment.

Neil Gray: I do not have a specific timescale that I can articulate to you, convener, because the matter is still subject to negotiation and discussion with the United Kingdom Government. We have had constructive discussions with the Home Office on the drug checking pilot, and our interaction with it is important. We certainly believe that the evidence points to its being another harm reduction measure that can make a difference in saving people's lives. It is linked to some of the work on the rapid action drug alert and response—or RADAR—system to identify issues with regard to the supply of drugs and to give people a greater understanding of what they are purchasing and, therefore, what they are using.

We want to take forward the pilot sites in Aberdeen, Dundee and Glasgow, and that, alongside the safer consumption facility, will help us take forward our work on the basis of harm reduction, and give people the opportunity to access treatment as a result. As with the safer consumption facility, signposting would be available to help people move towards recovery opportunities. Predominantly, it is all about ensuring that we reduce harm.

The Convener: The committee would welcome an update on potential timescales, if possible.

Neil Gray: I would be happy to provide that, convener.

The Convener: There is a lot of interest in this issue, and there are many areas to cover. I now open it up to questions from members.

Marie McNair (Clydebank and Milngavie) (SNP): Good morning to the cabinet secretary and his officials. With the election of a new UK Labour Government in July, I am interested in hearing about any discussions that have taken place with it on its position on safer drug consumption facilities, drug testing and related issues. If you have not had those discussions, do you have plans to do so in the future?

Neil Gray: I met the new Secretary of State for Health and Social Care, Wes Streeting, pretty early in his tenure, and we are due to meet again soon. However, the issues that we are discussing were not covered in our ministerial discussion.

I will bring in Richard Foggo to talk about interactions that officials have had, but I think that it is safe to say that there is greater recognition from the new UK Government of the importance of taking a harm reduction, public health approach to tackling the issue of reducing drug and alcohol-related deaths. I am hopeful that we will have a constructive relationship on that basis to allow us to see progress on some of the areas that we are discussing. Those areas will include the safer consumption facility and the drug-checking facility, which the convener asked about, but I hope that

the interaction of those things with reserved legislation will be open for discussion, too.

Richard Foggo (Scottish Government): Just last week, I met Sir Matthew Rycroft, the permanent secretary at the Home Office, to form initial relationships. Sir Matthew was in Glasgow specifically; we had hoped that he might have been able to visit the Hunter Street centre and the new facility, but that was not possible. At that meeting, we covered a range of issues, including the overall strategic relationship. The UK Government is establishing its own health mission, so there is a wider set of issues around social determinants that is very much relevant to our work on poverty.

Much more specifically, we were able to offer Sir Matthew a clear briefing on the new facility and to inquire after the issue of drug testing. At this stage, it is not appropriate for us to press the matter, as it is for the Home Office to proceed on that, but we were able to cover the new safer drug consumption facility and the drug-checking facility. We also had the opportunity to discuss the threat of synthetics, and the joint work that we need to do, through the task force on synthetics, to prepare and respond collectively to those new threats.

In the past few days, therefore, we have had a good and constructive discussion at the highest level, with the permanent secretary of the Home Office.

Marie McNair: There are three drug-checking facilities in Scotland. I know that they are part of a pilot, but is there any scope to include additional facilities if they are required?

Neil Gray: I know that there is interest in other areas; Edinburgh is looking closely at such facilities, too. The scheme is a pilot, so we are starting from a smaller place. If it is successful, we can, based on the test-and-learn process, build it up from there.

If it is successful, I expect that we will consider wider participation in addition to the facilities in Aberdeen, Dundee and Glasgow. Those cities have particular challenges, but the issue is facing all communities across Scotland.

The Convener: I will bring in Clare Haughey and then Sharon Dowey.

Clare Haughey (Rutherglen) (SNP): Good morning to you, cabinet secretary, and to your officials. I put on record a declaration of interest, as I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

Thank you for the update that you provided in your letter to the committee about the stigma action plan and the on-going work to address and challenge stigma. Can you give us a bit more detail about that work, and perhaps set out some of the timescales for implementing the plan?

Neil Gray: I will bring in Maggie Page to talk about that area in a moment.

In the discussions that I have had with family members—those who are currently experiencing having a family member with a drug dependency and those who have lost a loved one through drug-related death—they tell me that stigma is one of the areas in which the national mission has been of greatest importance and where it has made the biggest strides. The shift in that respect, allowing people the space and the opportunity to feel confident about accessing services, both for themselves and their family members, has, they tell me, been incredibly important.

I felt that particularly keenly when I visited the service in Dumbarton, and during the private session that the First Minister and I had when the travelling Cabinet visited Ayr last week. Family members believe that the reduction in stigma is having a major impact on people feeling able to come forward.

That is why it is so important that we take a public health approach to the issue, as opposed to a justice approach. It is about keeping people in their communities and supporting them with some of the issues that underlie their drug, or indeed alcohol, dependency. As Richard Foggo has set out, it is important to acknowledge the clear correlation with poverty.

I will bring in Maggie Page to talk about the timescales in order to address Ms Haughey's specific question.

Maggie Page (Scottish Government): The issue of stigma is a cross-cutting priority for the national mission; indeed, it cuts across all that we do, and the stigma action plan should be seen not in isolation as a plan in and of itself, but as part of something much wider.

We have already invested more than £3 million in ensuring that people with lived and living experience are genuinely at the heart of everything that we do. The stigma action plan, which was published in January 2023, is now being delivered alongside the national collaborative's work, which is due to be published later this year. A change team has already been recruited, and it is operating to make sure that a co-production approach is taken to implementing a national programme. The change team has met on two—or possibly three—occasions already and is taking that work forward.

In addition, our workforce development action plan is a key pillar of the stigma work. Stigma in the workforce, and the challenges that people face in accessing services—not just drug and alcohol

services, but care and public services more widely—are important aspects, and it is important to view that work in the round with the other work that is happening.

09:45

Clare Haughey: You will be aware that the three committees commissioned a people's panel, which met last month, and some panel members were interested in the role that the media play in reinforcing stereotypes. I am interested, therefore, in hearing what other work, alongside the stigma action plan, is being carried out on that particular issue, which might in itself be a barrier to people accessing treatment and help.

Neil Gray: Ms Haughey touches on an important issue. We all have agency in respect of tackling stigma, with regard to the language and terminology that we use and the recognition that drug or alcohol dependency is a health issue. Government can show clear leadership in that regard, and we are trying to do so.

Nonetheless, there is a role for, and a responsibility on, those who report the news to be cognisant of not only the people who have a drug or alcohol dependency, but their family members. They should ensure that the language that is used to describe those issues does not create greater barriers, or maintain barriers, that prevent people from feeling that they are able to access treatment. That is the stigma issue.

We need to move on from the stereotypes and some of the language that is and has traditionally been used in this area. That is clear in the language that we in Government use, and in how we approach the issue, and I believe that we are making progress on that as a Parliament, too. However, you are right that all of us, including our colleagues in the media, have a role to play in that regard.

The Convener: I call Sharon Dowey, to be followed by Annie Wells.

Sharon Dowey (South Scotland) (Con): Good morning, cabinet secretary and officials. I have some questions on Audit Scotland's "Alcohol and drug services" report, which was published recently.

Do you accept all the recommendations in the report, and can you give us an update on any progress that has been made on those recommendations?

Neil Gray: We are considering the recommendations carefully. There is a lot in the report that demonstrates the progress that we have made already. Some of the recommendations, such as strengthening local leadership and providing greater transparency, are areas in which we are already developing work. We welcome the report, and we are still considering our direct response to each individual recommendation, as the report was published only on 31 October.

We take seriously all the commentary that comes from Audit Scotland in general and in this area in particular. We will consider all the recommendations carefully and respond in due course.

Sharon Dowey: You are considering them just now, so you cannot say that you fully accept them.

Neil Gray: It is important to proceed as I have just set out. There are recommendations in the report on which we are already making progress. I accept those areas of challenge, including around local leadership, that need to be addressed.

I welcome the report in general; it recognises—as I said in my opening statement—the national leadership that has been provided and the progress that is being made, and the progress that has been made through the interventions from the Scottish Drug Deaths taskforce.

We will respond more formally in due course, but I do not think that the committees will see much challenge from us to the report, if I can put it that way. We will take seriously the recommendations that are in there.

Sharon Dowey: The report says:

"Funding for tackling alcohol and drug harm has more than doubled over the last ten years",

but it goes on to say:

"However, ADPs have seen an eight per cent decrease in real terms funding over the last two years",

It also states:

"The Scottish Government has yet to undertake an evaluation of the costs and effectiveness of alcohol and drug services to determine if they are delivering value for money",

and it highlights as important the need to ensure

"that ... funding is directed in the most effective way."

I have heard people describe the funding landscape as like spaghetti: when they try to find help or a pathway, there are a lot of groups that are trying to help people, but it can be confusing. What is the Scottish Government doing to ensure that we are putting the funding into the right areas? The level of drug and alcohol deaths in Scotland is still far too high.

Neil Gray: Ms Dowey touches on an important issue, which is the focus that is required. The Audit Scotland report recognises the national leadership and our consistency in setting out what we expect; it also recognises that there is more

work to be done to provide that consistency at a local level.

I spoke earlier about the foundations that have been put in place through the national mission. Our work now is about building on that and ensuring that we are able to provide consistency.

We have provided record levels of funding to alcohol and drug partnerships, with £112 million this year; around £50 million in recurring funding; and the national mission funding. We want to ensure that there is consistency in that regard, but I also recognise the local decision making at ADP level. We will bring forward further recommendations on providing consistent standards—I will bring in Richard Foggo to provide greater clarity on that point.

Richard Foggo: One of the key points is that we cannot view the services in isolation. One of the problems, as Ms Dowey identifies, is fragmentation, which requires us to look beyond the alcohol and drug services themselves.

One of the critical things that we are trying to do in relation to the national mission is make those connections. A critical recommendation from Audit Scotland was about taking a wider whole-systems approach. Through the work that we are doing locally, in areas such as Glasgow in particular, around supporting and enabling public sector reform, we are ensuring that alcohol and drug services are part of that consideration. We are ensuring that they are person-centred, rights-based services that are trying to move away from the stigma and the fragmentation.

I absolutely recognise where Audit Scotland is coming from, but the key point is that we need to look at the wider context, not just at the alcohol and drug services. We accept that those services are fragmented, so we are supporting local partners through our work, through investments and through the fairer futures partnerships that we are developing.

Alcohol and drug services are central to that work, because that is where we bring in the other services that will be so critical to making progress in this area. That can include housing services or, more broadly, service provision in areas such as transport.

I assure the committees that we are looking at these issues in the round. That is absolutely based on the insight that Audit Scotland has offered us with regard to the need for a whole-systems approach to how we support alcohol and drug services. I offer an assurance that we are looking at these issues in broad terms.

Sharon Dowey: That sounds good, and there are a lot of buzzwords in there. You said that there is a record amount of funding going into ADPs, but the report says that

"ADPs have seen an eight per cent decrease in real terms".

We are putting a lot of money in, but we are not seeing any improvement in the figures—the numbers of people who are actually losing their lives.

Are you telling me, "Right—we've cut money for the ADPs, but we've now directed money to somewhere else and that's why we are seeing a cut for ADPs"? Can you tell us about any specific actions that you are taking in that regard?

Neil Gray: Yes. We will continue to work with local systems on ensuring that the money that is provided for ADPs is spent on the services that we would expect to be delivered.

ADP funding has doubled, as Ms Dowey recognises, and as is covered by Audit Scotland. There has been an increase in ADP funding, and that is provided both through the regular funding for alcohol and drug partnerships and through the increase that has been provided from the national mission funding.

There is local decision making at play here, and I do not want to cut across that, nor disrespect the principle of local decision making itself, as Ms Dowey will recognise. However, we are looking at how we can work with local systems. I have a wider interest, beyond this policy area, in our health and social care partnerships on issues such as social care and making sure that there is transparency about where the money is going so that services are tailored to the people who need them. That is as true for social care as it is, in this case, for people seeking alcohol and drug services.

Sharon Dowey: The report also lists three areas in drug services where progress has been particularly slow: publishing a mental health and substance use protocol; delivering a stigma action plan; and implementing a drugs and alcohol workforce action plan. Will you give us an update on the progress on those and the reasons for the slow progress? Again, a lot of money is going into this, and many other areas would love to have that budget. What progress are we making, and why is it so slow?

Neil Gray: We are making progress on the stigma action plan, as Maggie Page set out. The workforce plan—I will be corrected if I am wrong—is being progressed at the end of this year, and we are coming forward with more advice there. There is work in train on all three areas, and I would be happy to provide the committees with more information on that if it is not in the written evidence that I provided previously.

The Convener: Before I bring in Annie Wells, I have a quick supplementary question on funding. I am a bit like a broken record when it comes to the issue of multiyear funding. I know that there are some signals that the new UK Government is slightly more willing to look at the option of multiyear funding. All committees hear about the benefit of multiyear funding, and Mr Foggo's point about whole systems working together is certainly relevant to that in the criminal justice space. Notwithstanding the point that the cabinet secretary made about local decision making, would the Government want multiyear funding in this space, given the significant role that the third sector plays in the area?

Neil Gray: Absolutely, convener. You have hit on an incredibly important area, particularly for the community and voluntary sector. As a Government, we would appreciate a greater line of sight on what budgets will look like, which would help us with our aspirations to provide multiyear funding settlements. We recognise that those who deliver statutory services would also benefit from that.

We are making some progress in that space. The funding that we provide to the Corra Foundation is an example of that. That is the route through which we are providing support for community and voluntary organisations to develop their services. I will bring in Maggie Page to develop that point.

Maggie Page: As the cabinet secretary says, the Corra Foundation funding, which is £13 million a year, is in recognition of that challenge, particularly for third sector and smaller third sector organisations. We made a decision that the Corra Foundation funding would be multiyear, so, where appropriate, many of those programmes are funded on a multiyear basis.

In addition, we provided written updates to the committees on the breakdown of our budget, and you will see that, of the £112.9 million that goes out to ADPs, around £56 million is a baseline allocation that goes out via health boards. That gives ADPs more security—and there is more dependence on that. In recognition of that, and having worked with ADPs and received their feedback, we are baselining further funding from the drug and alcohol policy budget in order for them to be able to forward plan and recruit effectively.

We are very conscious of that challenge, and we have taken many steps to be able to provide that assurance, but we operate within an annualised budget, so we are limited in how much we can do.

The Convener: That is very helpful. I will bring in Annie Wells and then Pauline McNeill.

Annie Wells (Glasgow) (Con): Good morning. I am sure that it will come as no surprise to the cabinet secretary that I will ask about residential rehabilitation. How many beds are available in Scotland, and how many are in use at the moment?

Neil Gray: I will get Maggie Page to provide the exact number. The most recent increase that we gave to funding residential rehab was £38 million, providing an increase of 140 beds. Public Health Scotland has estimated that, in the most recent period for which we have data available, 938 people have been publicly funded to go through residential rehab. We can say with confidence that we are on track to meet the commitment that 1,000 publicly funded spaces a year will be available.

10:00

That is an important aspect of the wider commitment that we are making, because there is no single route by which people can achieve recovery. As Ms Wells will testify, there will be different circumstances at play for every person who has a drug or alcohol dependency. It is therefore important that we take a person-centred approach. We need to provide a balance and make available a range of harm reduction and treatment, so that we can give people the opportunity to find a way to recover at a pace that suits them. That includes the Corra Foundation support that we are providing.

Maggie Page will be able to provide you with the exact numbers of what we have.

Maggie Page: Through our investment in increasing capacity through eight programmes, we hope to see an additional 140 beds, which will go towards our target of increasing the number of beds by 50 per cent to 650.

I cannot tell you exactly how many people are in beds in services right now—I always think that it is strange to say "beds", because that is not really how residential rehab works, but it is our unit of measurement—because we do not have live recording of that. However, we are commissioning analysts within the Scottish Government to do another capacity audit. We did one around the start of the national mission as a baseline, and work is now being done to see how much progress we have made.

From our investment through the rapid capacity fund, we know that 36 of those beds are already operational, and that a lot of other beds are due to come on stream as and when those projects finish.

Taking all that into account, we know that, through our investment in supporting additional

placements, which has created more demand, other beds have been created in services. The mapping exercise will be able to give us a better understanding and we will naturally share that as soon as the work is finished.

Annie Wells: Thanks very much for that. That is really helpful.

The target and ambition is that 1,000 people will be publicly funded by 2026. You have spoken about 938 people being publicly funded this year, but is 1,000 the right number? How did we come to the figure of 1,000?

Neil Gray: I will be honest. I do not know why 1,000 was set as the target, and whether that is the right measure of—I do not think that "success" is the right word, but I think that Ms Wells understands where I am coming from. That target predates my involvement, so I do not know why it is 1,000.

What we can demonstrate is the clear progress that is being made on the availability of residential rehab. Audit Scotland recognised that in its report, to go back to Ms Dowey's line of questioning.

We need to demonstrate that we are making progress across all areas. We are reducing stigma, thereby giving people the opportunity to access support and breaking down the barriers to that support, as well giving their families the opportunity to receive support. The progress that has been made in access to residential rehabilitation beds is a sign of that progress.

Again, as I say, I honestly do not know the reason behind 1,000 being the target, and it will be for us all to judge whether that is the right measure. The important thing is that demonstrable progress is being made in availability and in the capacity of the system, and that is clear.

Annie Wells: I have one more small question. It would probably be useful if we could find out how many beds there are in each health board area—or perhaps we could split it up into regions. It would be a useful for us to know that, because we know that Glasgow and Dundee have more issues and have been impacted more. It would be useful if we could get that information. I know that you probably will not have it today, but if we could get it, that would be helpful.

Neil Gray: I expect that that will form part of the audit work on bed availability that Maggie Page referred to. If we have further detail at local authority or health board level once that work is complete, we will certainly seek to provide that to the committees.

The Convener: We turn to questions from Pauline McNeill and then Paul O'Kane.

Pauline McNeill (Glasgow) (Lab): I want to follow on from Annie Wells's line of questioning, because she asked what I think is an essential question about demand. We acknowledge the progress that has been made; however, we do not know what the demand is, so it is important to establish that. I know that there are many ways of approaching that question, but to what extent do you think that access to rehabilitation programmes is central to tackling drugs deaths?

Neil Gray: It is one aspect. The idea of getting it right for everyone is central not only to this policy area but to the wider health and social care policy work that we are taking forward. We must recognise that residential rehab will not work for everyone and that the abstinence route will not be the right route for everyone. Access to rehab is a central part of our national mission, as has been demonstrated by the investment we have made, but it is only one part. There are other elements, including the investment in the Corra Foundation to support community and voluntary elements.

Pauline McNeill: I understand that, but I want to get a sense of how important and central you think access to rehab is. At some point, we need an answer to the question about demand.

I do not know how easy it is for drug users to access rehabilitation, although I am quite familiar with how difficult it is for those who are dependent on alcohol to access such facilities or to know who to call. What is the pathway? Are you satisfied that it is clear? People might be on their own, because they do not have family support or because their family might not be able to cope any more. Are you clear about how easy it is to access facilities?

Neil Gray: Ms McNeill touches on another really important area, which is the awareness and availability of services. Given that the question is about residential rehab, I again think back to my interaction with families who have a loved one or family member currently experiencing drug or alcohol dependency or who have lost loved ones to drug or alcohol dependency. Their lived experience is of prime importance and those families take a very clear view that availability of rehab and the awareness of the routes to that are improving. That is not to say that everything is all right or perfect, but it is improving.

As for access to residential rehab, medical professionals carry out clinical assessments as to whether such an approach is appropriate for a particular person. I think that Ms McNeill will recognise that it would not be right for me to interfere with the clinical decision-making process, but I do think we must ensure wider awareness in the health service and in community services of the availability of rehab and of what might be right for a particular person if that is not the right route.

I go back to Ms Dowey's questions on the need for clarity about what is available in communities and the role of alcohol and drug partnerships and community organisations that help with signposting. The next stage will be to ensure that we can give people a clear picture, so that, if one particular route to recovery is not right for them, they can be aware of other opportunities.

Pauline McNeill: I might come back on the point about medical assessment at a future date. It is worth considering whether there might be any blockages facing someone who comes forward because they think that they need help—that is, the possibility of their being rejected after making such a big step, just because of a medical assessment. As I have said, I might come back to that at another date.

I also want to ask about the fact that men are twice as heavy users of services. I do not detect a lot of discussion about the approach that we should take, given that high numbers of men are harming themselves. How is that factored into the approach that you are taking to drug misuse and stopping drug deaths?

Neil Gray: I will come back to the first point that Ms McNeill made, and then I will address her second point, on the gendered aspect. I will bring Maggie Page in on both questions, too.

On the first point, constituents have come to me who are in exactly the situation that Ms McNeill has outlined. They believe that residential rehab is right for them, but clinical decisions have been made that make that more challenging.

That touches on some of the work that we are seeking to do to provide clarity and ensure that guidance is in place with regard to people who present with both mental health and substance dependency issues at the same time. I am clear that we must support people to tackle both issues concurrently, as they drive one another—the substance dependency drives the mental health issues, and vice versa. We need to be clear on that, and I certainly believe that we need to support people in both aspects. I would be happy to return to Ms McNeill's points in that regard.

On the gendered aspect of this issue, Ms McNeill is absolutely right. The figures are clear on the level of drug deaths among men, and indeed on the prevalence of poverty and the correlation between people living in poverty and the impact of that in terms of substance abuse. I will bring in Maggie Page to talk about this, but we have been developing work on how we target men to ensure that they understand what support is available.

Again, that brings us back to the landscape of destigmatisation, which is so important when it comes to men's interaction with health services. Mr Sweeney and I are currently participating in Movember, because we need to promote greater awareness among, and provide a greater level of comfort for, people with regard to the need to interact with health services, regardless of how uncomfortable it might be to talk about health. Over the past couple of weeks, Chris Hoy has demonstrated the importance of doing that when it comes to prostate cancer, and it is just as important in this area with regard to the drivers of drug dependency among men and the mental health aspects in that respect.

I will bring in Maggie Page to talk about the specific action that we have been taking in that area and the work that is developing there.

Maggie Page: We know from the drug deaths data that around two thirds of such deaths are males and one third are females. Looking at the longer-term trend, however, we have moved on from the previous situation, in which drug deaths were roughly around one quarter female and three quarters male. We have, therefore, seen a disproportionate increase in drug deaths in women in comparison with men, but men still dominate.

That means that men dominate services, too. We have done a lot of work on looking at the needs of women and, through that, looking at taking a gendered approach to what both sexes need. That has been enlightening and has enabled us to understand that there are different drivers and different needs, and that the sexes face different challenges. That work has been relevant for both sexes; although a lot of it has been about looking at the needs of women, a distinction has been made between the two.

The Convener: Bob Doris, do you want to come in with a follow-up question?

Bob Doris (Glasgow Maryhill and Springburn) (SNP): Just briefly, convener. I apologise for my delay in attending the committee.

In her line of questioning, Pauline McNeill has interrogated an important aspect of this issue—the pathway into residential rehab. There are two things here: what is or is not clinically appropriate, which the cabinet secretary referred to, and I go back to the point that Annie Wells made about availability and access.

What data does the Government, or the services, hold on the numbers of individuals presenting and requesting rehab, and on where rehab has been determined not to be clinically appropriate? I know that some individuals will dispute whether such a decision is accurate—that is just the world that we live in—but we do need to look at the lack of access to services.

After all, there are two reasons why someone will not get a rehab bed—although I know that Maggie Page does not like to use the word "bed".

One is that it is deemed not to be clinically appropriate, and the other is that the resource is not there. Is that mapped out? Do we have statistics in relation to that?

10:15

Neil Gray: Again, I will bring in Maggie Page to develop the point.

Mr Doris touches on an important consideration. I am not familiar with the specifics, but I do not think that the Government holds data on that area, and whether individual ADPs or health and social care partnerships hold it is a question to be answered.

In response to that line of inquiry, however, I absolutely see merit in looking at whether we could take this matter forward and develop it further to ensure transparency around not only availability, but clinical decision making. I will bring in Maggie Page, as she might be able to provide greater detail on that.

Maggie Page: Essentially, our residential rehab programme has three broad strands. One is on increasing the number of people going in, by funding placements, and another is on improving and increasing capacity. The third, which is important, is on pathways, not only into residential rehab but out again—and, occasionally, back in again. Some people need to go in more than once, and we have to recognise that.

A lot of investment and work is happening in that respect. For example, we are supporting Healthcare Improvement Scotland in the development of regional improvement hubs to work with groups of ADPs on improving pathways and awareness.

We do not have robust data or statistics on the number of people who have requested residential rehab. I think that, once we started to unpick that, we would find it quite difficult to measure it accurately. With the improvement approach, however, we are working with clinicians and other service managers to think about residential rehab, and that has really contributed to the number of referrals and supported places.

Earlier this year, we launched an additional placement fund, which is an additional £2 million in the current year, and it means that those areas that have already used the money that they were allocated for residential rehab can apply to a national pot to fund more places. It is all about improving the flow and the pathway.

We are also looking at the other side of that pathway, which is about going through and out of residential rehab. That is important, because it is potentially a dangerous time, so we need to ensure that people transition safely out of it.

We launched the rehab.scot website, which lists all the residential rehab facilities that are available and the types of services that they provide. They are a very diverse group; there are around 20 different service providers—I would have to check exactly how many—and they are quite different. Some cater to specific groups, and they cover different geographical areas.

That covers where things are right now. I can send the committees a link to that website.

Bob Doris: I know that other members want to come in, and that a supplementary question from me will tie up the committees' time, but I just want to say that I am conscious that the Government has promised to look at, for example, rejected referrals to child and adolescent mental health services and to audit those decisions to see how robust they were. I will just leave that hanging there. The fact that the data on this is difficult to establish is no reason for not trying to establish robust data.

Maggie Page made an interesting point about individuals needing residential rehab more than once. Living with addiction is a lifelong challenge—or a lifelong success, for many people—and people might need rehab more than once. Of course, when an individual leaves rehab, they are not leaving that journey and its challenges. Is there any monitoring or auditing of the support services that exist for people when they leave rehab? After all, rehab itself is only part of the picture.

Neil Gray: On Mr Doris's first point, he touches on an area that we need to consider, which is whether there is a route by which we can collect robust data that is able to be published. We will consider whether more could be done in that regard.

On the second point, Maggie Page has already addressed the fact that support is available outwith the residential rehab picture and that people are being supported throughout their journey. Depending on the individual, that will shift between community organisations, statutory services and general practitioners; indeed, a variety of different individuals and organisations could and should be involved. Again, it will be difficult to audit that journey, as everybody's journey will be slightly different, but I take the point about whether more could be done, and we will take that away and look at it.

Paul O'Kane (West Scotland) (Lab): Good morning to the cabinet secretary and his officials. The committee has been very interested in the progress of medication-assisted treatment standards and the cross-cutting nature of implementing those in healthcare settings and beyond.

In the latest data from Public Health Scotland, we have seen improved progress, which is welcome, but I am keen to get the cabinet secretary's view on the targets for the MAT standards—that is, their full implementation in community and justice settings by April 2025, and their sustainability across all settings by April 2026. To what extent are those targets on track, and what work is being done to make sure that they are?

Neil Gray: That important area forms part of the suite of investments that are being made and the interventions that are available in order to provide a person-centred approach to responding to drug or alcohol dependency.

We have made particularly good progress on MAT standards 1 to 5, and I commend the alcohol and drug partnerships, as well as the statutory services that Paul O'Kane referenced, on the work that has been done.

Standards 6 to 10 have been more challenging, and we have more work to do on them. The intervention of some of my predecessors has been important in providing direction to alcohol and drug partnerships to meet the targets and to invest in interventions to ensure that the MAT standards are met.

Mr O'Kane queries whether there is confidence on timescales. I cannot give a guarantee today that we will meet them, but I believe that good progress is being made, as has been referenced. We will continue to support ADPs, as well as the statutory services involved, to ensure that the importance of meeting those timescales is recognised.

For some people, residential rehab and abstinence are the right route, while for others, a medically assisted treatment pathway works best. In trying to get it right for everyone, we must recognise the need for person-centred approach.

I will bring in Richard Foggo to provide more detail.

Richard Foggo: The area that we are working on most systematically—the area that involves most risk—is definitely the justice setting. Working with the Scottish Prison Service on MAT standards in prisons is involving a huge amount of collective work. I have not had any indication that we are not on track with that, but it is taking the most work.

At the moment, the pressure on the Scottish Prison Service, across a range of issues, is profound. I spoke to Teresa Medhurst, its chief executive, very recently, and Angela Constance is chairing a group of ministers, including health ministers, to work systematically on that. In fact, the last deep dive at that cross-ministerial group was on MAT standards in prisons, and we heard from front-line system leaders—governors in charge and others—about the challenges.

I therefore offer an assurance that we have recognised that area as probably the one in which the risk is biggest, and it is the area on which we are working our hardest to ensure that we are on track. Given the current pressure on the justice system—in particular, on the Prison Service—we absolutely recognise that we should collectively pay attention to that area over the next 18 months.

Paul O'Kane: Thank you for those answers and, indeed, for the candour. That is helpful to the committee.

The cabinet secretary outlined some of the progress that is being made and some of the interventions and directions that have been made by his predecessors, but I have a concern. The Scottish Drugs Forum recently evaluated current practice with medication-assisted treatment, and its findings suggested that only 15 per cent of the participants in the evaluation were aware of the MAT standards. That has to be concerning, because it goes to the heart of how professionals and others in the partnerships that we require, as well as those who are in receipt of the services, are aware of those standards.

Some of the other themes that have been discussed this morning—including stigma, waiting times, delays and being able to access the support that is needed in the right setting—are things that users felt were difficult. I am keen to understand how the cabinet secretary is drilling into those issues and what sort of approach he is taking to them, because those figures are worrying.

Neil Gray: I absolutely concur with Mr O'Kane. That is a serious concern. I repeat that our interventions were not made lightly, and ministerial directions are not made often. We expect ADPs not just to implement the MAT standards but to provide greater awareness of them.

When we are talking about getting it right for everyone, it is important to recognise that that is particularly important for those with an opioid dependency. Across the country, cocaine use is prevalent and has been implicated in a rising number of drug-related deaths, but we do not currently have a medication-assisted treatment pathway available. That is why it is important that we look in the round at all the interventions that are available.

I am absolutely clear about the importance of making continued progress on the MAT standards, because, for a great many people, that helps to save lives. It reduces harm and gives them a pathway to seek recovery. I do not want there to be any quibbling about whether we are committed to that—we are, and I take very seriously the statistics that Mr O'Kane mentioned.

Richard Foggo: I fully recognise the potential tension relating to the SDF findings; I absolutely take that point seriously. In relation to points that were made earlier, one of our next steps is the release of the charter of rights for people who use substances, which we are about to do. Bringing those two perspectives together will be fundamental for us in reviewing the MAT standards. We can tell you a really good story about our work with Healthcare Improvement Scotland, Public Health Scotland and others, and about how the system and system leaders are being made aware of the issue, but there is a disconnect. We are working from the bottom up, with those with lived and living experience, through the leadership of Professor Alan Miller and the national collaborative.

From a policy perspective, over the next period, a fundamental priority is for us to bring those two agendas together. There is a risk that the MAT standards approach is quite technical. Ms Dowey, understandably, accused me of playing buzzword bingo. I understand that, and I want to avoid it, but there is a professional language. The MAT standards operate at that level, but what we are getting from the SDF is that, in reality and on the ground, that language feels a bit alienating.

The next big challenge for us, as policy makers, is to bring those two things together, and we commend the work of the national collaborative. That is where the bottom-up approach, with those with lived and living experience, is coming from. In that forum, we have discussed the specific question of how we can make the MAT standards a more accessible and understandable approach for those who are experiencing the services, not just for the managers, who also need clarity on how the services are run.

I offer the assurance that, although it will not be done today—I get that—it is an absolute priority for us to bring together the charter of rights plus the MAT standards approach, and to review and refresh that in the next few months.

The Convener: Before I bring in Jeremy Balfour, I will pick up on Mr Foggo's point about the helpful update on the challenges relating to the prison population. The Criminal Justice Committee and the wider Parliament are obviously interested in that. I am aware that naloxone is now available for use in the prison estate. Cabinet secretary, you gave a helpful update in September in response to a question that was asked in the chamber about the work that is being done by the UK Government to make naloxone more available. Could you provide an update on that?

10:30

Neil Gray: The convener is right that there is interaction with the UK Government because of the legislation that governs our ability to roll out the naloxone programme. I do not have a specific update on the UK Government's latest thinking on that, but I am aware of the prevalence of naloxone—it is being used and carried across statutory services, including by the Scottish Fire and Rescue Service and Police Scotland, and it is available further afield for those who are involved in alcohol and drug treatment. In addition, I believe that more than 30,000 take-home naloxone kits have been distributed, and I think that 530 doses have been administered by the police service.

We can confidently say that a substantial number of lives have been saved as a result of the naloxone programme. I commend all those in the public sector—including those in Police Scotland and the Scottish Fire and Rescue Service, as well as health professionals and others—who carry naloxone and are helping to save lives as a result.

The Convener: I interpret the increase in emergency naloxone administration as a positive, with that option now having a broader reach, as you mentioned. Committee members would be interested in any update that was available on the UK Government's work on the issue.

Neil Gray: Alongside my other updates, I will be happy to provide that information, if there is anything further on which to update the committee.

The Convener: That would be very helpful.

Jeremy Balfour (Lothian) (Con): Good morning, cabinet secretary, and to your team. Could you give us an update on the expected opening date of the safer drug consumption facility in Glasgow? It was due to open last month, so where are we with the timescales?

Neil Gray: There have been delays. Mr Balfour referenced that the facility was due to open in October. The Glasgow health and social care partnership is working with partners to ensure that it is operational as soon as possible. I am hopeful that that will happen before the end of the year.

Jeremy Balfour: Thank you.

Paul Sweeney (Glasgow) (Lab): I thank the cabinet secretary and his colleagues for their comments so far. Does the cabinet secretary have any insight on the nature of, or the reason for, the delays with NHS Scotland Assure's approval of the facility at Hunter Street?

Neil Gray: I thank Mr Sweeney for his long-standing interest in, and campaigning on, the issue. I will defer to Maggie Page on the detail to ensure that I do not speak out of turn. NHS Scotland Assure is involved, and there have been

delays in ensuring that the facility can be operational.

Maggie Page: We can provide full details in writing, but my understanding is that there is water testing, which has to be done over a three-week period. The final snags are being looked at and the assurance processes are being conducted.

Paul Sweeney: On 11 September 2023, the Lord Advocate stated her intention to publish a prosecution policy for the safer consumption facility. Do you have any insight on when that will be published?

Neil Gray: That is a matter for the Lord Advocate. She will determine when it is right and appropriate to do that. I do not have any further update on her thinking on that or on the timescales that are involved.

Paul Sweeney: It is certainly timely that the pilot is getting under way, given that there has been a reported increase in street injection in Glasgow. I am concerned about the 12-hour gap in operation between 9 pm and 9 am. Does the cabinet secretary share that concern? Should there be an effort to increase operating hours, if that is deemed to be necessary by the health and social care partnership?

Neil Gray: As Mr Sweeney will understand, that is a matter for the health and social care partnership to consider. We already have a pretty lengthy opening period. I recognise his concern about what happens between 9 pm and 9 am, but this is a pilot and a test of change. It is an area for us to test and learn from. I fully anticipate that the health and social care partnership will look at whether availability could be increased, depending on what the demand looks like, but he will understand that that is a matter for the health and social care partnership to consider.

Paul Sweeney: Last year, I had the opportunity to visit Copenhagen to see how its model operates. I was struck by how sophisticated it is. One of the key aspects of the visit was to understand the interface between the safer consumption facility, the overdose prevention facility and referral pathways into rehabilitation. The staff said that they had noted a significant increase in interest in accessing rehabilitation. Sometimes, it is non-linear—people go into rehabilitation and then come back to use the facility, or vice versa. Staff noted that services were in close proximity; it was a matter of minutes to walk to the residential rehabilitation facility.

I have just checked, and the closest rehabilitation facility to Hunter Street is the Thistle centre, as it will be known, which is about 4.5 miles away. The Phoenix Futures centre is the closest one in Anniesland. Does the cabinet secretary have a longer-term view that we should try to co-locate or at least bring facilities into closer proximity where there are concentrations of street injection?

Neil Gray: Mr Sweeney makes a good point. The work that we have been doing to support the health and social care partnership has been around ensuring that there is signposting and support available, so that those conversations can be had.

Maggie Page referenced the varying landscape in residential rehab in Scotland and what practices would be right for people. The Phoenix Futures centre, for instance, might not be appropriate for some people, so they might need to travel further afield. That is something for us to consider. As we look to increase the availability of residential rehab, we try to make sure that that is available as close to home as possible and that we have a variety of services available.

Mr Sweeney makes a cogent point about having services as close together as possible. That said, in some cases, we are reliant on others, particularly those from the community and voluntary sector, coming forward to deliver some of those services, particularly for residential rehab. Further work will be required if we are going to do that on a co-location basis.

Paul Sweeney: Does the cabinet secretary recognise that the recruitment has been very positive? There have been more than 700 applications for about 34 posts in the centre, which is encouraging. That is a significant overhead for operating one facility, which might present challenges when it comes to scaling up such facilities. Have the cabinet secretary and his colleagues considered how to create a hub model, with some outreach, which might be less expensive to establish?

In relation to the pattern of where discarded needles are clustered in Glasgow city centre, there is an element in the east end around the Barrowlands and a cluster near George Square and Central station. Might there be an opportunity to build the main base at Hunter Street and then have a series of satellite facilities or perhaps even mobile facilities along the lines of the converted ambulance that the unofficial pilot utilised? Are those options for how we develop the pilot? Is there scope for doing something such as that to try to capture more people? We know that people do not tend to travel very far from where they purchase drugs to where they inject them.

Neil Gray: There is certainly scope, and this is a pilot. The health and social care partnership, alongside the Government, will look at the success of the centre being set up as it is, and at what might be possible if we were to explore alternative or increased opportunities. Mr Sweeney made a

suggestion in relation to the work that Peter Krykant did. That is potentially part of the exploration, and I am certainly not ruling any of that out, because we want to respond to what the evidence demonstrates works. It is important that we have the pilot so that we can demonstrate that it works. If further innovations could provide greater help and support, both the Government and, I would expect, the health and social care partnership would explore those.

Paul Sweeney: Is there a proactive engagement plan to enable colleagues across the Scottish Government, local authorities and the UK Government to see the facility in operation, once it is established? Recently, I happened to meet Dame Diana Johnson, who, as the Home Office minister, expressed a keen interest in coming to see it and was very open minded about how it could be developed. Is there an active plan for the Scottish Government to invite colleagues to see the facility in operation?

Neil Gray: I would very much welcome that interaction. Again, I go back to Ms McNair's questions on interaction with UK ministers at a minister-to-minister level. Those conversations have not happened, but I would very much welcome them, and I believe that the relevant health and social care partnership—without wanting to speak for it—would welcome them, too.

With regard to the learning from the facility, I expect that a great number of people will have an interest in looking at the success, or otherwise, of the pilot. In Scotland, we have to contend with a specific, and greater, issue with drug-related deaths. The recent statistics show that there has been a rise in the prevalence of drug-related deaths elsewhere in the UK, but it is not on the same scale that we are seeing in Scotland. I do not wish to diminish in any way the challenge that we have in Scotland, but I believe that there is, and there should be, a wider interest in the success, or otherwise, of the pilot at Hunter Street.

The Convener: We have a few minutes left, so I will bring in Sharon Dowey for a final question.

Sharon Dowey: In response to my previous questions, the national mission was mentioned. However, at our previous evidence session, the issue of an implementation gap between legislation, policy and strategy and what is being felt by people on the ground was raised. That has also been an area of interest for the people's panel. Why do you think that there is a perceived implementation gap, and what is the Scottish Government doing about it?

Neil Gray: It is clear that we have work to do to build on the foundations that have been put in place by the national mission. We are looking to provide systematic change in the availability of services and the types of interventions that we make. As has been demonstrated today through the lines of questioning, the Government is supporting a variety of interventions, from the implementation of the MAT standards to safer consumption facilities, and from drug-testing facilities to residential rehab. There is a broad range of interventions at play, and those take time to build up.

I recognise that there might be a feeling or a perception that there is a disconnect, but I believe that we are making progress. I say that because of the interactions that I have had with families, who say that progress is being made.

We have more work to do—that is clear, and the perception that Ms Dowey narrated demonstrates that. We need to ensure that we deliver demonstrable change that is felt at a local level and by individuals and their families. That is certainly what our collective effort is geared towards across the Government, in partnership with local authorities, health and social care partnerships and alcohol drug partnerships, with those in the community and voluntary sector who are involved in this area, and with families and advocacy organisations.

Sharon Dowey: Mr Foggo mentioned earlier that I had said that it was "buzzword bingo" today. I have not heard that phrase before, but I am sure that I will use it in the future.

As committees, we are interested in seeing action that ensures that we end up with improved results. It would be good to ensure that we do not simply talk about strategies but actually see them being implemented, so I would like to get more evidence on that.

The Convener: On that point, I will bring the session to a close. I thank the cabinet secretary and his officials for a very interesting session.

I am aware that some of the issues that were covered this morning are of interest to the people's panel, which has been mentioned throughout the session. I hope that this evidence session will inform some of the panel's further deliberations during its final meeting, which will take place this weekend.

That completes the public part of our meeting.

10:45

Meeting continued in private until 11:23.

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