OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 14 September 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 14 September 2021

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
4th Meeting 2021, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
Evelyn Tweed (Stirling) (SNP)
*Annie Wells (Glasgow) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Angela Constance (Minister for Drugs Policy)
Marie McNair (Clydebank and Milngavie) (SNP) (Committee Substitute)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 14 September 2021

[The Convener opened the meeting at 09:34]

Interests

The Convener (Gillian Martin): Welcome to the Health, Social Care and Sport Committee's fourth meeting in 2021. I have received apologies from Evelyn Tweed and I welcome Marie McNair who is attending this morning's meeting in Evelyn's absence.

Our first agenda item is to invite Marie McNair to declare any relevant interests to the committee.

Marie McNair (Clydebank and Milngavie) (SNP): Good morning. I confirm that I am an elected member of West Dunbartonshire Council, and that I was a part-time social care worker until June this year.

Decision on Taking Business in Private

09:34

The Convener: Our second item is to consider whether to take item 4 in private, to consider the evidence that will have been heard on the Minister for Drugs Policy's session 6 priorities. Do members agree to do that?

Members *indicated agreement.*

Session 6 Priorities (Drugs Policy)

09:35

The Convener: Our third item today is to take evidence from the Minister for Drugs Policy on her priorities for session 6. I welcome Angela Constance, the Minister for Drugs Policy. Her officials from the Scottish Government—Michael Crook, the head of the drug deaths team, and Morris Fraser, the head of the delivery and support unit in the drugs policy division—join us remotely.

I believe that the minister has a brief opening statement.

The Minister for Drugs Policy (Angela Constance): I do, convener. I am grateful to the committee for the opportunity to provide evidence on my priorities over the next five years.

The loss of life from drug-related deaths is as heart-breaking as it is unacceptable. I once again offer my condolences to all those who have lost a loved one, and I restate my continuing commitment to do everything possible during this parliamentary session and beyond to turn the tide on drug-related deaths.

This morning, the Scottish Government published the first of its quarterly reports on suspected drug deaths, which focuses on management information from Police Scotland and covers the first two quarters of 2021—the first six months of our national mission. Although that report is not a replacement for the national statistics on confirmed drug-related deaths, which National Records of Scotland publish annually, as those official statistics are based on death registration records that information from the Crown Office and forensic pathologists supplement, it will help services to respond quicker to what is needed and Parliament to monitor progress, and will provide a barometer of drug death trends over time.

We can cautiously take some encouragement from what appears to be a slightly lower figure of suspected drug deaths than for the same period in 2020, but I stress that there is a long way to go, because both suspected and actual drug-related deaths remain too high in Scotland today.

My priorities start with getting more people into protective treatment and recovery on the back of our commitment to an additional investment of £250 million, which includes £100 million for residential rehabilitation, over this parliamentary term. Information from quarterly reporting will allow me to set a treatment target for 2022, which is one of my main priorities.

The implementation of the medication-assisted treatment standards by April 2022 is a key priority as well. Those standards set out what people should expect and can demand from services—in particular, same-day treatment and access to a wider range of MAT options. That implementation is part of our overall approach to making people's rights a reality. However, the options that we offer people must also include access to residential rehabilitation, which is clearly a priority for us all.

We recognise that the number of cases of poly-drug-use deaths involving methadone and benzodiazepine has risen. We need to understand how that situation is happening and be able to offer safer alternatives, such as Buvidal and new treatments, to reduce overdose cases. The role of prescribers, including general practitioners, will be crucial in that work.

In October, the Advisory Council on the Misuse of Drugs will have its first meeting in Scotland, and there will be a four-nations drugs meeting in Belfast later that month. I will use that opportunity to continue to press the United Kingdom Government on the evidence for drug-checking facilities and safe consumption rooms, while pursuing further action via our devolved powers.

I will continue to prioritise people with lived and living experience, through local panels and a national collaborative. That approach already plays a vital role in service design and delivery across Scotland, but my priority will be ensuring that we make everyone's rights to the highest standard of healthcare a reality.

We will also continue to strengthen the links across portfolios. Our mission is linked to other vital work to improve mental health, to address poverty and inequality, to ensure that we are keeping the promise to our children, to build resilience through education and prevention and to bring public health approaches to our justice system. Another priority will be to develop and scale up women-specific services. I have announced that Phoenix Futures has been successful in principle in a bid to establish a new national specialist family service. That facility will be the first of what, I hope, will be many new residential rehabilitation facilities. I will soon set out to Parliament our milestones for further growth over the next five years.

I will continue to prioritise the use of naloxone. Those services have made great strides, but I want to see more. Last month, we launched a national naloxone campaign that has already significantly increased demand through our third sector partners. I am encouraging community pharmacists to be more active in the use of naloxone, too.

In November, we will launch a campaign to tackle stigma, which is still, for many people, a barrier to accessing life-saving services. I am also making it a priority for alcohol and drugs services to be featured in the proposed national care service. This is a real opportunity to consider how we can better support some of Scotland's most marginalised and vulnerable people.

I am conscious that it is not possible to cover in detail every priority for the new parliamentary session in the time that we have available. I hope that this summary is helpful to the committee and is the start of a conversation that we will have over the years. I will, of course, continue to update Parliament regularly.

The Convener: Thank you, that was helpful. There were a number of things in your remarks that my colleagues are going to ask you for more detail on.

I will open up by asking for your reflections. You have been in post for about nine months, and you have outlined some of your strategies and priorities. Over those nine months, and given that you have a hinterland of lots of experience in areas that have an impact on drug use in Scotland, what is your assessment of how we got to this place? What are you prepared to consider, within the bounds of what we can do in Scotland, but also pushing the boundaries of what we need to do?

Angela Constance: For me, it is always about following the evidence and what works, and listening to the people who are most affected by drug deaths in their communities. That is people with lived experience, but also people with living experience.

When it comes to encapsulating where we are and the question of why our challenge in Scotland is so acute and severe, I have my own views. In the past, there have been many discussions about culture, patterns of drug use and concentrated levels of poverty. However, I always distil our challenge in Scotland into three areas.

We have a higher proportion of people who use drugs. I suppose that the reason why is quite an existential question, and much research has been done on it. However, we need to recognise that a higher proportion of our people use drugs, and therefore we have proportionally more people with problem drug use. The rate of drug use in Scotland is about double that in England.

Another issue is benzodiazepines. The use of illicit benzodiazepines is an issue across the United Kingdom, but it is more acute in Scotland—again, the facts show that. Since 2009, there has been a 450 per cent increase in Scotland in the implication of benzodiazepines in drug deaths. By comparison, south of the border, it is 53 per cent.

Again, to be frank—this is at the heart of the matter—we do not have enough of our people in treatment. That is the core of my assessment. We know that treatment is protective, and so we need a culture of change and a culture of compassion in our services. That will enable people to access those services more easily, and services can be more fleet of foot in following people up. People should be able to make informed choices about their services and treatment.

We have made progress around other preventable deaths. We must consider drug deaths not just as tragic but also as preventable. While the scale of the challenge is massive, we can and must turn it around.

09:45

The Convener: There are a couple of specific things in there that I want to pick up on. You were saying that we do not have enough people in treatment. Are there two parts to that, one being getting hold of people and giving them the pathways to get treatment, and the other being having enough treatment capacity? That strays into the area of what is reserved and what is devolved. Is it fair to say that the drug consumption facilities are more than just a facility for the safe use of drugs, and that they are also a pathway to getting people into treatment?

Where do you see general practitioners in this? People might not be in treatment, but most people are registered with a GP, and that is an early intervention pathway for them, too. How do you see both of those things matching up and helping people to get into treatment?

Angela Constance: We know that emergency interventions and harm reduction interventions such as safe consumption rooms and the heroin-assisted project in Glasgow not only help to reach people where they are at any particular time and help them to reduce the risks that they face; they also form part of a longer conversation and journey to help people connect with other services. That may involve connecting with primary care and connecting with services for blood-borne viruses. It may involve helping people with the practicalities of addressing other issues in their lives, whether those are problems with personal care, housing or some of the underlying causes. As all the evidence would show, the importance of harm reduction lies in meeting people where they are now and working with them through the good times and the bad and sticking with them in whatever onward journey they choose.

Turning to the distillation that you made, convener, we indeed need to increase the capacity of services, and that will involve workforce planning. There is a lot of baseline

information that we do not have, so we need to update our work on prevalence—we are in the process of updating that—and on baseline information about the number of people in treatment. That will help us to make progress on our target for treatment, for instance.

This is clear, and people on the committee will know the issues that are reserved and those that are devolved, but the challenge for us is to leave no stone unturned so that, whatever our powers and whatever resources we have at our disposal, we make all the vital connections and take every opportunity to implement evidence-based practice.

The Convener: Sandesh, do you wish to ask a supplementary question about what I have just raised? I would ask you to make it short, please, and I will then move on to Gillian Mackay.

Sandesh Gulhane (Glasgow) (Con): I wish to press a little bit more on what Gillian Martin asked—specifically about what you feel the role of GPs will be.

Angela Constance: That is a really important question, Mr Gulhane; I know that you are a former GP. I often talk about our life-saving work being connected to the work to improve people's lives. You and I may take the role of primary care for granted in our own lives, but I know that many general practices are the front line of our communities and are already doing great work to support people and their families who are struggling with drug use.

We are finding across Scotland that there are different pictures of the organisation of services. In some areas, GPs can offer more services to people who are affected by drug use, while in others pathways and routes point more towards specialist services. Regional variation is fine as long as it works.

However, in taking a public health approach, GPs can play an absolutely core role. Part of my job is to engage with clinicians from all backgrounds—psychiatrists, GPs and clinicians from specialist addiction services. The connection between the important issue of harm reduction and immediate access to treatment for a drug problem and primary care is made in standard 7 of the new medication-assisted treatment standards. People should have choice with regard to the connections between their MAT and primary care.

The Convener: Thank you. We move to questions from Gillian Mackay.

Gillian Mackay (Central Scotland) (Green): Although many of Scotland's drug deaths involve more than one substance, drug deaths figures show a continued upward trend in cocaine being implicated in the cause of death. The Scottish Drugs Forum has warned that efforts to get more people into treatment must take account of the needs of people who use cocaine as well as those who use depressant drugs. How will you ensure that drug treatment services serve the needs of people who are using cocaine or, indeed, a number of substances?

Angela Constance: Ms Mackay has made a really important point. Person-centred care lies at the core of this. We can get into areas of real complexity; I know that there are medication-assisted treatments, including methadone and Buvidal, that are geared towards opioid dependency and opioid substitution therapy, but we have to watch that we do not silo services. The number of deaths in which cocaine was the only implicated drug is comparatively small—I think about 16. We are therefore looking at cocaine in the context of poly-drug misuse. Because that picture is much more complex, we have to take action at the level of the individual, with services engaging with individuals as individuals first and foremost, and working out what support and help they need.

The point about cocaine is important, given the 23 per cent to 25 per cent increase in its implication in drug-related deaths. We have heard a lot about its purity increasing as well as its price being lowered, and in thinking about our approach to services, we also have to bear it in mind that cocaine use is more a feature among younger people. I realise that I am generalising, but it tends to be people over 25 who use opioids, whereas there has been a rise in cocaine use among younger people. As a result, some services will have to be age appropriate, given the different pattern of drug use among young people.

There are no easy answers. We need to think about whole packages of care and support and to get underneath the skin of the reasons why people use drugs and particular substances.

The Convener: Marie McNair has some questions on prevention and early intervention.

Marie McNair (Clydebank and Milngavie) (SNP): Good morning, minister. As I am sure you agree, the reasons for addiction are complex and multifaceted, and we will never address the problem without joint working across all disciplines. Is the Government doing enough to fund effective integrated working that covers health, social work, housing, training and employment?

Angela Constance: You are absolutely right to make those vital connections. We have a national mission in the first place because we need to take a helicopter, whole-systems, approach. At the core of that approach we have early intervention and prevention, which includes our work on poverty

and with young people in our health and education systems.

We probably know much more now about what works with young people than we did, say, 20 years ago. In the context of curriculum for excellence, we note that young people respond better to approaches that are about upskilling them and increasing their personal resilience, self-esteem and confidence. There are also opportunities for diversionary activities in communities.

The point about housing is well made. There is massive investment planned to increase the supply of affordable housing over the current session of Parliament, with some very stretching goals, including provision of 110,000 houses by 2032. All that work must connect with the getting it right for every child and keeping the promise agendas. There are, in the drugs policy part of my portfolio, examples of our investment in supporting family-inclusive approaches, including specific funds for work with families and children. It is vital that drugs policy be connected with every aspect of Government policy.

The Convener: I will pick up on your point about families. You mentioned that there are services for women. I watched your evidence to our predecessor committee in March, in the previous session of Parliament, in which you picked up on some of the historical difficulties in accessing treatment for women who have families and caring responsibilities. Can you give me a wee bit more information on how you have moved on that and what interventions you are putting in place to help more women with families to get the treatment that they need?

Angela Constance: We know that there is often great fear among women with regard to reaching out for help and disclosing the level of their drug use, especially when they have children. That is one of the reasons—there are many—why we are investing in whole-family approaches and family-inclusive practice.

The committee might recall that I announced in my statement to Parliament on 3 August substantial investment in an organisation called Phoenix Futures, which is to establish a national residential family service for the whole of Scotland. The announcement outlined that, subject to various approvals and consultation within communities, the facility would be able to accommodate up to 20 families, including mums and dads who have children aged from birth to 11. As well as thinking about services at the national level, we need to think about them at the regional level. That is one example of a step forward. There will be other work and announcements, in due course.

We have channelled funding through alcohol and drug partnerships, in which there is a specific allocation of £3.5 million for local ADPs to invest in whole-family approaches.

We need to support families as collective units, but we also need, within families, to support individuals in their own right. We will publish a framework on what family-inclusive practice should look and feel like on the ground. We are making progress in that area, and I will keep the committee informed.

The Convener: Thank you; that was really helpful. Annie Wells has a supplementary question.

10:00

Annie Wells (Glasgow) (Con): Good morning, minister, and thank you very much for attending.

I have just been trawling through the latest statistics. The police division with the greatest number of suspected drug deaths—187—was greater Glasgow, followed by Lanarkshire with 67, Edinburgh city with 64, and Tayside with 64. Is any specific work taking place in those divisions to identify what the issue is and how we can help and support people?

Angela Constance: Thank you for that question. On the information that was published this morning on suspected drug deaths, you are correct to point out that it is based on police divisions. It concerns deaths that are suspected to involve drugs, on the basis of enquiries by attending police officers. The information does not tell us things such as what substances are involved. We get that level of detail from the annual report on confirmed cases.

A lot is being done. A few weeks ago, I visited the Glasgow overdose response team. That service seeks to quickly follow up with people who have survived a near-fatal overdose. We know from successive annual reports that more than half our people who die have a history of overdosing, so when people survive a near-fatal overdose, we really need services to kick in quickly.

A range of projects are funded through the new community funds that we have opened—for example, through local alcohol and drug partnerships. Some of the drug death task force projects are specific to Glasgow.

Information is available by region on specific services and projects or tests of change. It might be helpful if I were to pull that together to share with the committee. The committee includes a broad selection of MSPs from across the country; I know that you will be very interested to look at that in detail.

The Convener: That would be really helpful. Thank you. I come to Paul O'Kane and ask him to be quick.

Paul O'Kane (West Scotland) (Lab): Good morning, minister. I will follow up on that point. We all understand the importance of better understanding the information on and patterns of instances of people overdosing and being treated in or attending hospital. On reporting, I am keen to understand what we can do to get more data. For example, hospital admissions information does not cover accident and emergency attendances, nor does it cover cases in which people are treated by the Scottish Ambulance Service. How can we get more data on where people are treated, and how can we make sure that we follow them up?

Angela Constance: I am absolutely committed to getting more information and data that will help us to improve our services and our offering. That will tie every step of our national mission to being based on evidence on the issues that we know exist in Scotland. I think that Paul O'Kane's question is about how we link information and data. In very general terms, the annual report gives us some quite rich information about substances. That information is also available by local authority and month by month.

It is important that we are able to understand more about other health problems in the context of drug use, and about the involvement of other services. We have some of that information, so we know about such things as drug-related admissions to accident and emergency departments and psychiatric admissions, but there is a time lag in receiving that information. Some of our work with Public Health Scotland is on how to get that type of detailed information more quickly.

Notwithstanding the time lags, in time we can gather quite a lot of information that tells us about the circumstances of people's tragic deaths. I suggest that we need to know more about people's lives. Although some of the information that we gather absolutely connects with our lived and living experience strategy and people's engagement with services locally, other data could tell us more about the lives that people lead, which could help us to shape services.

We also need more data in order to set the quality indicators that will underpin our treatment target.

The Convener: Carol Mochan has questions about inequalities.

Carol Mochan (South Scotland) (Lab): Thank you, cabinet secretary, for your answers so far on treatment and families. I am very keen for us to explore the links with social inequalities, deprivation and poverty. It is important that we understand the commitment from you and the Government to make use of all the powers that we have to ensure that we tackle childhood poverty and housing issues, and to ensure that people have employment opportunities. What are your thoughts on those issues?

Angela Constance: That is a really good question. I reiterate this often: it is absolutely about connecting emergency life-saving work with work that improves life chances. The statistics speak for themselves. We know that people in the poorest communities are 18 times more likely to suffer drug-related death than people in the least-deprived communities.

It is important to stress that drug-related deaths and drug use are an issue throughout Scotland. Drug-related deaths in the Highlands are the lowest in Scotland, but they are still higher than drug-related deaths in the north-east of England. That shows that this is an all-Scotland problem.

However, there is no doubt that the increase in drug-related deaths is being driven by an increase in the number of the poorest people in our communities dying such deaths. Therefore, work on child poverty, for example, is absolutely crucial. We have a £23 million tackling child poverty fund, a cross-Government child poverty action plan, and colleagues will be well aware of the Scottish child payment. That work must connect with drugs policy work.

There is also greater Government action, through which £2 billion of our resources are invested in low-income families. A proportion of that—half, I think—is focused on households with children. That £2 billion investment is intended to alleviate pressures on low-income households.

All that is connected with our economy, the fair work agenda and so on. We could talk about all those things in detail, as well as the work that is being done on adverse childhood experiences and trauma. ACEs, of course, have a huge link to people's living environment.

The Convener: We will move on to other drugs policy issues, in particular progress and priorities.

Gillian Mackay: People who leave residential rehabilitation are at increased risk of overdoses, because the period of abstinence lowers their tolerance to drugs. It is important that we recognise that people do not leave rehab cured and that they often need on-going treatment and support. How will the Government ensure that residential rehab services are well integrated with other health and care services and that follow-up support is provided to those who leave rehab?

Angela Constance: Our commitment to increasing the capacity and the reach of drug services and to improving access to residential rehab applies very much to aftercare, too. We

must recognise that drug addiction can be a chronic condition—it should be no surprise to anyone who is involved in the provision of drug services that people sometimes relapse. Progress in life is rarely linear, and it should not be that people run out of chances; we should give people as many chances as they need to get onto the road to recovery. The work that we do with local services and that integration with aftercare is crucial.

We also need to think about rehabilitation in a community context, as well as in a residential one. We know that risk can be elevated in times of transition, such as when someone leaves residential rehab, so people must have wraparound person-centred support that meets their needs. That approach also applies to people who leave prison or move from, or leave services. Our work and investments around outreach are particularly important in that area. We also need to be far better at following up when people disengage from services.

Gillian Mackay: I want to pick up on an earlier point about access to rehab. There was a greater discussion about how residential rehab interacts with the rest of the mix of treatment options, but many people might be afraid of losing their tenancy if they enter rehab or they might have caring responsibilities, as the convener pointed out earlier. Some people have unplanned discharges from treatment, and there is the matter of the police and hopefully the wider public carrying naloxone.

You have touched on the issue slightly, but how do you see integration across various areas of Government, in relation to supporting people in their tenancies or encouraging more people to take up carrying naloxone? That could be used to support those people who find themselves in a period of homelessness in particular, as many people with drug and alcohol addiction do.

Angela Constance: There is a lot in that question, but the member is quite right to make all of those connections. The point about access to residential rehabilitation is important. The work that the residential rehab development working group has undertaken is about the development of clearer pathways, because pathways vary across the country. I think that I am on record as saying that sometimes, pathways into residential rehab are as clear as mud, which is neither right nor acceptable.

There is also an issue about access to community services. There can be many barriers to people getting into treatment: you have to do this; you have to be on this level of treatment; you have to be abstinent and so on. With regard to residential rehab, which is an abstinence-based model, there are certain expectations around people's personal commitment, detox and lowering substances to facilitate the process, but it is fair to point out that there are perhaps too many barriers to accessing other services.

10:15

An early action that I took was the result of information that Shelter provided. There is a bit of confusion about housing benefit rules. Anyone who knows anything about housing benefit will know about the minutiae of detail that often have to be unravelled. Different things were happening in different local authority areas to apply rules. I was not going to put up with people having to choose between keeping their tenancy and going into residential rehab. Funds have been allocated and are available to address that while we sort out the complexities of regulation or whatever. That is one example of how we can invest resource. We will sort out the situation, but we are not putting up with people facing that choice.

I have always been a big fan of the housing first approach and other housing models that do not put up barriers. We should take people as they are; the priority is to get them into a home, and we will work out the rest, whether that involves people's drug use, health problems or other issues. I have spoken about parents and in particular mothers with caring responsibilities, so I will not repeat that.

The naloxone issue is important. Naloxone helps to save lives; it buys time for the emergency services because it temporarily reverses the impact of an opioid overdose. It is safe and easy to use. Because of the pandemic, the previous Lord Advocate issued guidance that enabled us to widen the distribution of naloxone to third sector settings.

I must give a shout-out to Scottish Families Affected by Alcohol and Drugs. As a result of our national naloxone campaign and people going to the Stop the Deaths website, more than 460 people have applied to that organisation for the naloxone kits that it provides through its click and deliver service. Families who have a loved one at risk can have naloxone to hand. More than two thirds of ambulance technicians are trained in naloxone use and can give out take-home kits to people they come across. It is important that people who distribute naloxone in non-drug services make the connections, support people and refer them to drug services.

I apologise for the length of my reply, but I hope that I have at least outlined some important connections.

The Convener: You mentioned that the Ambulance Service has naloxone and that families

can apply for kits. What is the policy of the police? Do they carry naloxone?

Angela Constance: The police have been carrying naloxone in three areas—the east end of Glasgow, Falkirk and Dundee. That pilot has been successful and the police have used naloxone 40 times. We have entered a review period and we will want to discuss with justice colleagues how the programme could be extended. It is important for statutory services to play their part, which also helps us to communicate with wider communities and the wider population that a tool can be used to help to prevent people from dying when help has been called for.

Of course we need to prevent people from having an overdose in the first place—we have covered that extensively. Naloxone is one piece of the jigsaw; other pieces involve preventing people from getting into crisis in the first place and how we connect people with support services when they survive an overdose.

Emma Harper (South Scotland) (SNP): I will pick up on what the convener was saying about naloxone. Front-line workers are carrying out testing for the naloxone pilot, and ambulance crews, front-line police officers and even families are being trained to use naloxone. How is that being received? Has being engaged in the naloxone testing been positive for front-line workers?

Angela Constance: That is certainly my understanding. A very high proportion of police officers will carry naloxone after they have undertaken the training. I speak to families—I am sure that many committee members do, too—and they will give many examples of how naloxone has saved the life of a loved one. When we speak to people about their lived and living experience, they talk about the range of services that have helped them on their journey. The key challenge for us now is to widen that distribution and for it not to retract. We will participate in a four-nations consultation about permanently widening the distribution of naloxone. Although it is safe to use, naloxone is a controlled drug.

The Lord Advocate, as a result of the pandemic, was able to use his discretion to give confidence to widen the distribution of naloxone to non-drug services, such as homelessness services. We now need the changes that the Lord Advocate made as a result of the pandemic to be made permanent. We are participating in a UK-wide, four-nations consultation. I had some concerns about some of the language used in the consultation and about its scope. Nonetheless, the Scottish Government has participated in that four-nations consultation, because we want a permanent change to the arrangements that are made, so as to widen the distribution of naloxone.

Paul O'Kane: Prior to the summer recess, we had quite a consensual debate on many of these issues, certainly on medication-assisted treatment standards and the need for strong and timely implementation of them—April 2022 has been set as the target. I am keen to hear a progress update from the minister. Also, how will that progress be reported? I think that the minister made a commitment to report to the Parliament six-monthly on MAT standards. Could you address those points, please?

Angela Constance: As you know, MAT standards are important for laying a foundation for change. The implementation and embedding of the new MAT standards is really important for making further progress and building on that foundation, particularly when it comes to widening access to treatment, integrating addiction and mental health services further and making the links with primary care that we discussed earlier.

For the first time, we have published the MAT standards. There is a financial resource for their implementation: £4 million was allocated to that for this financial year. Crucially—and this lies at the nub of Mr O'Kane's question—we have the MAT standards implementation support team, or MIST. It is examining the reported progress from different areas, testing that progress and engaging with people in local areas about what support they need. I was very keen for us to have MIST.

The scale of the challenge in implementing MAT is significant: we are moving away from the three-week waiting-time target that our system operates around, turning the ship around and providing MAT standard 1, for example, for same-day prescribing. There is a lot of work to do; progress is being made, but it needs to happen over the whole area. As with other matters, we will keep the Parliament informed.

Although we are absolutely serious about the April 2022 target, support will not simply stop at that point. As the quality improvement, quality assurance and support role played by MIST is part of a three-year programme, it will continue. What we cannot do is get this over the line and embedded and then go, "Whew! Job done!"; we are going to have to keep on it. The target is next April, but we will continue that monitoring and support role, and there are also some clear asks from particular local authority areas for resource and help that we are seeking to deliver on as quickly as possible.

Paul O'Kane: Alcohol and drug partnerships play a very localised role with regard to their relationship with their integration joint boards and delivery. I note that, in the consultation on the national care service, there has been discussion about whether ADPs should form part of a more national service delivery approach or whether they

should remain more local. I am therefore keen to hear your views on that issue and the question of where they can be used most effectively.

Angela Constance: As you will have heard Mr Kevin Stewart often say, the national care service is the biggest reform of the national health service since 1948. Although it will be immensely complex and challenging to build such a service and deliver it over the lifetime of this parliamentary session, the proposition itself is also very significant and exciting. At a fundamental level, it is about how we care for people and how we value those who do so. Given that people with drug-related difficulties are amongst the most marginalised, excluded and stigmatised in our communities, it is important that we ask about the benefits of making drug and alcohol services part of the biggest change in our national service in over 70 years.

Some of the synergies in what we are trying to do to improve services have a strong connection with the work on the national care service and its focus on person-centred care and informed choice. It is not just about caring and treating folk but about helping them live their lives, and I therefore feel strongly that questions about drug and alcohol services should be part of that consultation. What we need to test and explore in the consultation are opportunities via the national care service to improve accountability, governance and, indeed, the status of drug and alcohol work. I know people working in and delivering these services who feel that it is not just those whom they serve who are stigmatised; sometimes they, too, feel a bit forgotten and that the service itself is somewhat stigmatised. I also believe very much in accountability at every level and I have an interest in and focus on governance in that respect.

The challenge with alcohol and drug partnerships is that partnership needs to happen at a local level—and sometimes at a very local level if we are going to reach into the most deprived and disadvantaged communities. Those are the issues that we are testing at the moment.

The national care service is about taking a rights-based approach, which fits with what we are trying to achieve in drug and alcohol services. It is in the consultation, and there are some quite deep and fundamental issues that we need to test out.

10:30

Paul O'Kane: I agree with much of what the minister said, certainly on the need for local connections and accountability and the need to improve the status of those services. It will be interesting to see people's views during the consultation.

I want to ask about alcohol and drug partnership reporting in the here and now. The Government previously committed to providing information from ADPs on spending by integration joint boards. That happened in 2016-17 and 2017-18; I think that 2018 was the last time that we had those figures.

That was going to be a baseline for future reporting, but there has been no further information since then. As part of the intelligence to enable us to understand what is working on a local level and where spend is going, it would be helpful to have such information. Will the minister say something about that? What other intelligence can we garner from ADPs that will help us to map some of this area and meet the MAT standards?

Angela Constance: On alcohol and drug partnerships, I think that it is fair to say that we are making a bigger ask of them as part of the quid pro quo for the bigger investment in funding that has been made. They have had an uplift this year of £13.5 million from the national mission funds, and we have been specific about the proportions of that fund that are to be spent on family and child services, residential rehabilitation and aftercare and other front-line services.

We have also agreed a framework in and around governance with the Convention of Scottish Local Authorities. I will speak with COSLA to see whether it has information on that which might be of interest to the committee. Reporting is not just writing an annual report on what has been done—it is about undertaking more work to assess local need and evaluate what is being done. There is some external validation built into the process. It is essentially about forward planning and what the partnerships will do over the next year. Again, we are supporting ADPs in and around how to do that.

We also came to agreements with COSLA on the role of chief finance officers in integration joint boards in this area and the role of service-level agreements between alcohol and drug partnerships and the people with whom they commission services. I am cognisant too of the role of alcohol and drug partnerships vis-à-vis the role of integration joint boards.

On your fundamental question about understanding the total spend, there is a clear need for Government, in the drugs policy division, to articulate how much we are spending and what it is spent on. There is information on what we spend on drug and alcohol services overall in all our budget documentation. However, I appreciate that, when we look at what local government puts in from its funds, and at the additional funds that come from IJBs or the NHS, the picture becomes far more complex.

I understand the committee's interest in this area. It would indeed be beneficial to know the size of the total investment; I too am interested in

that question. I hope that some of the work that we are undertaking in Government might help with that, but it may be helpful, when I next meet Councillor Currie of COSLA, for me to discuss these issues with him.

I know that the committee has expressed an interest in these matters over a number of years, and I will discuss with Councillor Currie, who is COSLA's health and social care spokesperson, the need to look ahead, building on the new governance arrangements that we have agreed for the here and now, and think about how we might begin to shed light on that.

The information should be available at a local level, but we will try to unravel the issue. I add, for the sake of my officials, that we will not necessarily do so quickly, because they are engaged in increasing capacity in residential rehab, implementing MAT standards and a whole host of other work. I undertake, however, to at least explore the issue with COSLA.

David Torrance (Kirkcaldy) (SNP): As far back as 2017, a public petition was raised on the harms of prescription drugs. A short-life working group took it up and made its recommendations in March this year. In addition, in January, the First Minister announced a national mission to reverse the number of deaths from prescription drugs. What progress has been made on the dependency on prescription drugs?

Angela Constance: There are two important strands to that question, but the committee will appreciate that my work on reducing drug-related deaths focuses primarily, although not exclusively, on illicit drug use. My colleagues in public health focus more on how we reduce dependency on prescribed drugs.

The issue is of interest to me, however, because we know—I am not telling you anything that you do not know—that people can, and do, become addicted to prescribed drugs. A consultation took place on the recommendations of the short-life working group, and health colleagues are implementing an action plan about prescribing guidance and assessing, monitoring and recording prescriptions.

It is a side issue, but the Royal Pharmaceutical Society is interested in how it could work with Government to implement a tool that better records the amount of over-the-counter medications that people buy, because that is an issue for some people as well.

The prescribing guidance around proscribed drugs is complementary to the prescribing guidance around illicit benzodiazepine use. For the drugs policy division, the work to reduce dependency on and the use of illicit benzodiazepines in our communities is connected to the work around prescribed benzodiazepines, for example. We are involved in a range of work—in devolved and reserved areas—to tackle the issue around street Valium as well. I will stop here, convener. Someone might want to pick up the benzodiazepine issue later.

Emma Harper: I have a quick question. The issue of drug-related deaths is complex and work is being done in many strands. In previous questions in the chamber, I was interested in the tackling of stigma. We know that the Scottish drugs task force, in collaboration with other partners, has a strategy for addressing stigmatisation among people, communities and families. Stigmatisation is an issue in rural areas as well.

How important is it to tackle stigma, so that the media uses correct images, or better ones, and so that healthcare professionals who do not work in direct services with alcohol and drug users—people such as myself, when I worked in the recovery room—have a better understanding around the use of stigmatising language?

Angela Constance: We know that stigma is a huge barrier to people accessing treatment, and that it has a huge impact on people's wellbeing and on how people are treated in services and the community. Parliamentarians, as well as people in the media, care services and the wider public sector workforce, have a role to play in that situation.

Some of the work around a trauma-informed workforce is really important in this regard, too. Ms Harper raised an issue about the anti-stigma charter that has been developed by lived-experience representatives, in engagement with other lived-experience groups. The purpose of that charter is for it to be used by different organisations and services, and it can be adapted. I would describe the charter as having a core purpose, but it can be adapted to other services.

Part of the national naloxone campaign is about stigma. We are talking about lives that we can and must save, and here is how to do it. It is about engaging the wider population in what they can do, as part of the national mission, to help save lives. Later this year, we will report back to Parliament about a national campaign on stigma.

Gillian Mackay: I have a quick question this time. People who use drugs may be subject to multiple stigmas, not just that related to their drug use. That can include stigma relating to homelessness, mental health and, for some, HIV status. How will the Government ensure that the multiple stigmas are tackled within systems used by people who use drugs, and not just in relation to their drug use and the stigma surrounding it?

Angela Constance: You are quite correct to be making all those connections. It is important that strategies and approaches complement and connect with one another. There is a lot to learn from other campaigns and approaches.

The Convener: Annie Wells has some questions on residential rehabilitation.

Annie Wells: The Scottish Government's residential rehab mapping report stated that the Government funded only 13 per cent of residential rehab places in Scotland in 2019-20. Promises have been put forward regarding funding and places. Can the minister tell me how many extra residential rehab beds will be available by the end of this year?

Angela Constance: We know from that information that 13 per cent of beds that were accessed in that timeframe came from alcohol and drug partnership funding, and that there were also publicly funded places from housing benefit and social security. People would be accessing private and charitable funding as well.

Regarding the first quarter of this calendar year, you might recall that we published information on how the emergency funding was used. In the period from January to March, we quickly initiated £5 million out the door, and £3 million of that went to ADPs. Some of that money was for a separate improvement fund that people could apply for. There was also a grass-roots fund. We published information on how ADPs allocated that money, so that is available. We are currently gathering further information from ADPs and, again, we will make that available.

As for what we know about current capacity, earlier this year we published information on how, overall, the 20 facilities in Scotland were operating at about two-thirds capacity, so we know that there is capacity there to be utilised. I have given a commitment to return to Parliament with our milestones over the next five years. That is about how to improve access—and, as Ms Wells rightly points out, it is also about the extent to which we will improve capacity over the next five years. We will come to Parliament with much more detail on that.

Annie Wells: Can I ask one more question, convener?

The Convener: Yes. [*Interruption*.]

Annie Wells: I am sorry—my dog is barking.

I have repeatedly spoken about the right to recovery bill, which will be proposed in Parliament in the next couple of weeks. We have worked with front-line organisations that say that the bill is the right thing to do. Once she has seen its content, will the minister back the bill?

10:45

Angela Constance: I am keen to look at the bill in detail; it needs to be published before I can consider it fully. If Ms Wells pursues a member's bill, she will follow a well-trodden path for the requirements on the member to consult, engage with and convince others of their proposition and a well-trodden path for the considerations that the Government applies to a member's bill.

I have a track record of always giving members a fair hearing and I will look at the proposal on its merits. I have never ruled out further legislation, but I will want to test whether the bill would do what is claimed. I do not want the legislative process to hold us back from doing things now. I will want to see how any bill would help us with the integration of services.

I have outlined my rationale for why I wanted alcohol and drug services to be part of the national care service consultation. Before the Government introduces a bill to establish that service, the consultation responses will help to inform whether and how drug and alcohol services are part of that.

In thinking about the national care service, I note that there is a strong argument for national commissioning of residential rehabilitation. I can say more about that if members wish.

Further down the track, the Government is also committed to human rights and implementing international treaties. How do we make human rights real in people's lives and communities? That broad issue will inform my thinking about my response to the proposed bill.

I apologise for the time that I am taking, convener, but it is also important to say that we have made a commitment to a national collaborative on how those with lived and living experience plug into the national mission. A national collaborative is not something that we will do to people; it will enable the wider lived and living experience community to have its say on a range of issues.

We will look at the detail of the proposed bill when it comes.

The Convener: Marie, do you still want to ask about inequalities?

Marie McNair: Yes. I want to take the minister back to the impact of deprivation. We have long been aware of the link between deprivation and drugs. I worry that, while we study that, more avoidable deaths will occur. How do we get the right balance between the risk of analysing the link and getting meaningful data that helps us to respond to the main reasons for the link?

Angela Constance: I will not repeat what I said in response to Mr O'Kane about the purpose of

getting more data and what we are doing to acquire more meaningful information, but I assure Ms McNair that the purpose of the work that I am leading in the Government is to turn words into actions.

On the link between deprivation and drug deaths, I refer to my answers to Ms Mackay about the additional funding and action on measures such as the child poverty action plan and annual report; the tracking work; the fair work agenda; the work that is being done in and around social security; the massive expansion of early years provision for our youngest citizens; and the work to reduce the attainment gap. All that is absolutely connected and, at its core, it addresses the impacts of deprivation on every aspect of people's lives.

The Convener: Thank you. We will move on to the impact of Covid-19, with questions from Stephanie Callaghan.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Good morning, cabinet secretary. Clearly, Covid has not hit everybody equally, and people have struggled to access treatment and support. I am interested in what specific changes to approaches and treatment during Covid have had a positive impact. How can those benefits be maximised so that we ensure that we take that learning forward with us and use it to support and help people?

Angela Constance: One example is the use of Buvidal, which was introduced into the prison estate during the pandemic. Buvidal is a long-acting buprenorphine that can be administered as an injection weekly or monthly; it does not require a daily dosage. The use of Buvidal in prisons was evaluated very positively. It will not suit everybody—it is important to stress that no treatment will meet the needs of everyone—but it had some benefits in terms of clarity of thought and of not tying people to daily dispensing. It is also rarely associated with overdose, because it is a protective factor in relation to how opioids attach to brain receptors. It is a bit like a blocker: if you take an opioid on top of your Buvidal, you do not get the high from the opioid.

Having looked at the results of Buvidal in some of our prison estate, I was keen to find out how we could introduce it to the community and widen access to treatment. That is why this financial year there is a £4 million investment in widening choice to people, and that includes Buvidal. Widening that choice of treatment is a change in practice that occurred in response to the pandemic, but it is one that we want to continue and to implement further.

The committee has already spoken about our work around naloxone as well and how its distribution has widened during the pandemic. We do not want to detract from that change.

The Convener: I will bring in Marie McNair on this theme—[*Interruption.*]—I did not realise that Stephanie Callaghan had a supplementary. Stephanie, carry on.

Stephanie Callaghan: Sorry, convener—my apologies.

Again thinking of the impacts of Covid, we have all realised how isolation arises and how important connections to our families are for us to stay mentally healthy. However, not everybody has that support.

Earlier you spoke about the promise of how the relationships and trust that people build with other people—not just with families, but with organisations that provide support—help them to sustain progress. My question is about how we can sustain that progress. People who are coming through addiction and starting to move on with their lives will have struggles at times. How do we ensure that they are able to connect back in and get the support that they need as they move forward?

Angela Constance: Social isolation is also a public health issue. Committee members might be aware that a few years back the Government introduced a tackling isolation and loneliness strategy, and there is a range of investments and funds around that.

With regard to tackling drug-related deaths, I have to point to the lived experience and recovery community, because much of what they do is based on their own, real-life experience and the expertise that they bring to the community.

Mobilising the lived-experience community can help to reach people that services might struggle to reach. The relationship aspect of support is crucially important. The peer navigator system that Medics Against Violence have been strong proponents of in our prisons and hospitals is also really important. Peer navigators with lived experience from organisations such as Aid & Abet make contact with people when they come into police custody. All of that is about making connections and building relationships with people to support and help them in their onward journey, and it goes along with referring them to services.

Marie McNair: Covid-19 has had a negative impact on many in society. I am concerned about its impact on deprived communities and how that may be turbo charged when the UK Government removes the £20 uplift to universal credit later this month. Has Covid-19 made it more difficult for people in deprived communities to access drug services? Is there a concern that the welfare changes will increase that challenge?

Angela Constance: People experienced challenges in accessing services during lockdown. The work of the lived-experience community was particularly helpful and imaginative. The Government worked with organisations such as the Scottish Recovery Consortium on guidance about how to continue having meetings, whether online, in open-air settings or over the phone. I know that the recovery community in Glasgow did amazing work throughout the pandemic.

Other smaller organisations such as Recovery Enterprises Scotland, which is based in East Ayrshire, were under enormous strain during the pandemic. That is why some of the new funds that I introduced are particularly geared at smaller and more local grass-roots organisations and give them access to funding that can help with work in their communities. We have worked hard to make it as easy as possible to access that funding.

There is no doubt that so-called welfare reforms have an impact on the lives of the poorest. The frustration for many of us round the table is that, although increasing investment in the Scottish child payment will lift tens of thousands of children out of poverty, the ending of the temporary increase to universal credit means that £20 a week will be taken away from people when we are still not out of Covid and are far away from recovery, both socially and economically.

Marie McNair: Have there been any positive responses to Covid that we would want to keep after the pandemic?

Angela Constance: I outlined those in my previous answers. Perhaps Ms McNair's connection is not very good. I talked about our work on Buvidal and naloxone. I did not talk about our £1.9 million investment in our work on prison to rehab.

The work and contribution of the lived-experience and recovery community throughout the pandemic should remind us well of the value of engaging meaningfully with—not just paying lip service to—the recovery community and those with lived and living experience. That is why we want to take that work further forward with our work on a national collaborative.

11:00

The Convener: A couple of members want to ask questions on funding, which will be the last theme that we touch on. I thank the minister for the huge amount of information that she has already given us.

Emma Harper: All the matters that we have discussed this morning involve financial input, and I am aware that the Scottish Government has committed to increasing funding. There was £5 million at the end of the previous financial year, and an allocation of an additional £50 million of funding each year, which will total £250 million over this session of Parliament. That will support further investment in a range of community-based interventions, including primary prevention and the expansion of residential rehabilitation, which you have covered a wee bit. Will you provide a breakdown of how that funding is allocated? Will we have reporting from the alcohol and drug partnerships that spend the money, and will we get an idea of how that spending will be assessed and evaluated?

Angela Constance: The £5 million in additional resource was released in the final quarter of the previous financial year, which was the first quarter of this calendar year. Of that, £3 million went to alcohol and drug partnerships—as I mentioned, we published their returns on how that was invested—£1 million was put into a grass-roots fund, and £1 million went into a service improvement fund.

At the turn of the financial year—after Easter, on 18 March—I announced four new funds totalling £18 million. I hasten to add that they are multiyear funds. Those four new funds opened in May. There is a £5 million recovery fund; a £5 million service improvement fund; a £5 million local fund, which again is geared towards grass-roots organisations; and a £3 million families and children fund. Those are available via the Corra Foundation for all non-profit organisations to apply for. We have worked really hard to make the application process accessible and quick. To date, we have funded in excess of 50 projects through that. Adding in other funding—for example, through work that the task force has done—I think that we have funded over 80 specific projects.

This year, we will invest around £13.5 million in residential rehab. That money will come from ADPs and from the recovery fund and other sources of funding within Government. I will outline to the Parliament in more detail the profile of that funding, because we have a commitment to provide £100 million for residential rehab and aftercare over five years.

On the £50 million for this year, there is also the specific £13.5 million uplift to ADPs that I have mentioned, and around £14 million is going on £3 million for outreach, £3 million for non-fatal overdose, £4 million on widening the distribution of Buvidal, and £4 million on implementing the MAT standards. I hope that that gives an overview.

A small amount of resource is going on research. Resources have also been set aside for the national stigma campaign and our lived and living experience strategy work on establishing the national collaborative.

Emma Harper: Thank you for breaking down the finances.

Much has been made of the cost of residential rehab. The Castle Craig clinic, which is mentioned in a BBC article, costs £2,500 a week for one person. There is a variety of residential approaches. The number of residential beds in Scotland has increased to 418, which is up from 365 previously. That is good news. There is a breadth of residential rehabilitation and a variety of costs. The Scottish Government is looking at a tailored person-centred approach that fits each person. You have talked about families and about Phoenix Futures.

Will you report back to us, in the chamber or in committee, on your assessment of all those pathways for funding and how they are working?

Angela Constance: The average cost of a residential rehab placement is £17,000, although it is greater in some areas. The length of placements also varies. The residential development working group has looked at that in detail. I do not want to be prescriptive about the length of stay in residential care, which should be person-centred and flexible. As Ms Mackay said, we must recognise that there is a link between residential rehab and aftercare and that there is also a link to detoxification services. Some residential rehabilitation units have in-house detox; some do not. It is important always to think about the journey that people will take and the services, opportunities and care that they need on that journey.

Emma Harper: Recovery must continue after someone's stay in residential rehab. That is also part of the funding. Assertive outreach is another part. There are lots of strands that support people through the process. The third sector and charities are important to any funding model that we consider.

Angela Constance: We must stick with people. There is an important role for us in changing how our statutory, NHS and local government services work and how they meet the needs of people who struggle with drugs and the needs of their families.

The third sector has a valuable role. We have taken a belt and braces approach. As well as increasing the investment in ADPs, many of which will enter into agreements with the third sector, we have set up the four multiyear funds that are within the £18 million pot and are available to third sector organisations. The third sector is vital, along with our public services and the lived and living experience community. Those are the three strands of the partnership: the lived and living-experience community, the third sector and statutory services.

Sandesh Gulhane: I have a number of questions. I will just correct what you said earlier—I am a practising GP, so I am still working.

I have a question about the medication-assisted treatment standards. Standard 7 states:

"all people have the option of MAT shared with Primary Care".

Can you define "primary care"?

Angela Constance: Primary care is multidisciplinary and often led by general practitioners, and it is located in our communities. It is often the first port of call and is supported by nursing staff. There are efforts to connect GP practices with the voluntary sector and welfare advice, such as the work around deep-end practices. I am sure that my health and public health colleagues may have a more technical definition or description, but that is how I see general practices.

Sandesh Gulhane: In relation to standard 7 in particular, could you explain in more detail the option to have MAT shared with primary care? Does that mean that the patient would be with an organisation, and that would count as primary care, or would they have to be with the GP?

Angela Constance: A lot would depend on the nature of the care that they are receiving. If we are talking specifically about medication-assisted treatment, that needs to be delivered by someone who is qualified to prescribe. The important thing about the medication-assisted treatment standards is that they make connections with other aspects of treatment—what is collectively known as psychosocial treatment and work to help people to address past trauma. A lot would depend on the type of care required and the type of care available in a local practice.

Sandesh Gulhane: Staying on standard 7, at the moment not all GPs are qualified to prescribe medication-assisted treatment—most probably do not. Is that something that you would like to happen more?

Angela Constance: Practice varies. For example, my understanding from NHS Lothian is that the majority of GPs are involved or could be involved in prescribing medication-assisted treatment to their patients. In other parts of the country, such as Tayside, the practice has been that people have been referred to more specialist centralised addiction services. As well as supporting GP practices with the resources and the range of services and support that they need to serve our communities, we have to recognise that there are vital connections for patients who are receiving medication-assisted treatment and who have primary care needs.

Laying aside the issue of who prescribes a medication-assisted treatment, every GP that I have engaged with says that they could do more at a community level—for example, for the physical needs that people who live with drug use experience. You will know better than me that people often have other health issues that can be addressed by accessing primary care.

Sandesh Gulhane: Absolutely, and GPs would look after their patients' needs—I certainly would—but my question is more specifically about who prescribes the medication. Would increased funding be given to general practice?

Angela Constance: The funding arrangements for general practice sit with the Cabinet Secretary for Health and Social Care, and I assure you that he engages well and often with the GP community on the host of issues that flow from the GP contract. I have opportunities with the additional resource that we have to reduce drug-related deaths, but it is not prescriptive—I have not said that all that money goes to ADPs or the third sector. It is about investing in services and approaches where the evidence shows that lives can be saved.

11:15

Sandesh Gulhane: I was heartened to hear that you have a focus on governance. With that in mind, how will you assess the 10 standards?

Angela Constance: I have a focus on governance and implementation. I answered the same question from Mr O'Kane. As well as the practical support provided through MIST to get the 10 standards embedded by next April, its work covers at least a three-year period for quality improvement and quality assurance. I said to Mr O'Kane that the last thing we want to do is to put all that additional investment, time, resource and support to embed the standards and then sit back and relax. We cannot sit back and relax; we need to keep on this.

Sandesh Gulhane: Absolutely. I listened to your answer to Mr O'Kane's question, but can you be more specific about what measures will be in place for that?

Angela Constance: In relation to the quality assurance and quality improvement that will underpin the on-going work of MIST, when I introduce a target for treatment, which will be at the turn of the year, the indicators that underlie that target will relate to qualitative information that will be informed by our experience of implementing the MAT standards.

The Convener: This has to be the last question, as we are running out of time.

Sandesh Gulhane: Absolutely—this is my last question. What will happen if you do not achieve the target?

Angela Constance: That will be for others to decide. My focus is not my future; I have been in Parliament for some time and have been in Government before, and I had a life before I was a parliamentarian. My focus is on getting the work done.

The Convener: I thank the minister for the time that she has spent with us this morning and, in particular, for the update and the offers of specific information on services around the country. That would be really helpful to us, because we are considering our work programme for the next year.

The committee's next meeting will be on 21 September, when we will host two round-table discussions with key stakeholders to explore session 6 priorities in relation to public health and NHS policy.

11:18

Meeting continued in private until 11:36.

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba