OFFICIAL REPORT
AITHISG OIFIGEIL

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

Thursday 24 November 2022

Session 6

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CONVENER

*Natalie Don (Renfrewshire North and West) (SNP) (Social Justice and Social Security Committee)
*Gillian Martin (Aberdeenshire East) (SNP) (Health, Social Care and Sport Committee)
*Audrey Nicoll (Aberdeen South and North Kincardine) (SNP) (Criminal Justice Committee)

DEPUTY CONVENER

*Russell Findlay (West Scotland) (Con) (Criminal Justice Committee)
*Paul O'Kane (West Scotland) (Lab) (Health, Social Care and Sport Committee)
Emma Roddick (Highlands and Islands) (SNP) (Social Justice and Social Security Committee)

COMMITTEE MEMBERS

Jeremy Balfour (Lothian) (Con) (Social Justice and Social Security Committee)
*Miles Briggs (Lothian) (Con) (Social Justice and Social Security Committee)
Stephanie Callaghan (Uddingston and Bellshill) (SNP) (Health, Social Care and Sport Committee)
*Foysol Choudhury (Lothian) (Lab) (Social Justice and Social Security Committee)
*Katy Clark (West Scotland) (Lab) (Criminal Justice Committee)
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Carol Mochan (South Scotland) (Lab) (Health, Social Care and Sport Committee)
Alex Rowley (Mid Scotland and Fife) (Lab) (Criminal Justice Committee)
Collette Stevenson (East Kilbride) (SNP) (Criminal Justice Committee)
David Torrance (Kirkcaldy) (SNP) (Health, Social Care and Sport Committee)
Evelyn Tweed (Stirling) (SNP) (Health, Social Care and Sport Committee)
Tess White (North East Scotland) (Con) (Health, Social Care and Sport Committee)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Alex Cole-Hamilton (Edinburgh Western) (LD)
Angela Constance (Minister for Drugs Policy)
Sue Webber (Lothian) (Con) (Committee Substitute) (Health, Social Care and Sport Committee)

CLERK TO THE COMMITTEE

Alex Bruce (Health, Social Care and Sport Committee)
Stephen Imrie (Criminal Justice Committee)
Claire Menzies (Social Justice and Social Security Committee)

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Criminal Justice Committee Health, Social Care and Sport Committee, and Social Justice and Social Security Committee

Thursday 24 November 2022

[The Convener opened the meeting at 08:33]

Decision on Taking Business in Private

The Convener (Audrey Nicoll): Good morning, and welcome to the third joint meeting in 2022 of the Criminal Justice Committee, the Health, Social Care and Sport Committee and the Social Justice and Social Security Committee to consider the progress that is being made in implementing the recommendations of the Scottish Drug Deaths Taskforce.

We have received no apologies. I welcome Alex Cole-Hamilton to the meeting. Foysol Choudhury should be joining us online shortly.

Our first agenda item is a decision on taking in private item 3, which is consideration of our forward work programme. Do we agree to take item 3 in private?

Members *indicated agreement.*

Reducing Drug Deaths in Scotland and Tackling Problem Drug Use

08:34

The Convener: Our next item is our third evidence session on reducing drug deaths in Scotland and tackling problem drug use. I refer members to papers 1 and 2.

I welcome to the meeting Angela Constance, Minister for Drugs Policy, and her Scottish Government officials: Orlando Heijmer-Mason, deputy director for drugs policy; and Roz Currie, team leader with the Drug Deaths Taskforce response. Thank you very much indeed, minister and colleagues, for joining us—and for forgoing your opportunity to make some opening remarks, minister. We will therefore move straight to questions.

I will jump straight in, if I may. First, thank you for keeping the committees informed about the development of the national mission plan and the oversight group, and for keeping the Parliament updated on a range of developments relating to drug deaths, the medication-assisted treatment standards, substance misuse and the justice system, and other areas of on-going work.

I will open up the evidence session with a couple of questions on alcohol and drug partnerships. The “Changing Lives” report sets out some of the challenges experienced by specific populations, including women and young people. I was disturbed to understand the correlation between deaths of

“women with substance use problems that occur in the perinatal period”

and

“child protection proceedings or having their child taken into care.”

On young people, the report says:

“Drug-related deaths among young people (under 25 years) have risen sharply in recent years.”

Related to that particular issue, action 30 outlines how

“ADPs and services must ensure specific pathways are developed to ensure young people can access the support they need when they need it.”

As a former member of the Aberdeen City ADP, I would be interested to hear any update that you can provide on action 29, relating to pathways for women, and action 30, relating to young people. Specifically, I would like to know about the progress being made by ADPs in developing local pathways to services and support, given their

crucial role in ultimately reducing drug harm and drug death numbers.

The Minister for Drugs Policy (Angela Constance): Thank you very much, convener, and good morning to all your colleagues. I very much appreciate the opportunity to come back to this tripartite committee as we embark on the national mission, particularly in our work to respond to the vital final recommendations of the Drug Deaths Taskforce, which are essentially about ensuring that all aspects of the public sector and all parts of Government are aligned. Although it is not for me to tell the committees how to proceed with their scrutiny of Government, it appears to be a fitting approach for scrutiny to be joined up, too.

You raise two crucially important aspects of our drug death challenge. When we look at the annual report that was published in the summer, we see that, although more men die, and significantly so, there has been a disproportionate increase in the number of women who are dying, and that has been a trend for some years. The annual report shows a small decrease in the number of men who are dying, but a continued increase in the number of women we are losing.

We know that the issue is complex. It relates to trauma, including past life trauma, but it also relates to women who are mothers. If we think that people who use drugs are stigmatised, that is even greater for women, in my view, and particularly women who are mothers. We know that the removal of children has a huge, traumatic impact and is a contributory factor to deaths.

We are working through the recommendations of the Drug Deaths Taskforce, and we will be supporting alcohol and drug partnerships to do likewise and, indeed, to develop pathways. You may have noticed that, earlier this week, we published the first annual report on the national mission and the alcohol and drug partnerships. We need to make more progress with some specific care pathways for women. Some of our investment in residential rehabilitation and residential services has been prioritised to meet that need.

On young people, the annual report that was published in the summer shows that, although the number of young people under 25 who had died reduced in 2021, it remains too high. It is important not to look at one year's figures in isolation; we know that the three preceding years showed concerning increases. As you will see in the annual report, although alcohol and drug partnerships all have services and supports available for young people, we need to do much more to be clear about the types and range of services that should be available in each area. That, in part, is why we have a stream of work specifically on young people, which relates to the co-design of standards of care and treatment and to the range of services. That work is proceeding, and I will endeavour to keep the committee and Parliament up to date on it.

The Convener: Thank you very much, minister. I will not ask questions on it just now, but that relates to how important lived and living experience will be in informing specific areas of work. Other members will touch on that later.

I open up the meeting to questions from members, starting with Alex Cole-Hamilton.

Alex Cole-Hamilton (Edinburgh Western) (LD): Thank you very much, convener. I appreciate the offer to allow me to come and sit with the committees today.

I have a couple of questions on ADPs and MAT standards, but I would like to start immediately with deaths among young people. It is a topical issue, as there was a death in my constituency a couple of weeks ago, at a festival, as a result of someone taking drugs. I have had meetings with the festival organisers, whom I had met beforehand, and they are exemplars in providing a safe space, with a state-of-the-art medical facility on site, security and healthcare staff.

Very sadly, the young lady died having ingested substances before she attended the festival, so there was nothing that a zero-tolerance approach could have done to protect her. However, there is a perverse reality in the way that we are policing our festivals in Scotland at the moment, as opposed to the approach in England. We have a zero-tolerance approach to drug use at festivals, and I understand that, on paper, that sounds compelling. In England, there is pill testing, with a recognition that some people will just get high at festivals; we want them to be able to do so in safety.

Have you considered having discussions with the Lord Advocate around the policing of such events, so that we can allow young people, or people of any age, to attend festivals as safely as possible, with a recognition that we will just not stop people choosing to take substances on occasion and that we need to allow them to do so in safety, as is done in England and Wales?

Angela Constance: First, I offer my condolences to the family of Mr Cole-Hamilton's constituent. Any death is a tragedy. We all feel that, and the death of young people is always particularly sore.

That points to the need for drug-checking facilities. I have discussed the matter fairly extensively with the United Kingdom Government and UK ministers such as the Minister for Crime, Policing and Fire. Mr Cole-Hamilton may have a

slightly different understanding of the position in England. In my engagement with UK ministers, they have been really resistant to drug-checking facilities at festivals. I am aware of one licence having recently been made available to support festivals on a short-term basis.

08:45

It is fair to say that we do not have enough drug-checking facilities at those types of events across the UK. Drug-checking facilities require a Home Office licence. For years, a postal service has operated in Wales whereby people can get substances tested.

The important thing about drug-checking facilities is how they are layered with other methods of harm reduction. I am very much in favour of extending drug-checking facilities. Across the UK, we are not doing enough of that . In Scotland, there is work on three projects, and research is going on at the same time that those projects are being developed. One of those projects is nearing a position at which it will be able to make a licence application to the Home Office. The projects are geographically specific.

We will, of course, engage with all colleagues, including the Lord Advocate, on whether different approaches are required, based on experience and such tragedies.

Alex Cole-Hamilton: I am grateful.

Despite some success in the recent implementation of the MAT standards, it is still proving difficult to access same-day services in rural areas, in which clinics are few and far between. What are your plans to increase the provision of same-day services in rural and harder-to-reach areas?

Angela Constance: That is a fair point. I will not sugar-coat instances in which progress has not been good enough or fast enough. You are right to allude to the fact that, although the majority of the red-amber-green statuses in the benchmarking report by Public Health Scotland were amber, there were not enough greens and there were too many reds, particularly in and around MAT standard 1, which is that crucial, life-saving, same-day treatment. That is why, for the very first time, we have a ministerial direction that places certain requirements on chief officers and chief executives of health boards, integration joint boards and local authorities.

I am due to update the Parliament imminently—maybe in the next fortnight or so; certainly in the next month—on progress since my last update. That is based on the improvement plans that we have received from every area. Some areas are in a cycle of quarterly reporting. Others, where the challenge is greater, are subject to monthly reporting.

We are beginning to see some good and innovative practice in and around rural areas, and perhaps we should share some case studies with the joint committee. I point to the Borders, which is a rural area and is the only area that was able to secure green status across MAT standards 1 to 5. If we can do it in the Borders, we can do it elsewhere. Let us not underestimate the challenge, but that can and should be done.

Alex Cole-Hamilton: May I have a final question, convener?

The Convener: I will come back to you. A lot of members have questions.

I bring in Katy Clark, after whom we will move on to questions about statistics, for which I will bring in Natalie Don.

Katy Clark (West Scotland) (Lab) (Criminal Justice Committee): Minister, as you are well aware, drug deaths are significantly higher in Scotland than in other parts of Europe. From the work that you have been involved with so far, and all the work that has been carried out, have you been able to come to any conclusions as to why that is? What evidence is there to show why we fare so badly?

Angela Constance: I distil that into three important factors. It is complex, and we have deep-rooted challenges in Scotland. The task force and various other academics have written extensively about the acute poverty in particular areas of the country. We all know the research on the relationship between substance use, past trauma and poverty.

You asked specifically why there is an issue in Scotland. First, according to the information that we are able to gather, there is a higher prevalence of problematic drug use in Scotland. There is an existential question as to why that is.

The second point is the prevalence of heroin and benzodiazepines in drug-related deaths. It is not always possible to make direct comparisons, because England is a bit different when it comes to the underlying work on drug misuse deaths and the proportion of cases that go through toxicology and forensic screening. However, benzodiazepines are much more greatly implicated in our deaths than is the case in England and Wales—although I have noticed that some reporting and recording have begun to indicate a rise in benzodiazepine problems south of the border. The higher implication of opioids and heroin in our drug deaths speaks to higher-risk behaviours, more injecting and the lethal combinations of polydrug misuse and people with multiple and complex needs.

Thirdly, it is about treatment. Time and again, I have been utterly frank that not enough of our people are under the protection of treatment. We need to get more people into treatment—and, if they fall out of treatment, we need to follow up on that. That speaks to the importance of the MAT standards, and not just investing in services but reforming them. I have opinions on other aspects—for example, the Misuse of Drugs Act 1971. However, a core part of the national mission is about the need to invest in and reform our treatment services, which we are doing. Crucially, however, that must not be done in isolation from the other cross-Government work that is so important.

Katy Clark: The task force report contains 20 recommendations and 139 actions. Will you put on record whether you accept all those recommendations and actions, and whether the Scottish Government is going to pursue all of them?

Angela Constance: As you will appreciate in the context of those 20 recommendations and 139 actions, the task force was an iterative process; other recommendations came out earlier. Through the information that I have given to the committee, I hope that I have demonstrated that progress is already under way. We did not sit back and wait for the final recommendations of the task force. I gave a very warm welcome to the challenge, and to the criticism—to be frank—that the final report contained for the Government.

Given all those actions, we have a lot to work through, but I will endeavour to demonstrate an overwhelmingly positive response at the turn of the year, when we come back to the Parliament with the cross-Government action plan and the stigma action plan.

On whether we will implement every recommendation in the precise way that is envisaged in the report, you will appreciate that it is the role of organisations and people who make recommendations to make those recommendations, and it is for Government to work out how they might be delivered.

Katy Clark: So will we hear more on that?

Angela Constance: You will indeed.

The Convener: I call Natalie Don, after whom I will bring in Paul O’Kane.

Natalie Don (Renfrewshire North and West) (SNP) (Social Justice and Social Security Committee): Thank you, convener, and thank you for letting me join the meeting. Good morning to the minister.

According to the statistics, in 93 per cent of drug deaths, more than one drug was present. I note that the report contains little reference to alcohol. Do we know how regularly alcohol was present with another substance? From my experience, both in my personal life and in dealing with constituents, I know that alcohol often leads to other things. When it comes to measures for prevention and early intervention, what research is being done on the part that alcohol plays in drug misuse or, equally, on those statistics?

Angela Constance: The member is probably aware that separate statistics are produced about deaths that relate to illnesses or health conditions that can be traced to the problematic use of alcohol. I know that we are talking about statistics but, for the record, we are also talking about lost lives and people. I will try to do that as sensitively as I can, rather than get into a too dispassionate discussion of statistics.

The annual figure for drug-related deaths is in relation to the use of illicit substances and controlled drugs. That is the purpose of those statistics—they show how many deaths happen as a result of controlled drugs and illicit substances. You are right to point to the figure that 93 per cent of the people we lose have more than one substance in their system. Of those we lose, 11 to 12 per cent also have alcohol in their system. That figure is down on previous years. In some years, it was up to about 30 per cent. That speaks to the growing problem with other substances, as opposed to a reducing problem with alcohol.

There is another area in which we need to distinguish. The national mission is absolutely focused on those who are at risk of dying, and therefore on developing treatment options for opiates, benzodiazepines and cocaine. However, if we speak to organisations such as Scottish Families Affected by Alcohol and Drugs, they will say that their number 1 concern about the families and people that they support is still alcohol. The work done by David Nutt and published in *The Lancet* details the harms caused to individuals, society and others by various substances, and it shows that alcohol is at the top of the list.

Natalie Don: In recent years, drug misuse deaths have increased in all age groups except for those under 25, although, as the minister said, the figure for that group is still too high. Does that offer any hope that preventative or early intervention measures are working or starting to work? Do we have any data on drug use in the 15 to 24 age group or about the drugs that are being used by those people in comparison to any other age group? Does the minister feel that enough work is being done to distinguish between the different age groups, the kinds of drugs that are being used and the frequency of use? That information is vital for education and for the early intervention measures that we have discussed.

Angela Constance: We have information from some of the surveys that are done in education. We know that young people are different from those in other age groups—I refuse to use the term “older”. We know that young people are less inclined to use heroin, and that cannabis and cocaine are bigger factors in young people’s drug use patterns.

I did not address the part of your earlier question about what we are doing on education and prevention. That is why we have a national mission. Our drugs policy and our work in the here and now to prevent people from dying cannot be in isolation from the longer-term and very necessary work. I do not want to read too much into the reduction in the number of young people dying in one year’s statistics, because it is always important to get underneath the headlines.

The work in schools is crucial. There is work with young people that is about substances overall. We should not overly fragment that. We must engage, and we are engaging, with young people through a curriculum that looks at tobacco, alcohol and illicit substances.

09:00

One of the asks in the cross-Government plan is to review what we are doing, and there are strong arguments with regard to the need to up the data. Last year, we published research on interventions, which must be about increasing young people’s resilience, confidence and knowledge. Although we want young people to have particular information so that they are equipped to reduce the harm that is associated with substances, there is a broad approach that is about upskilling young people and increasing their resilience.

There is a larger agenda outwith education about diversion from the criminal justice system. I am interested in the way that some areas are looking to adapt—not just shift and lift—aspects of the Icelandic model. That model is about not just treatment and diversion from the criminal justice system but investment in young people and their resources, pastimes and broader health and wellbeing as well as other purposeful activities.

Paul O’Kane (West Scotland) (Lab) (Health, Social Care and Sport Committee): The figures on drug deaths focus on overdose, and much of our approach has been focused on that. However, it is clear that there are other drug-related issues that can lead to deaths, not least of which are issues such as HIV, hepatitis C, cardiovascular problems and end-of-life liver and lung disease. My understanding is that we do not capture the data with regard to such deaths, so what are your reflections on how we might collect some of that data to ensure that we push the resources to the right places?

Angela Constance: That is a fair point, and it is important to remember that our focus on the national mission and on drug deaths sits in the context of wider efforts to improve the health of the population as a whole. My understanding is that some data is collected with regard to deaths for specific reasons, including deaths as a result of HIV. Information is published on issues such as wound care and blood-borne viruses. However, I will consider whether enough of that information is routinely published—it is a conversation that I have with Ms Todd—as well as where that sits with regard to management information and experimental information and whether there is an appropriate regular publication cycle. That issue sits very much in the terrain of improving overall population health. I will come back to the member on that.

Paul O’Kane: That is helpful. I am keen to ensure that the minister reviews that matter. I am not trying to catch her out or to add to what is an important piece of work, but it is important that we capture those other aspects, so that we can ensure that all our resource is focused. That is particularly important with regard to the resources that are available to communities for work on the broader associated issues, including accidents that are related to drug use and personal safety. Does the minister want to add anything on that?

Angela Constance: I agree that it is important that we have a wide and appropriate dashboard of information so that we can understand all the harms as well as the contributing factors to drug-related deaths. It is important that we have that information about all drug-related harms. Through the publication of the national mission plan in September and the national mission annual report and the ADP annual report, I hope that I have demonstrated, at least to some extent, that we have an outcomes framework. In the national mission plan and the national mission plan annual report, you will see the information that we are using and that feeds in so that we can capture those harms. However, if the committee came to the view that we were not capturing all that, we would endeavour to address that.

Paul O’Kane: Thank you.

The Convener: We move on to questions on lived experience. I will bring in Gillian Martin and then Miles Briggs.

Gillian Martin (Aberdeenshire East) (SNP) (Health, Social Care and Sport Committee): I would like to ask the minister, as I have done quite a few times, about people who need to access treatment but have caring responsibilities, particularly mums and dads. The framework for

families that was published last year had a lot in it about that.

What progress has there been? I know that, this week, there were significant announcements about progress in relation to facilities, but what progress has there been in helping people to access treatment, of whatever type, when they have caring responsibilities?

Angela Constance: I will give you one example. Yesterday, I was at a recovery-oriented systems of care event for women, where 200 women in Glasgow with lived and living experience were putting the world to rights and certainly holding my feet to the fire. It was a fabulous event with the Glasgow ADP lived and living experience reference group, which will also be one of the reference groups for the national collaborative.

I met a woman at the event who told me that, when she embarked on the early stages of her recovery journey, social work were involved with her and her children, and they were of the view that she could not take her child to a fellowship meeting—a recovery meeting. In my view, although I am not making judgments about such cases, that begs the question whether we understand enough about the recovery community and recovery opportunities. That meant that that lady was very constrained in the time that she could spend going to meetings and investing in herself and her recovery. Sometimes, quite simple things can be done in practice that involve taking a more personalised care approach by acknowledging the challenges that parents with caring responsibilities have.

Monday was a great day with the official opening of Harper house in Saltcoats. It has actually been open for a few weeks now, and the first families have begun to come in. It opened for referrals last month, and we are now beginning to see more referrals, with families entering the great facility. Harper house is a national specialist facility that is available to families from all over Scotland. It will be a leading therapeutic facility, and services across the country will be able to learn from it.

We are doing other work, such as our work with Aberlour. On child and mother houses, we are working with the River Garden Auchincruive in Ayrshire, which is increasing its facilities for women.

In relation to the whole-family approach, the families framework is a stream of work that is led by multidisciplinary experts in the area. They are, of course, working to support and share best practice, but they will also do an audit of how the framework is being implemented. Again, that is about gathering and publishing more information so that we can support, but also scrutinise, what is happening on the ground.

Gillian Martin: You have pre-empted my second question, which is about auditing what has happened previously.

All of us will have heard of situations in which a mother has had a child taken away from her and has then fallen pregnant again, with the expectation that that child will be taken, too. Will we drill down to see where support can be put in place to help somebody to have a better outcome when they find themselves pregnant again and are worried about their child being taken off them?

Angela Constance: We have made a cross-Government commitment to keep the Promise, which is about keeping families together and preventing the unnecessary separation of children from their parents, because that is in everybody's interest. Our work also speaks to the additional stigma that women and mothers experience if they have a problem with substances—I know that we will discuss stigma later today in the chamber. Many women fear coming forward to seek help so, as well as early intervention, cultural changes are needed to ensure that women feel safe in coming forward and can build trusted relationships.

Miles Briggs (Lothian) (Con) (Social Justice and Social Security Committee): Good morning. In what we are examining, a gap exists in relation to housing and homelessness. I have raised that issue with the minister a few times, but it is still not being addressed. Frankly, the Government is also not talking about the housing crisis.

This week's statistics show that, of the deaths of 222 homeless people, half were drug deaths. Ministers seem to have taken their eyes off the ball in that area, but we need action and supported housing models to be put in place. What is the Government doing about that?

Angela Constance: That area has certainly not been forgotten. All the lived experience evidence tells us that, when we distil all this, what people need is a home, relationships and to feel valued and that they have a purpose in life. We can help with that by supporting people to take up volunteering opportunities or employment.

People have a basic, fundamental need for accommodation. I hope not to depersonalise the loss of life in any way by talking about statistics, but the information from the homelessness death statistics is crucial. Mr Briggs is absolutely correct to say that death rates among homeless people are too high and that more than half of those deaths are drug related—a very close association exists between homelessness and drug-related deaths. I am not one for overreading one set of statistics but, by way of information, I note that the number of drug-related deaths in that set of figures

reduced from 151 to 127—in the homelessness death figures, there was a reduction in the number of drug-related fatalities. That figure is still too high, but the reduction points to some movement.

I am a big proponent of the housing first approach. Mr Briggs will be well aware of the Government's ambitious record on building social housing. However, there cannot be housing without support, which is why Ms Robison and her team are taking forward the housing first approach—as well as other ones—to provide care for people as well as accommodation.

Miles Briggs: I shadow Ms Robison and—let us be honest—the housing first model is sometimes part of the problem. Often, people who have chaotic lives are not able to hold down a tenancy, and that sets them up to fail. I have asked why we do not fund the building and putting in place of more supported accommodation, because we should have done so years ago.

I hope that, if she has not already seen it, the minister will visit Rowan Alba in Edinburgh with me at some point. The charity provides accommodation—supported living—for individuals with alcohol brain damage, which stops them being homeless. In Edinburgh, 50 people who could be in that type of accommodation are on a waiting list, but nothing is happening to take that forward.

There are also 1,095 children living in temporary accommodation in Edinburgh, and I know from my casework that they are developing acute substance abuse issues. We need to see a shift in that regard. Housing first is a good policy, but it is not delivering for that group of people and it needs to be rethought.

09:15

Angela Constance: I will say something that, I hope, is positive but is perhaps also a bit defensive. The housing first model is good in that it is designed to provide enough flexibility to meet the needs of individuals. It recognises that it is unrealistic that some people, because of the chaos and trauma that they live with, will be able to sustain their tenancy on their own, so we should not step back from the housing first model.

However, you have a point about other models of care. In relation to drug treatment, we have strong and clear commitments on residential rehabilitation and the abstinence-based recovery model—we are not stepping away from that—but there is a need for other models of care. Supported accommodation is clearly part of that, and that links with the work on homelessness and mental health.

There will be an opportunity for the Parliament to consider our approach when the homelessness prevention duties are refreshed. There is something very powerful about the ask and act approach. Too many people are in inappropriate temporary accommodation. As a constituency MSP—although I do not represent a city—I have encountered young people being put into inappropriate accommodation, and that is not keeping the Promise or doing our best by every child.

I appreciate that there are challenges in and around cities. Through our work on the cross-Government action plan that we will produce, we are thinking about specific things that we can do more of to scrutinise and support cities, bearing in mind that, as we know from the annual report, Glasgow, Edinburgh and Aberdeen all had rising drug death rates.

Miles Briggs: Have I got time to ask an additional question, convener?

The Convener: I might come back to you. I still have a number of members to bring in, so I would appreciate as succinct questions and answers as possible.

Russell Findlay (West Scotland) (Con) (Criminal Justice Committee): I have got a lot to ask about but so, too, does everyone else, so I will stick to what I think is the most important issue.

Yesterday, Faces and Voices of Recovery UK published a new report, which, as I am sure that the minister is aware, is quite critical of the Scottish Government. It talks about a phenomenon that it identifies as "pretend rehab services" in which services that are being categorised for the purpose of rehab are really for stabilisation. As helpful and important as stabilisation is, do you accept that criticism, and how do you respond to it?

Angela Constance: The Government and the residential rehabilitation development working group are very clear about what residential rehabilitation is and what it is not. The definition is very clear: residential rehabilitation is structured, residential and therapeutic programmes that support people towards an alcohol and drug-free lifestyle. There are other models of residential services, whether those focus on crisis care or stabilisation.

Those models are also important in ensuring that we have a wide spectrum of treatment opportunities and services to get the right people into the right treatment at the right time. I dispute the claim that we are investing in pretendy residential rehabilitation; that is unfair. What we are counting, if I can put it that way, and what we are funding is a traditional residential rehabilitation

model that has been undervalued and underinvested in historically.

Russell Findlay: It is worth noting that the FAVOR report did not use the word “pretendy” but the word “pretend”.

On the subject of counting rehab beds, I have seen an email that a senior policy officer in the Scottish Government’s residential rehab team sent this month. That official said that there was an error in a Scottish Government report about rehab beds.

It became clear after the report’s publication that wrong information had been published about more than 40 rehab beds. Those were in fact stabilisation beds, not rehab beds. That meant that the document wrongly said that there were 218 rehab beds when there were in fact 170. How can something like that happen in an official Government report? Does that speak to FAVOR’s concerns about a blurring of the lines—as evidenced by that mistake—between rehab beds and stabilisation beds?

Angela Constance: First, Mr Findlay, that was not a Government report; it was a Public Health Scotland report. You are right to say that an error was established in the information that Public Health Scotland had received from Glasgow. Therefore, the quarterly figures had to be revised down, and there was transparency around that.

Regarding the quarterly figures to which you refer, 170 residential rehab placements have been funded by the Government, which is the highest-ever number that has been funded in any quarter.

One reason that we publish information is so that we can scrutinise what is happening in every local area. I know for a fact that, in the past financial year, we have supported the funding of more than 500 residential rehabilitation placements and that, over the lifetime of the national mission, we have supported the funding of more than 700 residential rehabilitation services. I accept that it is important to distinguish between stabilisation services and residential rehabilitation.

Russell Findlay: On the subject of transparency, the Auditor General’s March report said that there is a lack of transparency about where spending is taking place. When I met him last month he told me that things are still much the same. Why is there no transparency about the £250 million?

Angela Constance: At the start of this week, I published—in part due to recommendations by the Auditor General—an annual report that details the spend and location of national mission moneys. I am determined to have as much transparency as possible about that.

I am determined to follow the money. I think that that is where I am on the same page as the Auditor General, because I want to ensure that the additional resource that the national mission has secured has the maximum effect. This Government has made a decision to allocate specific resources to residential rehabilitation and I want to ensure that that is used for pathways into residential rehabilitation, for residential rehabilitation beds and, of course, for the associated aftercare. I am accountable to Parliament and I want to satisfy myself that money is being spent on what it was destined for.

The Convener: I will bring in Gillian Mackay, who has some questions about safe consumption rooms, then I will bring Paul O’Kane back in.

Gillian Mackay (Central Scotland) (Green) (Health, Social Care and Sport Committee): The minister knows my interest in the progress of safe consumption rooms. Will she give an update on the work in that area?

Angela Constance: Ms Mackay knows that I firmly support safe drug consumption facilities. I had the opportunity to visit a facility in East Harlem in New York. Before there are any questions about that visit, please note that I was in the States in my own time and at my own expense.

The evidence shows that safe drug consumption facilities work and that they save lives. They are not a silver bullet, but they have a role to play. We have worked very hard with our partners, including Glasgow City Health and Social Care Partnership, the Crown Office, Police Scotland and others to develop a service specification proposition, which has been submitted to the Crown Office.

More specifically, the Crown Office has been gathering further information, as I understand, from Police Scotland, and it is nearing the point at which it can give advice to the Lord Advocate. You will appreciate that I cannot speak on behalf of the Crown Office or our independent Lord Advocate.

Gillian Mackay: We have a debate on stigma this afternoon, so I do not want to pre-empt anything in that. What work is being done in communities where safe consumption rooms could be placed to ensure that the stigma around the service is reduced, that people understand the purpose of the safe consumption rooms and that they know of their potential public health benefits?

Angela Constance: There is a role to play when it comes to tackling stigma, understanding drug and alcohol issues as a public health issue and understanding people’s attitudes towards various treatments. Sometimes, people have views about the location of any service in their community, so it is important that local services engage and have open dialogue with local communities.

The Convener: I move to Paul O'Kane, then I will bring in Alex Cole-Hamilton.

Paul O'Kane: In previous discussions of safe consumption facilities, we have talked about the legal barriers that exist, and I think that the minister would contend that that is a significant challenge to the ability to deliver them. I am interested to understand what analysis officials have done of current legislation that might help to overcome that. Have the provisions in the National Health Service (Scotland) Act 1947 been looked at, for example? They put a duty on Government to promote a comprehensive and integrated health service

"to secure improvement in the physical and mental health of the people",

and the prevention, diagnosis and treatment of illness sit within that. To what extent have officials looked at other legislation that might help us to move forward?

Angela Constance: I want to make two broad points. We are still waiting on the Lord Advocate to give us a view on whether the service specification and operational procedures are within our powers and whether it rests within her powers to determine prosecution policy and what is in the public interest. That is a core consideration of the matter.

Mr O'Kane is right to point to other health-related legislation. The other legislation that we cannot ignore is the Misuse of Drugs Act 1971. We have worked hard with partners to devise a proposition that is, we hope, within what we can currently do in Scotland, but I am not the final arbiter of that, hence the role of the Lord Advocate.

You also allude to Gillian Mackay's point that there are other models and other ways to implement safer drug consumption facilities. There is the fixed model with fixed premises, there are clinical medically led models and there are other models that are voluntary sector-led. Of course, there are models of mobile safe drug consumption facilities as well. Although I would ideally rather have started from the position of considering which model will best meet the needs of our people, because of the 1971 act, we are framing a service in relation to our powers.

The work has been detailed, difficult and precise, but the approach that we are looking at is not the ideal way to do things. There are other models. We are framing our proposition around what we hope is within our powers, but I am not the final arbiter of that, as you will appreciate.

Paul O'Kane: I will come back in briefly. It is helpful to hear about the context of what is being looked at. However, would the minister also be willing to share whatever information she has gathered on, for example, the specific act to which I referred?

09:30

Angela Constance: Yes, that is not a problem—we will have a look at that.

The Convener: Sue Webber has a follow-up question, then I will bring in Alex Cole-Hamilton.

Sue Webber (Lothian) (Con) (Committee Substitute) (Health, Social Care and Sport Committee): Minister, I have a specific question that follows on from what Paul O'Kane said. What correspondence have you had from Police Scotland, the Crown Office and other justice authorities regarding the proposal for safe consumption rooms, and can you make that public?

Angela Constance: The proposition could change depending on the feedback that we get from the Lord Advocate and the Crown Office in due course. Our work has centred on one service in one city, but there has been a broad range of work. The correspondence around that work is not all mine; the committee will appreciate that there is a central role for the independent Police Scotland and the integration joint board.

My approach in Government has been to facilitate and support that work, and to enable people to build from the ground up a proposition that is framed within the powers that we have. I will look at what it would be appropriate for me to share, because I appreciate the great interest in that aspect.

I also appreciate that there is strong parliamentary support for safe drug consumption facilities. Although I know that some Conservative members have reservations, I take them at their word that they are not looking to stand in the way of a pilot.

Sue Webber: Indeed. Thank you, minister.

The Convener: I will bring in Alex Cole-Hamilton.

Alex Cole-Hamilton: Thank you very much for bringing me back in, convener. The minister knows about my party's long-held support for safe consumption rooms. That speaks to the approach that we discussed in our earlier exchange, which is about understanding that people will always consume; that zero tolerance does not work; and that we need to help people to consume as safely as possible if that is their choice.

The matter now rests with the Lord Advocate. We know from yesterday's events that she has been very busy. Is the Lord Advocate working to a timeline? Do you have an expectation of when she

will come back to you on the matter? With every week that goes by, lives are potentially not being saved.

Angela Constance: I appreciate the point that time is of the essence. Again, as members will appreciate, it will not help matters if I step into other people's duties and terrain. Nevertheless, your point is well made. These services work. They are not the only solution, but they work, and I have seen them for myself.

The core aim of the national mission is to get people into the treatment that is right for them. Although I have—I hope—conveyed my conviction in and around abstinence-based intervention and traditional residential rehabilitation, I also stress that we need to be absolutely fearless about harm reduction, because lives depend on it.

I know that some aspects of harm reduction will feel counterintuitive to many people, but we have to do what works, follow the evidence and do what we can to reach people where they are, so that we can build relationships and begin the journey to connect them with other services. Safer drug consumption is part of that. It is about saying that we care and we want people to live, survive and thrive.

The Convener: I will bring Sue Webber back in to pick up some questions around early intervention, and then we will move on.

Sue Webber: Convener, can I also ask a question about the no-wrong-door approach?

The Convener: Yes.

Sue Webber: That is fine—I just wanted to check.

The Drug Deaths Taskforce has recommended that the Scottish Government prioritises intervention at an earlier stage, tackling the root causes of drug dependency, and that links between work on poverty, structural inequality, education and children and young people and work on drug policy be made clearer. Those are things that we hear about across all committee portfolios in relation to early intervention. Will the minister outline what early intervention should look like in this policy area? What steps will she be taking to ensure a more joined-up approach to tackling all the root causes of drug dependency? I note that Mr Briggs mentioned housing issues earlier.

Angela Constance: The reason why we have a national mission is to join the dots, so that drug policy does not sit in isolation. Ms Webber asks a fair question about what early intervention looks like in relation to drug policy, our work with families, work with communities and work with housing and homelessness. That all needs to be absolutely aligned. The purpose of the cross-government action plan is to align the whole breadth of actions and the huge investment that is being made—despite what are trying times across government—in a better way and to work better together to achieve better outcomes.

Regarding our support to alcohol and drug partnerships, it is clear that they should not be working in isolation. They need to be very much connected, and the work that they do must be central to children's services plans and broader community planning.

All public authorities have a fairer Scotland duty. I know that because I introduced it a number of years back, as Mr Cole-Hamilton might remember. In every strategic decision, we need to think about how the decisions that we make here and now have an impact on child poverty and on reducing poverty and inequality. Our work with ADPs is driven by the fact that the work that they have done has often been separate from other work done by IJBs or community planning partnerships—but it has to be front and centre.

Sue Webber: Thank you for that, minister. I am glad to hear what you say about joining the dots, which is the intention and ambition of what we are doing. We have had a discussion around a constituency case in which the individual found their situation very challenging, having first tried to access services in February but not gaining a space in rehabilitation until September. Again and again, we hear about people who seek services being treated like a pinball in a pinball machine: they are pinged about, and they follow the route that the service wants them to follow, rather than it being centred around them. We often hear about person-centred care, but I do not get a sense that the service is really delivering for people in that way.

As regards the no-wrong-door approach, we are not getting a sense that what is happening on the ground is the same as what is being stated in documents, by ministers and by civil servants. What can we do to address that implementation gap to ensure that there is no wrong door for people to go to and that they get help quickly, rather than having to wait six or seven months before they can access it?

Angela Constance: There are a number of layers to that. I return to a point that I made earlier: the reason why we are publishing lots of local information about what is happening with additional investment is so that it can be scrutinised and so that, where there are issues, they can be addressed. The member will be aware from our previous discussions, which I will not rehearse, that every area now has a pathway into residential rehabilitation.

What I hear about most from my engagement with people on the front line and people with real-life experience is the fragmentation of services. That is why we have a national mission and a Drug Deaths Taskforce, which has made some strong and challenging recommendations, and not just about no wrong door—there should be no closed doors to people.

The biggest frustration that people have is being bounced around between services. The ask and act homelessness prevention duties will help. It is not just about people being passed from pillar to post. In key posts in the public sector, people have duties to ask and then act.

The work on mental health and substance use services is also critical. Our response to the Drugs Deaths Taskforce will align with our response to the two reports that the Mental Welfare Commission for Scotland published this year and the rapid review into mental health and substance use services. Some of that is about services on the ground being really clear that they cannot deny somebody a service or treatment until the individual is, for example, abstaining from drugs or alcohol.

There needs to be much clearer understanding about what the lead service should be—whether it is mental health or substance use—and when the other partners should be brought in. We will come back to the Parliament on that.

Sue Webber: Where does accountability for that lie?

The Convener: I ask for a succinct answer. We still have a number of questions and about 15 minutes left.

Angela Constance: There is accountability at each and every level. I am stepping up accountability for local areas, but I stress that I am not asking other people to do anything that I am not prepared to do myself. Accountability and leadership are crucial not only at local level but at senior levels in IJBs, local authorities and Government. Accountability is needed at each and every level. We are accountable to ourselves and one another and we need to challenge ourselves and one another.

The Convener: We move on to questions on the national stigma action plan.

Foysol Choudhury (Lothian) (Lab) (Social Justice and Social Security Committee): Good morning, minister. People from a minority ethnic background are often hit harder by cultural or community stigma and might find it harder to seek help when they need to. What can be done to address that?

Angela Constance: That is an important point and is reflected in our national drugs mission plan. You will see in our outcomes framework the importance of not only tackling poverty and inequality but focusing on equalities and different groups.

I have already spoken about women and young people. My concern is that we are not doing enough to reach into other communities. I am conscious that, sometimes, services can have stereotypes and misconceptions about other communities. I assure Mr Choudhury that my officials and I have begun to make better contacts with groups.

The visibility of the recovery community is a factor as well. That has encouraged other groups. I recently made contact with the lady from the Scottish women's Muslim group, for example. I am conscious that, although drug and alcohol problems can be hidden across our society in general, they can be even more hidden in some communities. Some of that can be related to our false perceptions of other communities. We really need to think more sharply about how we reach out to other communities. If members, especially Mr Choudhury, wish to engage further on that, I would be delighted to do so.

Foysol Choudhury: Thanks for the answer, minister. I will be happy to get involved in future.

Gillian Martin: I have only one question, which is on stigma surrounding medication-assisted treatments. During the minister's tenure there has been a lot more nuanced conversation about how such treatments can form a pathway that will prevent many people from getting into crisis and also prevent drug-related deaths.

09:45

Will she outline how stigma around such treatment might cause massive harm to people? Could the discourse that we have in politics and in the media about people who have to access methadone, for example, cause more harm?

Angela Constance: It is fair to say that stigma about certain types of treatment exists in certain quarters. Some of the discourse that we read or hear about methadone, for example, is unhelpful. Time and time again, I have said that I am not interested in supporting harm reduction or medication-assisted treatment at the expense of residential rehab and abstinence. Neither am I interested in supporting abstinence over harm reduction. The only thing that I am interested in is supporting people, and they need to have informed choices and options.

There is a large international evidence base on different strands of medication-assisted treatment. However, medication should never be our only offer to people, hence the importance of

implementing MAT standards that involve treating drug and alcohol issues on a par with other health conditions. If any of us sitting here were to trip up to our doctor with any other health condition, we would be given information and choices and we would have a bit of a discussion about what is best. The same ethos should apply here: people should always have choices, options and the space in which to engage and make informed choices about what is best for them.

I am not interested in false arguments around, for example, harm reduction versus abstinence. We have to dump our own ideological perspectives—my views on many things have changed over the years—and we must follow the evidence, but it is crucial that we listen to what each individual wants and needs.

The Convener: I am going to move swiftly on. We have seven or eight minutes left to cover questions on public health approaches in the justice system.

Natalie Don: I note that the Drug Deaths Taskforce's final report states that it found

"tentative support ... for ... decriminalisation or a regulated market",

which have been shown to reduce drug deaths in other countries. Such an approach would allow resources to be better focused and could work to reduce stigma among the general population. Would the Government pursue such an approach if it were possible? Will the minister advise the committee of any discussions that have taken place with her counterparts at Westminster on the issue? The UK Government has recently suggested that it will follow a more punitive approach that could work against the public health approach that we are taking here in Scotland

Angela Constance: Gosh! How to answer that succinctly? I will do my best, convener.

My focus in this job has always been, first and foremost, on what I can do; therefore, my endeavours are focused on the powers and resources that are at my disposal. I am a pragmatist at heart, and I want to crack on and do things now. However, I do not ignore the implications of powers that exist elsewhere. I am not looking to enter into a constitutional debate here and now but, of course, the Misuse of Drugs Act 1971 has implications for what we can and cannot do. In my view, it impairs some of our approaches to harm reduction—or certainly makes the journey towards improving such interventions harder.

The issue of decriminalisation, or drug law reform, is complex. I would frame the issue as drug law reform more generally. Decriminalisation means different things in different countries, but in terms of going back to principles and the basics, the question is what is gonnae work—what is gonnae make folk safer, if not safe. I am very clear that we cannot punish people out of addiction.

We published a paper last March or May that looked at international responses to drug law reform. The international evidence that we have looked at shows, in very broad terms—I am summarising, convener—that the public health approach has been more effective at reducing harm. Some people have fears around drug law reform more broadly and often worry about increasing drug use, but the evidence does not appear to show that that happens.

In my view, we need to have a review of drug law across the UK, but I think that it is fair to say that the UK Government is not inclined to do that. I will meet the new minister at the beginning of December—that is a frequent discussion point.

The Convener: Finally, I come to Katy Clark, and then we will bring the session to a close.

Katy Clark: Minister, picking up on the point about your dialogue with Westminster, it is clear that the UK Government is taking a very different approach, which has been far more punitive than the public health approach that is being discussed here today. On the basis of the discussions that you have had so far, what scope is there to be able to do genuinely different things in Scotland? I appreciate that it has been a changing scene in Westminster and that you will meet a different person in December to those you have met before, but where are you in the discussions about having divergence in Scotland and being able to go ahead with some of the things that are within our competence, such as consumption rooms, as well as to consider other initiatives? How do you feel that you are getting on with that? Are you able to focus on specific proposals in your discussions?

Angela Constance: Despite some well-documented differences of opinion with Kit Malthouse, who was the first UK Government minister I met in relation to this job, we nonetheless had a lot of engagement. The quick succession of ministers in recent times that has coincided with recent changes of Prime Ministers means that two ministers were in office for such a short period of time that, although I wrote to them welcoming them to their role and raising all the issues that I wished to discuss with them, time did not permit us to actually meet them.

There is some agreement between us and the UK Government on issues such as leadership, investing in the reform of services and the importance of treatment. We have some agreement in and around the need to legislate for the regulation of pill presses, which is very important for tackling the illicit marketing of

benzodiazepines. We will see where we get to with Home Office applications in and around drug checking. We are at a completely different place on safe drug consumption facilities, but I will see where the new minister—a gentleman called Chris Philp—is on that.

Uppermost in my mind just now is the UK Government's white paper on "swift" and "tough" consequences. That approach is misguided. I think that it will potentially cause more harm and that it is based on an outmoded punitive approach, and I continue to seek urgent clarity as to whether and how it would apply to Scotland. The Home Office white paper states that tier 1 and tier 3 interventions could potentially apply to Scotland and Northern Ireland, and I would have grievous concerns about that. I am conscious that I have written to the committee about that, too.

The Convener: Time is against us, so I have to bring our meeting to a close. I know that members will have some questions outstanding, so we will write to the minister with follow-up points, if members would like.

I say a big thank you, minister, for what has been a really interesting and helpful session. I thank your officials, as well. I close the public part of our meeting.

09:55

Meeting continued in private until 09:59.

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