OFFICIAL REPORT
AITHISG OIFIGEIL

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

Tuesday 26 September 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 26 September 2023

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CONVENER

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

DEPUTY CONVENER

Bob Doris (Glasgow Maryhill and Springburn) (SNP)
*Russell Findlay (West Scotland) (Con)
*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

Jeremy Balfour (Lothian) (Con)
Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Katy Clark (West Scotland) (Lab)
James Dornan (Glasgow Cathcart) (SNP)
Sharon Dowey (South Scotland) (Con)
Sandesh Gulhane (Glasgow) (Con)
Emma Harper (South Scotland) (SNP)
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*Gillian Mackay (Central Scotland) (Green)
*Rona Mackay (Strathkelvin and Bearsden) (SNP)
*Roz McCall (Mid Scotland and Fife) (Con)
Marie McNair (Clydebank and Milngavie) (SNP)
*Pauline McNeill (Glasgow) (Lab)
Carol Mochan (South Scotland) (Lab)
Paul O'Kane (West Scotland) (Lab)
John Swinney (Perthshire North) (SNP)
David Torrance (Kirkcaldy) (SNP)
Evelyn Tweed (Stirling) (SNP)
*Sue Webber (Lothian) (Con)
Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Kirsten Horsburgh (Scottish Drugs Forum)
Tracey McFall (Scottish Recovery Consortium)
Simon Rayner (Aberdeen Alcohol and Drugs Partnership)
Wez Steele (Scottish Drugs Forum)

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 Sir Alexander Fleming Room (CR3)

Scottish Parliament

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

Tuesday 26 September 2023

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Audrey Nicoll): I wish you a very good morning, and welcome you to the second joint meeting in 2023 of members of the Criminal Justice Committee, the Health, Social Care and Sport Committee and the Social Justice and Social Security Committee, to consider the progress that has been made in implementing the recommendations of the Scottish Drug Deaths Taskforce.

We have received apologies from Paul O'Kane, who is attending a meeting of the Equalities, Human Rights and Civil Justice Committee.

Before we begin, I place on record our thanks to Clare Haughey and Sue Webber for visiting Aberlour's mother and child unit on our behalf, and for the helpful note that they provided of their meeting. I also thank Aberlour for facilitating the visit, and I particularly thank the two women who took the time to talk about their personal experiences. We are very grateful.

Agenda item 1 is a decision on taking business in private. Do members agree to take in private item 3, which is a review of today's evidence?

Members *indicated agreement.*

Drug Deaths and Drug Harm

09:16

The Convener: Agenda item 2 is an evidence-taking session on tackling drug deaths and drug harm. I am pleased to warmly welcome to the meeting our first panel of witnesses. Kirsten Horsburgh is chief executive officer, and Wez Steele is senior training and development officer, at the Scottish Drugs Forum; Simon Rayner is service lead at Aberdeen alcohol and drug partnership; and Tracey McFall is chairperson of the Scottish Recovery Consortium. I refer members to papers 1 and 2 and thank witnesses who have provided written submissions.

We move straight to questions. As ever, I will open with a question just to set the scene and get the discussion under way.

I wonder whether panel members can give us a broad response to the statistics on drug-related deaths, on which there has been a lot of commentary and coverage. The most recent publication of the statistics shows a decline; according to those figures, which have been published by National Records of Scotland, 1,051 people died due to drug misuse in 2022. That is a decrease on the figure for 2021 and the lowest annual total since 2017. However, given that drug death numbers remain stubbornly high, I ask individual witnesses for their response to, and any commentary that they might have on, those recent statistics. Do you feel that we have perhaps started to turn the corner a bit?

I will start with Kirsten Horsburgh and then work across the panel.

Kirsten Horsburgh (Scottish Drugs Forum): Thank you very much for having me. Obviously we welcome the news of a slight reduction in the numbers of drug-related deaths; that is, of course, much better than the numbers going up. However, we are still talking about more than 1,000 people who have died preventable deaths and more than 1,000 families and communities that have been affected. If we count the lives that have been lost over the years, the number is just totally unacceptable.

We would like to think that some of the things that have been put in place are making an impact, but it is impossible to say so after only a year of a small reduction in the numbers. Looking at the police-suspected drug deaths for the start of this year, I would say that we would need three to five years of the number of deaths coming down to know that what we were doing was really making an impact.

The issue gets described as a public health emergency, but we are frustrated about the level of urgency with which it is tackled. We talk about it being an emergency, but we do not see a true emergency response. There are good things that have been introduced, such as the medication assisted treatment standards, but those need to be rolled out much more rapidly and they need to meet the needs of everybody. There is still a lot more for us to do. Obviously, it is welcome news that there has been a slight reduction, but it is nowhere near the level of reduction that is needed.

Wez Steele (Scottish Drugs Forum): Thank you for inviting me along today. I echo pretty much everything that Kirsten Horsburgh has just said. We welcome the reduction, but it is way too early to say that it is a downward trend. For us to classify it as a downward trend, I would like to see a much more substantial reduction over many more years.

I am very apprehensive about what might be round the corner when it comes to substance use in Scotland. We have seen small amounts of more toxic drugs in our drug supply. I am worried about what will happen if more of those substances start to be present and we do not have things such as safe drug consumption rooms available to more people than will be the case through the Glasgow pilot.

Drug checking could help to reduce the harms of those substances. Street benzodiazepines are still strongly implicated in drug-related deaths. Until we address that issue and give people much more adequate wraparound support alongside medication, we will still be fighting an uphill battle. It is still massively unacceptable that Scotland's death rate is 2.7 times that of the rest of the United Kingdom. We can do much better.

Simon Rayner (Aberdeen Alcohol and Drugs Partnership): Good morning. I echo much of what has been said. Although there was a reduction in drug deaths in Aberdeen in 2022, 42 people still died. With regard to suspected deaths in 2023, there is a lot of concern about the numbers that are being presented in Aberdeen, so I do not expect that decrease to be continued this year.

A huge variable is the substances that people are taking. In a place the size of Aberdeen, it does not take much for a significant number of people to be affected very quickly. I am concerned that, despite all the things that we have done and the fact that there has been a bit of a reduction, that variation in the substances that are supplied means that it is a really dangerous situation.

The Convener: Thank you very much. We might come back to some of the underlying factors that have led to a slight decrease.

Tracey McFall (Scottish Recovery Consortium): Good morning, and thank you for inviting me. I echo everything that my colleagues have said in relation to drug-related deaths. As far as the trends are concerned, I do not think that we are out of the woods yet. One year is very early days to talk about a downward trend, especially when the police statistics show a potential upward trend.

There are a couple of anomalies. The statistics show that methadone was implicated in the deaths of 474 people. We need to understand whether those people were in treatment. Did they buy methadone on the street or were they in treatment? We need to do more work to look underneath the statistics. I spoke to Public Health Scotland before coming to the committee and was told that we have not recorded some of those statistics nationally for some time. Those statistics are collected locally by the drug-related death review groups. If we are talking about treatments such as the use of consumption rooms and heroin-assisted treatment that should be protective, we need to understand, if those people are dying in treatment, why that is.

As I said, there are a couple of anomalies in the stats. A big one for the Scottish Recovery Consortium relates to cocaine use, in which there has been an increase. We have the potential not to take an antagonistic approach involving methadone and opiates. That is about wraparound support and psychological support. The issue is bigger than treatment. We need to think about the broader wraparound and psychological support that people need.

It is early days but, for me, those were stand-outs in the trends that are emerging from the drug-related death statistics.

The Convener: Thank you. Collette Stevenson, did you want to come in with a follow-up?

Collette Stevenson (East Kilbride) (SNP): Thank you, and good morning to you all. When we talk about drug deaths and drug use in Scotland, we note how high the numbers are in comparison with the rest of Europe. Should we be looking at that more closely and carrying out more research into the reasons for that? I will put that question to Tracey McFall first.

Tracey McFall: Scotland is different from other countries in many respects, and we know that some of the underlying factors in drug-related deaths involve poverty, where people live in the country, whether people have opportunities and whether they have had adverse childhood experiences or trauma. There is already quite a body of evidence out there to give us a sense of what causes people to use alcohol and drugs.

However, we need to look more broadly as a country at some of those cross-cutting areas. I know that Audrey Nicoll is the convener of the Criminal Justice Committee, so let us look at mental health and justice. In our submission, we talk about the "Hard Edges Scotland" report. We have thousands of people in Scotland who are bouncing around mental health, addictions, justice services, domestic violence and homelessness, and we can do something to join those dots. There is not a big pot of money at the end of the rainbow, so we might save some money if we look at all this as a whole system. We need to start joining the dots. We need to take every opportunity at every intervention point when people are getting in touch with services, and the "no wrong door" approach is critical to that.

We could do more research—that would be fantastic—but we know that the underlying causes of drug use are poverty, trauma, where you come from, lack of opportunity, lack of hope and so on, and it is difficult to get off that merry-go-round once you are on it. We need to join the dots.

Collette Stevenson: You touched on methadone as a cause of drug-related overdoses. Is that a combined thing?

Tracey McFall: We do not know. Methadone has been implicated in 474 deaths but we do not know whether those people were in treatment. That is my point about how we need to dig a wee bit deeper. If people are dying and methadone is implicated in their death, is it because they are buying it from the street or were they actually in treatment? That is one of the reasons why we need to get underneath some of the stats and dig a wee bit deeper into the local drug-related death reviews to see what they look like nationally.

Collette Stevenson: Thanks. Simon Rayner, do you want to come in on that?

Simon Rayner: Research is always helpful and good. We probably fall into a trap a little in thinking of Scotland as a homogeneous unit, but the country has areas of extreme poverty and extreme rurality. Because the Parliament, politicians and major organisations are in the central belt, there is often a focus on the harm that goes on there, but we need to think about different ways of tackling it. Not all drug-related deaths are because of a single substance these days; multiple different substances are being used so we need to take different approaches to tackle that.

Collette Stevenson: Thank you. Wez Steele, would you like to come in?

Wez Steele: I would prefer additional resources to be put towards helping us with this public health emergency rather than researching the drivers and underlying causes, if I am honest. There needs to be a more immediate response to helping the people who are struggling and are at the most risk of drug-related harm right now. That is just my opinion.

On the question of methadone being implicated, I would hazard a guess that the number of deaths caused by methadone only are going to be lower than poly-drug use and drugs used in combination.

We know some of the drivers. We might not have gold-standard evidence to suggest exactly what they are, but we know that difficulty with access to treatment is one of the drivers of drug-related deaths in Scotland, and I would prefer it if resources went into helping people to get the support that they need.

09:30

Kirsten Horsburgh: I agree that we know what the drivers of problem drug use are, so it would not make sense to continue to research that. We should expend our efforts on actioning all the recommendations that numerous bodies have made on the topic.

On individual drug deaths and substances, we know generally from the drug death database report that comes out every other year that around 50 per cent of people who die with methadone in their system were in treatment at the time. The proportion of people who were not in treatment used to be higher but the figures have now levelled out so it would be interesting to see more up-to-date figures on that. However, the reality is that it is difficult to dig into the impact of individual substances that are found in a body in much detail because it is open to interpretation by the individual forensic pathologists who are involved in the post mortem and analysis. Therefore, we tend to try not to focus too much on the individual substances and trends but realise that the majority of people who die have died because they took multiple substances.

The Convener: I was going to move on to the cross-Government action plan but there is a lot to cover so, if we have time, I will come back to that. We will instead move on to some questions on safe consumption rooms, which is no surprise. I will bring in Sue Webber.

Sue Webber (Lothian) (Con): Thank you, convener. I thought that we were going to cover MAT standards first, but it is fine; perhaps I will get a chance to come in on that topic.

The Lord Advocate has provided evidence on the legalities of the drug consumption room that has been specified for Glasgow. Looking at the bigger picture, do you have any idea of how, logistically, it will work on the ground?

Kirsten Horsburgh is nodding the most fervently, so I will come to her first.

Kirsten Horsburgh: I have been interested in safer consumption rooms for some time. I was on the short-life working group in Glasgow when the proposal for the facility was introduced way back in 2016.

We have said for some time that the Lord Advocate would be in a position to provide a prosecution waiver to allow such facilities to exist, so it is great that that is finally happening, although we have concerns about some of the restrictions that will be in place. No change is being made to the Misuse of Drugs Act 1971, so there will be some restrictions on how the consumption room can operate.

I understand from the Glasgow service that the site has already been identified—it will be in the building that the heroin-assisted treatment or enhanced drug treatment service is in at the moment. It is likely that the service will operate from 9 o'clock to 9 o'clock, be open 365 days a year and be available to anyone in the locality who is injecting drugs. My understanding is that it will not be an inhalation facility, because of some of the restrictions.

We welcome the news. The anxiety about it is that we do not want one facility to be introduced in Glasgow that prevents any other facility from opening elsewhere in Scotland until the service has been evaluated. Therefore, we want to ensure that there is not a lengthy evaluation period that prevents other areas that are in need of introducing similar services from doing so.

In addition, we do not want the model that is introduced in Glasgow to set the precedent for every service that is introduced across Scotland. It is important that, when we introduce such facilities, we have lots of different types. We could have mobile units, fixed-site units or just a room in a place that already provides needle exchange facilities.

I hope that we will not delay consumption rooms in other areas by introducing the Glasgow one.

Sue Webber: Do you know what methods will be used to evaluate the service? A lot has been said about the consumption room being an opportunity to engage with people and get them into treatment, so I am curious to know what level of support and what other services will be available in the environment.

Kirsten Horsburgh: There will be an extensive community engagement and consultation period on the service for local businesses, local partners and, of course, people who would benefit from using the service.

I am sorry—I am trying to remember what the rest of your question was about.

Sue Webber: My question was about how the service will be evaluated, although I also wonder what will happen if the result of the consultation is that none of the local businesses wants to have the service there. How will the success of the service and what has worked well be determined? What other services will be there, to which people can be signposted?

Kirsten Horsburgh: I do not know the exact detail of the evaluation, but I know that partners and colleagues are working on that and have got a long way down the line with what will be evaluated. Other countries have evaluated things such as engagement with other services, as well as reductions in blood-borne virus transmission and drug-related deaths. The evaluation will not differ too much from the international evidence base around evaluation, so all those things will be looked at.

The biggest bonus of having those types of facilities and the biggest evidence base is around the fact that the more somebody attends such a facility, the more likely they are to subsequently engage with other wraparound services. Therefore, it will be key for the service to make sure that people can be linked into treatment services and that there will be services there for blood-borne virus treatment and wound care. All sorts of wraparound services will be attached to the service.

Sue Webber: You have mentioned a lot of harm reduction services, but I am interested in recovery services.

Kirsten Horsburgh: I mentioned treatment as well—I said that people would be able to access treatment services as part of that. However, if somebody attends a drug consumption room, there should not be an expectation that the absolute end goal is abstinence. That is key—we cannot turn the drug deaths crisis into a conversation about how we get everyone drug free.

Sue Webber: I am not doing that.

Kirsten Horsburgh: It is about how we make sure that people are not judged, that they are given an option to connect with people in a way that they have not been able to through any other service provision and that they make their own choices about what is best for them and their quality of life. Goals such as abstinence should absolutely be on the table, but that should never be promoted to people as where they should be heading. It should be entirely up to the individual.

Katy Clark (West Scotland) (Lab): The witnesses will have had the opportunity to look at the Lord Advocate's statement. Do you believe that the scope of the Lord Advocate's recent statement in relation to drug consumption rooms—

and, in particular, any potential criminal offences—is sufficient? Do you have any concerns that staff or others might not have the reassurance that they need in order to be involved in such an initiative? Tracey McFall might be interested in commenting on that.

Tracey McFall: Police Scotland will be key to how the service is managed and policed. We have to go through the process and see what it will look like. Because the direction has been given by the Lord Advocate, I hope that all of us—as a society and locally—want to see whether that option works. The SRC does not necessarily have any concerns. We need to see how it will work in practice.

From the SRC's experience—and my experience of working in the sector—we know that, if someone is in real chaos and is buying their street drugs in a particular area, it is very unlikely that they will catch two buses to get to an injecting facility in a safe consumption room. As Kirsten Horsburgh said, we need to be really careful about what that looks like. We should get the pilot up and running, but we need to consider what that looks like in local areas and where the hotspots are. Underlined by the Lord Advocate's letter, I hope that our Police Scotland colleagues will actually do what it says on the tin, which means not criminalising people when they are in or near the facility.

When it comes to wraparound services in relation to consumption rooms, there is some learning that we can look at. We can learn from the evaluation of the heroin-assisted treatment facility in Glasgow. Although there are limitations on what we can learn from that, there might be things that we can learn in relation to the safer consumption facility. There is a lack of dedicated medical staff, so we need the third sector to be involved to look at the broader recovery, which includes housing and mental health support.

The location of the service was a critical issue for the people who used the heroin-assisted treatment facility—it was hard to get to. Covid also had an impact on that. People had to walk through areas where there was a high level of drug use in order to get to it. We should look at and learn from all those things in relation to the drug consumption facility. People who talked to the research team said that the heroin-assisted treatment facility was overly clinical. It is very difficult to get a drug consumption room to be trauma informed—and, by that, I do not mean nice couches and fluffy carpets. We really need to take on board and learn from what the people who used that facility have told us. The high turnover of staff also had implications for the relationships that people built.

The more people come into the facility, the more chance they will have to engage with services over time, but we need to have consistency of staffing to create relationships. Recovery conversations need to happen at every stage of the journey. Does that make sense? I wanted to contextualise the issue.

Katy Clark: Do any other witnesses have concerns about the way in which the Lord Advocate's statement has been drafted, or does it provide sufficient comfort to enable the plans to go ahead?

Kirsten Horsburgh: It was interesting to see the specific wording that people accessing the service would not be charged with the possession of drugs. There was no mention of the staff. It is my understanding that Glasgow will cover that aspect and will ensure that the staff who provide the service are protected. I do not have any concerns, because Glasgow would not proceed if there were any concerns about the people who staff the service or who are involved in its running.

Ideally, a change to the Misuse of Drugs Act 1971 would make things better and would allow the rest of the United Kingdom to open up the doors a bit further, but I think that the Lord Advocate's statement is sufficient for what is being proposed.

Katy Clark: I think that we will come on to that issue.

The Convener: Tracey McFall, you mentioned the challenge caused by high staff turnover. It might be helpful if you could expand on that.

Tracey McFall: I am not sure whether I sent committee members the link to the evaluation of the heroin-assisted treatment facility. The pressures of working in a heroin-assisted treatment facility created a high turnover of national health service staff. The evaluation does not include a lot of detail on why that happened, but that is certainly a question that we should ask ourselves when we start developing a safe consumption facility. Staff have experienced burnout and trauma, and there is an opportunity to learn from that. I do not know the detail—that is a question for our NHS colleagues—but I can send the link to the evaluation.

The Convener: That would be welcome. I see that Sue Webber wants to come in, but I will ask Simon Rayner to comment on other issues that have an impact on staff turnover.

Simon Rayner: I am also a service manager in our local area and I work day in and day out with front-line staff, particularly third sector, nursing and clinical staff.

Our staff all work in this area because they want to help and to make a difference, but there are systemic workforce problems. There is no professional structure and there are no

professional qualifications for people working in the addictions field, although people can do additional post-qualification training. There are particular recruitment challenges in the north-east, especially for nursing and medical staff and for psychologists.

I appreciate what my colleague said about the involvement of the third sector. It is true that the third sector and people with lived experience should be at the core of our workforce, but clinical care is fundamental to safe drug consumption, stabilisation and meeting the MAT standards. However drug consumption facilities manifest themselves in Scotland, we cannot afford to have them fail, and they must be safe for the public and for staff and users.

In my view, we need to take a more considered look at the structure of addiction services and support. In Scotland, we have an estimated 60,000 people with problematic substance use, but only 20,000 people in treatment. We must vastly scale up and make this an attractive area for people to work in.

Staff feel daily pressure to deliver the MAT standards and reduce drug deaths. They feel that deaths are their fault and that they are not working hard enough to challenge the problems, which causes burnout, stress and trauma. We must turn that round. I know that a working group is looking at the workforce, but we need to increase the number of staff who work, and who want to work, in the area.

The Convener: Sue Webber has a very quick question.

Sue Webber: The Parliament is very close to the Access Place, and correspondence that I have received from people who work there shows how much they are committed to it, but having prescribers available is one of the biggest issues. Simon Rayner, do you agree with that?

09:45

Simon Rayner: Absolutely. There is innovation around non-medical prescribing, which is great, but certainly in the north-east, there is a deficit of nursing and medical staff who want to work in this area. It might be different in the central belt, because people can move around, but a band 5 nurse is not going to relocate to the north-east of Scotland to do this, because nurses can earn more on wards doing shifts.

If we are going to be innovative and aspirational by having drug consumption rooms, stabilisation facilities and all the other things that we should be providing as part of an emergency response, we need to have the infrastructure for that; we cannot just keep firefighting and stitching things together. A well-considered plan is needed, as well as the right structure and aspirations for the future. We need to have a workforce that is properly trained, supported, invested in and rewarded for the work that it does. The workforce should not be blamed for the drug death figures when all those involved are trying their best to do the right thing.

Paul Sweeney (Glasgow) (Lab): Thanks to the witnesses for their contributions so far.

The Minister for Drugs and Alcohol Policy said that the overdose prevention pilot in Glasgow will be limited to some extent by the Lord Advocate's guidance in relation to the constraints imposed by the Misuse of Drugs Act 1971**,** but it could also potentially be limited by the design of the facility. Does the panel have a view on whether the pilot being a higher-threshold service could hamper its efficacy, bearing in mind that the enhanced drug treatment service in Glasgow is available only to people who are already engaged with the homeless addiction team, and that it was only designed to scale up to accommodate a maximum of around 40 persons using the facility regularly? Do you believe that there are potential constraints?

Wez Steele: I would like to think that the drug consumption room will be piloted and then evaluated, and I hope that that will open the door to lower-threshold services, because I think that people would find it more acceptable to go to a third sector provider.

I would love to see the service being rolled out in homeless accommodation. I have a background in homelessness, and some work is being done on high tolerance in those services involving people who are already living there and already using drugs in or around that accommodation. That would increase the service's uptake and acceptability for people.

I think that there will be a barrier, if I am honest. The high clinical presence and high threshold will potentially put people off. The service needs to be piloted and evaluated and there needs to be evidence that it is safe. Then, I would love to see us drop that threshold. There is some good practice in Canada, where people with lived and living experience facilitate and run overdose prevention sites.

Paul Sweeney: Thanks for that. Are there any other thoughts on that and about the initial stages of the initiative?

Kirsten Horsburgh: That is what I was trying to hint at when I spoke about the different models that are required. I do not think that it is fair to describe the pilot as a "higher-threshold" model, because it is quite different from the enhanced drug treatment service, which is very high threshold, given the nature of prescribing there.

The drug consumption facility will have much more of an open-door policy.

There will be some restrictions because of what the Lord Advocate has put in place, which is in line with what is thought to be in her gift, such as the consumption room being attached to another service and the clinical element. Ideally, we want much more fluidity in how such services operate. We have numerous outlets for providing injecting equipment to people in the full knowledge that when we provide that equipment they might well nip around the corner and inject in a close, an abandoned building, a car park or under a bridge in very unhygienic, undignified and unsafe conditions.

In the future, we would like to see a strategy in which any place that provides injecting equipment also has a space where people can use, if their alternative is to use in one of those types of environments.

We cannot set a precedent that is too high for the rest of Scotland to follow and puts off other areas from introducing such facilities because they think that it will cost millions of pounds, and we absolutely need to have flexibility in how the facilities are delivered, going forward.

Paul Sweeney: I noted that the initial heroin-assisted treatment pilot in Glasgow was a capital spend of £1.2 million, which suggests that it was not scalable beyond a very limited network. In contrast, there are 45 needle exchanges in Glasgow, which might show the potential scale that we can move towards.

Are there any other thoughts on where this could evolve to?

Simon Rayner: We need to have as many different methods as possible to roll it out. The key principle is for people to have somewhere safe, clean, hygienic and monitored in which to use substances, which has not been available to them because of the stigma and the criminality that are associated with substance use. The drug consumption room is one way of providing that environment for people, but we need to think about other ways too. I think that it will cost millions of pounds to do it properly and safely.

Paul Sweeney: There will be co-location with the heroin-assisted treatment service. What will the interface for that be like? One of the big challenges with street injection is the purchasing of uncontrolled substances of unknown toxicity, dosage and so on. Will there be an effort to encourage people to substitute street-bought drugs with a prescribed alternative that is safer and more controlled?

Simon Rayner: That is a Glasgow question; I cannot answer it.

Paul Sweeney: Fair enough. Does anyone have an insight on that potential interface?

Tracey McFall: Kirsten Horsburgh might want to come in after me. One would hope that there will be a pathway that we could provide in relation to the treatment facility. As Kirsten said, if people are injecting unsafely and have not engaged with services for a long time, it will take a lot to build up the relationship that will enable them to come on to a treatment pathway. However, you would hope that there will be a treatment pathway that would help people to come through to safer injecting and safer use, and then to treatment and, potentially, recovery.

I have a couple of quick points on something that you said earlier. We need to make sure that we are not assuming that as professionals we know what people need in the facility. We need to make sure that lived experience drives this. That approach was very clear in the Scottish Drug Deaths Taskforce. It should not be service centric, but service-user centric. We need to remember that there are people involved in this, and we need to ask them what they need.

On how we will know that it is working, the evaluation needs to be very agile. We need to evaluate quickly and make changes quickly in relation to the thresholds. Thresholds generally create exclusion, so the evidence base needs to be very agile to enable us to adapt and shift. That is really important, because this is about early intervention and prevention. It is about saving people's lives. There is loads in that issue, but the big thing for me is that, when we start the evaluation, it needs to be agile. We need to make sure that it happens in real time, if possible, and we need to shift and change depending on what the different needs are.

I hope that that answers your question.

Paul Sweeney: That is very helpful. I have one more question. Wez Steele mentioned Canada as an interesting model to look at as a benchmark. I understand that there are around 147 overdose prevention sites globally, in 91 communities in 16 countries. Do other witnesses have thoughts on potential benchmarks that the committee might want to look at—places where it is performing relatively well, based on your experience?

Kirsten Horsburgh: I have visited a few in various countries. They all operate similarly but differently. I have had some thoughts about the different models in Barcelona. Some were based in hospital settings, but there were also mobile units, fixed-site units, units led by peers and some that involved a sort of community approach. One unit was opposite a police station. There were lots of different types of models.

We hope that once the facilities start to be introduced they will be accepted for what they are, which the evidence from all the countries that have introduced them suggests will happen. After I went out to explore facilities and bring back evidence about them for Scotland, part of what I tried to do was to give a balanced picture and say, "Here are some of the positives for introducing them and here are some of the potential negatives." However, you cannot argue against the facilities, because the outcomes that they can produce are overwhelmingly positive. There is a lot to learn from all the countries. Switzerland was the first to have them, and it now has multiple facilities.

Paul Sweeney: Thank you.

The Convener: I know that some members are interested in asking questions on stigma. I will bring in Clare Haughey and then Gillian Mackay on that.

Clare Haughey (Rutherglen) (SNP): Good morning, panel. Thank you for coming along. The Scottish Recovery Consortium submitted helpful evidence that highlighted that the biggest challenge to accessing treatment or recovery communities is stigma. I note that, in its final report, the Scottish Drug Deaths Taskforce also highlighted stigma and said that in offering treatment and care for people with addiction issues there had to be

"broad culture change from stigma, discrimination and punishment".

How effective has action on tackling stigma been to date? Perhaps Simon Rayner could start, then I will come to Wez Steele.

Simon Rayner: The groundwork on reducing stigma has started. However, I feel that treatment for alcohol-related and drug-related harm is still very much rooted in services such as ADPs and other specialist groups across the country. There needs to be wider debate and engagement with the public, particularly if we are getting into the territory of drug consumption, overdose prevention and decriminalisation.

If we are to understand the root causes of the problems that people experience, we need to better understand the drivers for them and what can be done to help with those. We have already seen comments in the press and social media on the ideas of drug consumption rooms and overdose prevention centres, with people misinterpreting or misunderstanding those. I go back to my earlier point that we cannot allow such facilities to fail, so we need to engage with the public on them.

The second aspect is the wider system, which, to some extent, is much more directly within our control. I would certainly welcome the leadership that would be shown through a cross-Government committee considering such matters. We need leadership across health and social care services—and all public services—in holding up a lens to drug and alcohol harm, and in ensuring that every opportunity counts and that our existing systems to help people are not barriers to their accessing help. Ideally, we would not need investment in overdose prevention centres or other such facilities if people were able to get mainstream help for their issues.

It will take a long time to get to the point where health and social issues relating to substance use are adequately supported in mainstream services, and where people can access them without feeling stigmatised or judged.

Wez Steele: We have a long way to go to reduce stigma, even in specialist services. We still see a lot of paternal and punitive practices around appointment systems, with people being discharged or having their prescriptions for other substance use reduced. If we are not getting the specialist services right, we definitely have a long way to go in the wider support services that are out there.

If I may, I will speak briefly about my personal experience. For me the irony is that, when I was a problematic substance user, I was unable to even try to address my substance use until I was accepted along with it. We often see services trying to lead people towards outcomes that they have not necessarily voiced that they want to pursue. When I was accepted—warts and all, for want of a better phrase—that was the point when I could start to look at my support needs. We have a long, long way to go on services in Scotland.

Clare Haughey: You touched on a few issues that I will explore a wee bit further. You spoke about leadership and leading people to outcomes that they do not necessarily want. You also touched on some of the commentary that has been in the press. I will quote from a couple of things that I have seen recently from MSPs.

One MSP wrote:

"Some campaigners have long demanded drug consumption rooms, where addicts will be free to take heroin, crack cocaine and other dangerous narcotics."

10:00

In relation to the siting of the Glasgow consumption room, another MSP tweeted:

"I have serious concerns for locals. It is very close to a large amount of student housing, as well as a fire station and family shopping areas."

How does that help to tackle stigma and to get people to access the help, care and treatment that they need?

Simon Rayner: I do not think that it does; it just reinforces many of the stereotypes. I suppose that some of the behaviour towards people who use substances and the public's perception of them have been driven by the fact that we criminalise use of substances. We say that drugs are bad and, therefore, that people who use them are bad. It is a devastating situation for any individual or family to be in and we need a mix of ways to deal with that. However, in Scotland, we have a significant problem. We need to recognise that 60,000 people in Scotland are not coping very well with life and that they need lots of non-judgmental help and support to reduce some of the associated harm. We need to be able to engage with the public on that and not just be seen to be working against any concerns or fears that members of the public might have.

Tracey McFall: We all have a responsibility to look at ourselves in relation to our communications, words, actions and language. When we talk about tackling stigma, the first person that I look at is myself. I need to think about my language, attitude and values in creating an environment in my workplace with my teams so that we can challenge that stigma. As leaders, the place to start with is ourselves. I think that that is really important.

Individually, institutionally and in society, there are problems with stigma across a range of different areas, including mental health, justice, addictions and homelessness. This is a joint committee meeting, so there is an opportunity to take a national look at the problem. We need to think about going back to education and training from primary school. This is about vulnerabilities. If we take away the drug and alcohol stigma, per se, it is about people being different and being judged for their differences and vulnerabilities, which cuts across a range of policy areas.

There is a massive opportunity here. As my colleagues have said, there is a huge way to go; however, this about more than simply addiction. It is about training and education, from primary school and secondary school to the workplace and academia—it goes through the whole system. We have to accept that changing the approach will take a long time. That should not stop us, but we need to keep drip feeding the approach across a range of different policy areas. That is another opportunity to join the dots.

Clare Haughey: The final report of the Scottish Drug Deaths Taskforce said that this is everyone's responsibility. From what you are saying, Tracey, it sounds as though you wholeheartedly agree with that statement.

Tracey McFall: I agree 110 per cent.

Gillian Mackay (Central Scotland) (Green): I will pick up on what Tracey was saying about the multiple ways in which people can be stigmatised. How do we address that compound stigma—stigma relating to mental health conditions, blood-borne viruses, housing status and various other things—that could also be impacting individuals who use drugs? We know that stigma kills and that it is compounded by the other things that I have mentioned. How do we give a voice to the impact of that stigma? I do not think that we hear enough of that. We all know that stigma has an impact on individuals, but I do not think that we hear enough of that in people's own words. Do you think that enough is being done to address the compound stigma?

Tracey McFall: That was one of the reasons why the Scottish Recovery Consortium wanted to get the voices of lived experience across. If you speak to people in most treatment services and recovery communities across Scotland, they will give you examples of how they have been stigmatised. This is another opportunity to raise and amplify the voices of lived experience.

Stigma absolutely devastates communities; it also devastates families and children in those families. Is there one solution? No. If you are asking me for a solution in relation to drugs and alcohol in isolation, I would say that there is a huge challenge ahead in workforce development. How do we train people to work with drugs and alcohol? What is our learning experience?

That goes back to a bigger question for me, because we need to think about how we commission services differently. We say things such as "trauma-informed, person-centred and human-rights-based approach", but what does that mean? It means that we need to do things differently, and in order to do things differently we need to commission services differently. You could put a thousand staff in Scotland on a training course about reducing stigma, but that learning needs to be embedded in the workplace, which means supervision, support, coaching and mentoring. There is very little room now to do that because of the way that services are commissioned and because we are so stretched.

We have to have those big discussions. I do not have the answer, but I am happy to continue those chats. It is a multipronged issue, and there is a massive workforce development issue, too.

Simon Rayner: I echo what Tracey said about the workforce and investment in infrastructure. There are voices there and people giving consistent messages on that, but I wonder whether the right people are listening. If the right people are not listening, we will not see the changes that are required.

Wez Steele: We need to increase the skill mix in the teams and increase the mix of people with lived and living experience of substance use in specialist services and third sector service providers. Services could do some mystery-shopper-type research into their services to find out what it is like to present at the service rather than it being a top-down approach. That would find out what it feels like to walk through the door and ask for help and support and what the environment is like for people.

Gillian Mackay: That is an interesting suggestion. We should definitely take that back.

I will move on to a slightly different topic. We have often spoken in Parliament about the need for a "no wrong door" approach. Is there evidence that that is being implemented in practice, or do people who use drugs still face barriers when accessing mental health treatment and other services? That comes back to what we said earlier about thresholds to services.

Tracey McFall: We have a strange thing in Scotland whereby mental health services come in through one funding stream, addiction services come in through another funding stream, justice services come in through another funding stream and housing and homelessness services come in through a range of different funding streams. That creates silos, so it can be difficult to have that "no wrong door" approach throughout the whole system. Are we there yet? No, because that is what is indicated by the Scottish Drug Deaths Taskforce and in the cross-Government action plan. Does it happen in some areas? Yes. Are there pockets of good practice? Yes, but the way that the funding streams come in to local authorities from Government does not help, because it creates silos.

There is potentially some learning there, and we could probably save money if we funded things slightly differently. Are we there yet? No. Does that approach work in some areas? Yes, but there is a long way to go on the "no wrong door" approach.

Gillian Mackay: Very briefly, if there was one area of anti-stigma work that the panel would like to see prioritised, what would it be?

Kirsten Horsburgh: If we were to truly address stigma, we would also decriminalise people who use drugs. That would go a long way to moving the discussion away from punishment and towards support. That would play a big role.

I will come back on your comments on the no-wrong-door approach in relation to mental health. My background is in mental health nursing and, for more than 10 years, I have seen the difficulties that people have in accessing specialist mental health support.

However, I firmly believe that we have a high proportion of mental health nurses working in our drug treatment services, and the majority of people who attend drug treatment services have mental health issues. I think that there is a capacity issue around services' ability to provide adequate mental health support instead of always pushing people into other services. With the "no wrong door" approach, I would like us to find different ways of providing treatment. For example, we should also provide prescribing through the third sector. I cannot remember who was talking about prescribers earlier, but having prescribers based within third sector services, so that we could provide people with a choice around which service they access to get their prescribing, would be important.

Wez Steele: Short of decriminalisation, I would say that staff training is important. It would be useful for services to have a policy in place that involves robust reflexive practice sessions, so that people could explore their own belief systems. Personally, I have been on quite a lengthy journey around even things such as fighting my own reflexes—it is sometimes really difficult to take an impartial non-judgmental and professional approach to supporting someone who you can see is doing massive harm to themselves and others around them. That is a really big thing to ask of people, which is why a package of workforce development training is important.

Simon Rayner: We could do an immediate thing around blame. Right now, we blame services for not doing the right thing or not being perfect, or we blame people for using substances. I think that taking the blame out of things would help a lot, even in terms of reinforcing the positive message to the workforce at the front line that, although individuals will have their own experiences, we are all, by and large, working flat out to improve things. Some 90 or 100 per cent of the workforce are there to do the right thing. Obviously, different people will be there for different reasons, but the vast majority of people are trying to do the right thing, and it makes that much more difficult and complicated if we have stigma and blame compounding the situation for them.

Tracey McFall: I have two things to say, very quickly. It is important for all of us, as leaders, to reflect on ourselves. I can change myself today, and it would be useful for all of us to do that. Also, it would be good for there to be more lived experience in the treatment system, because that helps all of us to see that change is possible and that people have something to contribute. That is two things, not one—sorry.

Rona Mackay: Two good things. Thank you.

The Convener: I will bring in Russell Findlay. I apologise, Russell; I should have brought you in

earlier. I know that you are interested in asking some questions around safe consumption rooms.

Russell Findlay (West Scotland) (Con): No problem, convener.

Kirsten Horsburgh, I know that you have spoken passionately in previous committee meetings about safe consumption rooms. You have worked on the issue for seven years and your knowledge is probably unmatched. My question is more about the practicalities. I should perhaps know this—maybe it has been said elsewhere—but is the facility in Glasgow going to be run entirely by the NHS?

Kirsten Horsburgh: I do not know the exact detail of this, but during the original discussions the idea was that the aftercare area was going to be run through a partnership approach and that people with lived experience would be involved in certain roles or remits. I do not know for sure, but I think that that is the case.

Russell Findlay: My understanding is that the initiative is primarily about safe injecting but is not necessarily limited to that. Do we know whether it will include other substances?

Kirsten Horsburgh: I do not think that the inhalation element is being taken forward, just because of the restrictions around what can be provided at the moment. It would just be for substances that are injected.

Russell Findlay: As far as we know, that has been decided—is that correct?

Kirsten Horsburgh: I think so, yes.

Russell Findlay: Simon Rayner talked about flexibility and other facilities opening elsewhere in the country, in places that have different needs. For example, Glasgow has a big problem with crack cocaine. If something relating to that is required, is that the next step? Should the facility offer services in that regard, too?

Kirsten Horsburgh: I hope that that would come out in the evaluation of the service, as soon as people start looking at what sort of substances people are appearing with. Tracey McFall mentioned timely action based on evaluation, and I think that that will be one of the key things. I think that the evaluation will highlight a lot of things that could be done differently and things that should be introduced.

Russell Findlay: The starting point is that the facility will be for injection only, as far as we know.

Kirsten Horsburgh: Yes.

Russell Findlay: However, you believe that it should, from the beginning, also provide for the inhalation of certain substances.

10:15

Kirsten Horsburgh: If we were providing a full range of support, yes—we should be providing for inhalation. However, I do not think that it is Glasgow's fault that it will not do that. It is restricted in what it is allowed to do.

Russell Findlay: Okay. There has been talk about stigma as well. The facility will be near a couple of businesses that have been identified in the media, and they may have difficulties with having the facility on their doorstep, given the associations with the crime that might take place and the behaviours that might occur. The Scottish social attitudes survey shows that a significant number of people in this country might support rehabilitation and treatment but they do not want such facilities on their doorstep. How do we persuade people that this is something that should be in their community or on their doorstep? I invite anyone to comment on that.

Simon Rayner: I go back to the point that it needs to be properly staffed, and we need to win the hearts and minds of the public in relation to there not being incidents, spill-out behaviours and things like that. All that I can really suggest is that it is important to have the right number of staff and to make sure that the facility is a safe environment for the public and the people who will use it.

Russell Findlay: That is about showing people that it works. Tracey, do you have anything to add?

Tracey McFall: We cannot do things to communities; we need to take them with us. There have been a number of examples over the years where there has been local opposition to residential rehabilitation services that have been set up but communities now engage with them. It is about demystifying and tackling the stigma that is attached to this work.

We need proper consultation—I think that Kirsten Horsburgh said that that is going to happen—and we need to talk to the community. We need to acknowledge people's fears and say, "We get it, but there's an evidence base across the world that says that there won't be crime or an increase in drug use in the area." We really need to start demystifying this—and, as leaders, we all have a responsibility to say, "This is what it means," and take people with us.

My experience in developing services over the years has been that, if we take communities with us, they get it. We cannot just drop things in and say, "This is happening in your area." However, I do not think that Glasgow is planning to do that. I think that it is planning a huge range of consultations, which will include local businesses. It needs to do that, because there is fear around this and that needs to be acknowledged.

Russell Findlay: Okay—thank you. Can I quickly move on to legislation, convener?

The Convener: Of course.

Russell Findlay: There is a lot of talk about decriminalisation being necessary or desirable but, in reality, if we look at the most recent statistics, we see that just over 30,000 people were found in possession of drugs in Scotland in 2019-20, of whom 158 were convicted of possession. Is it not the case that the police and the Crown are already operating de facto decriminalisation?

Kirsten Horsburgh: Decriminalisation is more about how people are perceived. Taking away the punitive undertone is key.

We introduced a policy that was described at the time as "de facto decriminalisation" when we made possession of all classes of substances eligible for recorded police warnings, but we do not seem to have any data on how that has been rolled out in practice. I would be really interested to find out how that is operating and whether it has been beneficial for the people in the target group who we would want it to be beneficial for—people who are experiencing drug problems.

That is one part of it. It is about sending fewer people to prison and putting fewer people through the court system, but the general sense that what people are doing is not illicit is important for them as well.

Russell Findlay: People are not getting sent to prison for possession of drugs—

Kirsten Horsburgh: They are going through the court system and they might be getting fines, and the undertone of criminality is still there.

Russell Findlay: However, the numbers of people who are convicted for simple possession are minuscule.

Kirsten Horsburgh: It also creates a hidden population. People are injecting in unsafe environments because they are hiding away their drug use from the rest of the population. The whole culture would be massively switched on its head without criminalisation.

Russell Findlay: We have struggled to get data on the use of recorded police warnings. Were you referring to the announcement that the Lord Advocate made in 2021?

Kirsten Horsburgh: Yes.

Russell Findlay: What she said at that time is that there would be a presumption against prosecution, which, based on the figures that I referred to, is a situtation that effectively already exists. However, she also said that the Crown ought to reserve the right to prosecute where it is deemed appropriate. Do you agree with that? Alternatively, do you think that that is completely wrong and there should just be a blanket non-prosecution presumption?

Kirsten Horsburgh: Yes—for personal use of substances.

Russell Findlay: Is that the universal view?

Wez Steele: When it is left to people's discretion, stigma can still play a part, because there could be inconsistency across different localities and in different geographical areas. Full decriminalisation would create a massive shift in the public's perception. Some people, who might not have any experience of substance use or of a loved one who has substance use issues, presume that something is bad if it is illegal, but that is not necessarily accurate. Therefore, decriminalisation could do more than only have a positive influence on and create a positive outcome for the person who is using the substance; it could also have a societal impact.

Russell Findlay: I think that the Lord Advocate wanted to maintain the right to prosecute for the purpose of prosecuting those who are dealing drugs but who have possession amounts on them, which might be reflected in the figures. That aside, do you still think that it is wrong that there should be a right to prosecute? Maybe you will have to repeat yourself.

Wez Steele: It is quite difficult for me to comment, because I would want to know the thresholds on the amounts before doing so. Someone who has really problematic substance use is probably going to be carrying what police might term a dealing amount, but it is for their own daily consumption, and someone who uses less frequently is going to carry much less. It would be open to interpretation and would be at the discretion of the officers, whereas if there was very strong guidance there would be a more consistent approach.

Russell Findlay: If we had better data and a better understanding of how recorded police warnings work, we could assess that a lot better.

Kirsten Horsburgh: We facilitate groups of people with living experience of substance use across the country—we probably meet about 200 individuals every week across Scotland—and the difference in how a person might receive a police warning in the Borders compared with Glasgow, for example, comes up. There are discrepancies in what people report about their own experiences.

Russell Findlay: I cannot understand the resistance to providing full details about what criteria are used for recorded police warnings, but there we go.

Simon Rayner: I cannot speak on the specific point that you ended on, but a discussion needs to

happen about decriminalisation and legalisation, in which what we mean by those terms is unpicked and unpacked.

One of the most powerful speakers that I have heard on that subject is Crispin Blunt, who is in favour of regulation on the supply side. We have a situation in which we are decriminalising the demand side of the drug business—let us call it a business, for now—but we are not tackling or changing the supply side of it, although that is where the majority of the harm comes from. Decriminalisation has to come with some rethinking about how we tackle the supply side.

One of the very interesting things that Crispin Blunt has said is that it is about decriminalisation in the context of regulation. We need to think about how we classify drugs by the harm that they cause, so that we are not just decriminalising to allow anybody to use a substance whenever they want—for example, if they are driving a car or teaching in a school. Parameters are needed, and that is why it is important to engage the whole population in the discussion about that.

The Convener: I will bring you back in if we have time, Russell, but next I will bring in Katy Clark on the issue of law reform and then we will move to questions on MAT standards. I am watching the time. Is everyone happy to stay on a little bit beyond 10.30? I am loth to cut things off when such helpful discussions are going on.

Katy Clark: I am here on behalf of the Criminal Justice Committee. I think that the witnesses have very clearly made the case on some of the public health arguments for decriminalisation and other harm-reduction measures. I am interested in the points that Simon Rayner made in relation to the supply side. Could you tell us what the impact of some of the proposals, such as decriminalisation, would be on reducing problem drug use and on the organised drug trade? Perhaps Simon Rayner could answer that.

Simon Rayner: The concern is that decriminalisation does not necessarily have an impact on the supply side. The supply side is hugely harmful to the population and impacts the most vulnerable people. In effect, the way in which people are exploited in our most vulnerable communities by the supply side is a pyramid scheme.

I go around in circles on whether decriminalisation is harmful or the right thing to do. It is absolutely right not to criminalise people for the trauma, poverty and so on that they have experienced and for their difficult lives. Criminalising those parts of the population does not help; all the evidence would suggest that it makes things worse. What decriminalisation does is shift our thinking about how we educate people on substances and invest in harm reduction. We know what the drivers are, but is there long-term investment in relation to parenting, attachment and reducing trauma that would help the longer-term impacts of harmful substance use?

The other jargon that gets thrown around relates to people using drugs on a recreational basis. The people who use various substances for enjoyment are a different population. People enjoy elements of substance use—we all enjoy substances such as alcohol and tea and coffee. We need to rethink our relationship with substances and consider what we are trying to achieve and how we reduce the greatest harm for our vulnerable populations.

I go back to the points that Tracey McFall made: a country the size of Scotland can absolutely have joined-up health and social care responses on mental health and justice. So much time and energy is created by the harm that it makes it difficult to join up responses and to get the integrated holistic care that people need. There are opportunities in the discussion around decriminalisation and challenging stigma to make a more structural change to the way in which we respond to the evident harm across Scotland.

Katy Clark: Would any other witness like to come in on the specific point about the impact of policies such as decriminalisation on the number of problem drug users in Scotland—whether it is likely to decrease or increase the numbers or to have no impact? What are the implications for organised crime through the drugs trade?

Kirsten Horsburgh: Reducing the stigma encourages people to access treatment. That would help to bring more people into treatment for sure.

Last week, I was at an event at the University of Strathclyde to hear presentations from international speakers on drug trafficking. It is just relentless. Decriminalisation would absolutely be a positive step forward, but we have to address trafficking and the global drug trade, and look towards future regulation. Speakers at the event described it as “a rat race” because of the amount of resource that goes into trying to chase illicit drugs constantly. I sincerely hope that, in decades to come, people will look back on this period in which we have continued the prohibition approach and ask, “What were they thinking?”

I am going off at a bit of a tangent, but I am not sure that, in Scotland, we could just regulate and everything would be fine; I think that it needs a global approach. However, although decriminalisation is positive, there is only so far you can go in a prohibition context.

10:30

The Convener: Do any other folks want to come in on that?

Tracey McFall: It is really important to look at the evidence base around this. If we choose to decriminalise and take a public health approach, people need access to services to support their addiction in the first place. Places around the world have done it, but they have had massive investment in public health, the social context, treatment and support. If we are taking people out of the justice system, not criminalising them and giving them the option of treatment, the treatment options need to be there. Huge investment is required in that regard.

Katy Clark: I have a clarification query for Kirsten Horsburgh. A lot of the drugs come from places such as Afghanistan and Colombia. What do you mean by regulation?

Kirsten Horsburgh: I mean legalisation with regard to our drug market in the future. That would be a sensible and appropriate way forward. Substances change all the time—we get fixated on which benzos are the most current in Scotland, but the market changes constantly. There are changes happening in Afghanistan that might well interrupt the heroin market for Scotland. We would then start to see more toxic substances introduced, such as nitazines, which have been talked about, and synthetic opioids.

Unfortunately, we will know as soon as we get an influx of those here because people will be overdosing even more than they are currently, due to the nature of those drugs. As a global economy, legalisation would, I think, be a good move forward in the future. I am not saying that that is something that we should be introducing in this Parliament, but we should be looking at it and keeping an eye on it in the future.

Simon Rayner: The bigger threat is the synthetic substances that are coming in. The traditional Afghanistan and South American routes are there, and they will continue, presumably. However, the manufacture of synthetic substances is extremely harmful in lots of ways. We use lots of different words—"decriminalisation","legalisation", and so on—but, for me, the important bit is regulation. There is a spectrum, and it is for Scotland to work out the best way to regulate, and to ensure that if people are going to use substances, it is done in a controlled and safe supply environment that involves services and wraparound care.

There is still the fundamental question of whether, if we go down those routes, the number of people using substances will increase. It is about considering why people are vulnerable to using substances to manage and cope with their lives and how we get into that space, rather than just focusing on the substances themselves. It is about how we help people and think about what they need to be resilient or to cope with the challenges that we all face.

Gillian Mackay: I will come back on Kirsten Horsburgh's comments. If we know what is in those drugs—if we do that level of regulation—what do you believe the public health outcomes will be? We know that one of the issues is that people are not aware of the strength of the drugs that they are taking. Often, they are told that one thing is in the drug, but it actually has something else in it as well. What do you believe the public health outcomes of that policy approach would be?

Kirsten Horsburgh: We could address a lot of that through drug-checking services right now. If we were able to provide services whereby people could check what was in the substances that they were using, people would have more autonomy over their substance use, and they would be able to make informed decisions about what they were using. At the moment, it is difficult for people to know that.

Other countries have made real efforts in drug checking, but we do not have pilots yet. I know that there are potential pilots in Scotland, but such a service would be hugely beneficial for people, to give them autonomy and allow them to make safer choices.

Gillian Mackay: Thank you.

The Convener: Thanks very much. We move to questions around MAT standards.

Sue Webber: We have heard a lot today about accessing services. I think that one of the first comments was that lack of access to treatment is one of the key drivers of drug-related deaths; it might have been Wez Steele who said that. I have the MAT standards in front of me and each one starts with the words, "All people", but clearly, not all people who require or wish access to the MAT standards are getting it. What more could be done to assist with that?

Simon Rayner: I go back to workforce investment. There needs to be an infrastructure that supports those sorts of quality developments. I am not sure whether our services in Aberdeen will achieve all the standards. We have made good progress and I believe that we have good services and very committed staff, but the structural challenges are fundamental. The standards are a good thing, but I worry that they have perhaps become a bit overcomplicated.

Sue Webber: What do you mean by that?

Simon Rayner: We are trying to do all the right things, such as gathering people's experiences

and feedback, gathering the data, improving the quality and having processes, but I feel that we do not have the infrastructure to support that. Certainly, the finance and the way in which the drug policy unit communicates about it is complicated.

Soon, we will have large numbers of staff who have started innovative projects under funding that has come through the Corra Foundation or other funding streams—at one point, I think that our ADP counted 17 income streams that we are trying to manage. We are trying to ensure that those services are joined up and will shortly be looking for security in terms of whether those projects can continue. I worry, because the momentum is huge but it needs to continue and potentially be scaled up.

The MAT standards are a huge task. I understand the political pressure from people to get them delivered as quickly as possible, and everybody would want to do that, but it is a big piece of work and we do not necessarily have the infrastructure to support it.

Sue Webber: Suzanne Gallagher from Scottish Families Affected by Alcohol and Drugs has commented that far too much time and effort is being spent on MAT standards 1 to 5 and that we are not really progressing to the others. Kirsten Horsburgh spoke at the beginning of the meeting about it being an emergency. We talk about that, but we do not get a sense of that on the ground. What are your views on that?

Simon Rayner: Badging the issue as a public health emergency is useful; the emergency context galvanises people. However, we cannot sustain an emergency response for years and years. We need to build the infrastructure to make some things business as usual. From my point of view, that is what we need.

There has been a lot of front loading for MAT standards 1 to 5. In terms of psychology support, the bit about funding coming in different silos is one thing but, equally, mental health services are as stretched and challenged around their tasks. At the moment, certainly in the north-east, it feels as though people do not have the headspace to be innovative or creative. However, if we do not spend the funding it is not retained. The Government pulls it back or something. I do not quite understand the restrictions around the funding and it is very directed.

We have tried to have a discussion with the policy unit about having an investment plan for Aberdeen and our aspirations. We would like something that is a bit more relationship based in terms of investment and aspiration, rather than it being done by letter and nothing happening in between. There is more that the policy unit could do to support implementation.

Sue Webber: That goes back to the agility that Kirsten Horsburgh spoke about earlier. Do you want to come in on that?

Kirsten Horsburgh: We are doing a piece of peer research in a number of health board areas that involves following about 60 people on their journey of trying to access treatment. It was intended to be an observational study that involved following people to their appointments and whatnot, but one of the real challenges has been that people are not offered face-to-face appointments—it has all been over the phone. We were quite shocked about that approach to follow-up. The findings of the study will show what the reality is for some people and will be interesting to the committee and to partners.

Do not get me wrong—there are good examples as well. A lot of those involve people talking about just being treated well by staff. Sometimes, it does not take a load of qualifications; it is just about being a nice human to people. People are not asking for a lot.

On what might improve access, as I mentioned, it is about having our third sector more involved in delivering prescribing. I will let Tracey McFall speak about that, but we support having different places for people to go for their services.

Tracey McFall: Institutional memory can be a positive and a negative, but I am old enough to know that we had the same discussions that we are having now when opioid substitution treatment with methadone was being implemented across Scotland. The approach became very clinical and was about getting people into treatment, but then we realised that people need the wraparound support to go with that or we will make no difference. We are having the same kind of conversations now.

Treatment is really important. People need to get into treatment, as it reduces the risk and harm, but there needs to be more than just treatment and I have not really seen that yet in the MAT standards. It is about psychological support and the underpinning approach around the MAT standards on social networks, recovery communities and moving people out of treatment. Simon Rayner is absolutely spot on that we need to move away from crisis management to embedding that approach into business as usual—that is really important.

I go back to the point that, underpinning all this, we need a “no wrong door” approach. Wherever people come, we should ask them, “What do you need support with?” That sounds easy, but it can be complex. However, we need to look across the

different systems of justice, homelessness, mental health and addiction services.

On Kirsten Horsburgh's point about face-to-face appointments, we see the situation that she described happening across the country. It is amazing to get people into treatment, but that needs to be followed up by regular relationships. Having a prescription and going to the chemist every day but not seeing your key worker for weeks on end does not build the foundations of a relationship that allows somebody to change. Some of what we need is really basic stuff that we have moved away from and that we need to get back to.

Sue Webber: That has been helpful—thank you.

Paul Sweeney: I thank the witnesses for that insight—it really helps to inform us.

It is interesting to reflect on the interface with the previous theme that we discussed, on supply chains. Throughout the 1990s, the national health service routinely prescribed benzodiazepines, and then there was a sudden pivot point in the early 2000s. Prescribing has since been restricted, thus seeding an illicit supply chain, which has caused significant problems, as you will be aware, and has driven the issues with drug-related deaths.

The June figures demonstrated that a third of alcohol and drug partnerships have failed to implement the first five MAT standards and we have covered some of the broad reasons for that. Does the overdose prevention pilot in Glasgow present a potentially novel interface for looking at how to improve MAT standards and provide an integrated interface for people to access care? It is about people transitioning from street-bought drugs into a more controlled MAT environment and so not relying on dangerous drugs that are supplied by organised criminals.

Kirsten Horsburgh: I do not think that that is the primary goal of the service, but that would absolutely be an additional benefit from it. As I said, the more times people attend such a service, the more likely they are to go on and access treatment. To go back to your previous point, the benefit of the co-location is that, inevitably, people who work in the facility will have discussions with people on treatment options, and the heroin-assisted treatment service will most likely have more recruits into the programme from that.

The pilot offers a unique opportunity to engage with people who do not often engage with services, which is why we would like to see similar services in other areas across Scotland, particularly where there are already issues with people injecting in outdoor environments. That reaching out and offering a connection is one of the biggest goals of the service—it is about getting people thinking about what options they might want for their future. I think that the service will be useful, and we could see more of them.

10:45

Simon Rayner: Stepping back from drug consumption, I suppose that the objective is to try to give people a safe and clean environment where they can engage in harm reduction activity, whether that is to do with injecting or the other harm reduction work that we can do.

It still comes down to the structural challenge. We would absolutely want to have a range of low-threshold ways that people can access all the support that they need, but the issue still comes down to having the structural capacity to be able to do that. Have we got staff? Can we make services safe for staff and for the public? Can we make them safe for people who need to use them? How is that support best delivered for the local community? How can we involve people who need to be involved in the consultation and the groundwork that needs to happen? Underpinning structural capability to engage and do that properly is fundamental.

The pilot in Glasgow is designed to meet a specific need in Glasgow, in terms of people who are injecting on the streets and in unclean environments, and that is not necessarily replicated across Scotland. We need to be able to use the legislation creatively to find solutions that people need and want in their local areas.

Tracey McFall: It is not an either/or for me. The Glasgow example is happening primarily because there is a cohort of very vulnerable people who are at real risk of drug-related death and drug-associated harm. A bigger, wider system is needed in relation to the MAT standards, because people should get access to treatment when they need it for as long as they need it, with the wraparound support. The example in Glasgow is for a specific population with a specific need. As Simon Rayner said, what people need will be different all over the country, but the fundamentals are that people should get access to treatment when they need it, for as long as they need it; they should be treated with dignity and respect; and the treatment should be holistic and wraparound. Excuse the jargon.

Wez Steele: There is something quite powerful about meeting a population's need and changing attitudes and cultures. There is a cohort of vulnerable people who need a service where they can use their drugs. That can have wider implications for other support needs that are out there and it can change perceptions. We need services that can respond to and meet needs where they are.

Paul Sweeney: Is a big institutional culture change still needed in Scotland? I know, for example, that when the unofficial overdose prevention pilot ran in Glasgow, the dean of the medical school at the University of Glasgow wrote to the students who were volunteering on it and said, "You're jeopardising your GMC registration as doctors. Desist from doing this." People were threatened with losing their jobs with third sector providers for volunteering and participating in those activities. Is there still an instinctive risk aversion from a lot of third sector and public sector bodies about engaging in MAT provision?

Simon Rayner: I wonder whether some of that—I am commenting on something that I do not actually know anything about—is to do with whether people were prosecuted. I suppose that we all have public liability and professional liability, in terms of insurance and cover, so it is one of those things that needs to be addressed.

That is different from the point that you are maybe trying to make, which is whether there are institutions that are fundamentally against what we are trying to do. In Aberdeen, we would welcome the opportunity to discuss and plan for services that meet the needs of people, whatever shape or form those services might take. However, that requires the structural capability of insurance and reassurance from institutions, whether third sector or otherwise, that will make it safe for people.

Tracey McFall: It comes down to stigma and people not understanding the problem. As a society in Scotland, who are we if we do not try to support the most vulnerable? That is the fundamental question for me. I do not think that many third sector organisations do not understand the rationale behind the MAT standards. There are still challenges across the NHS—we need to be clear about that—and there are challenges across statutory services. Fundamentally, however, I think that it comes down to stigma.

Paul Sweeney: Thank you—that is appreciated.

The Convener: I think that Roz McCall wanted to come in.

Roz McCall (Mid Scotland and Fife) (Con): I did, convener. First and foremost, you can spot the new girl in the room; I apologise for sitting quietly so far. I thank all the witnesses, because for the past hour and a half or so, I have been listening intently to the evidence, which has been very informative.

Tracey McFall made a point that, to me, in my lack of knowledge, sounded as if it was alluding to the national specification for a treatment and recovery system that should be in place across Scotland, which was mentioned earlier.

I know that we have moved on a bit, but I want to come back on that, because I am interested in hearing your opinion. How should we prioritise the creation of a national specification? Where are we on that and what are your thoughts on it? I know that I am taking a slightly different angle in the questioning, but it was alluded to in your evidence.

Tracey, perhaps you would not mind starting, and if anyone else wants to come in on that, they can do so.

Tracey McFall: What we know varies across Scotland. A lot of work has been done around the national specification and framework around residential rehab, and I believe that that is moving on apace. That provides a national framework, with national outcomes and national reporting.

We need to understand what that looks like, but it will, we hope, bring in that local flexibility and local need. Again, that is an important part of the puzzle because, ultimately, if we are not using the data to flex and shift and redesign and re-evaluate our provision to meet the population's needs, there is a fundamental flaw in our approach. National specification is good as it provides those things, but there needs to be local flexibility.

In the SRC's view, what is missing—to go back to the MAT standards—is not so much standardisation, but a national approach to recovery communities. I am not taking away from the agility and flexibility that recovery communities need, because they are mostly grass roots, but we do not have a standard for ADPs that says, "As part of your national specification for your treatment and recovery pathway, you need to have this, this and this, and that's what we're going to measure you on." That is important.

We keep talking about treatment. That is important, but we need to talk about moving people out of treatment to live fulfilling lives, so we need to think about the whole continuum of care.

I hope that that answers your question, Roz.

Roz McCall: It certainly does. I would be interested to know whether anyone else has any comments on that.

There is not a thing—good.

Simon Rayner: Sorry—I will come in on that one. We have national organisations such as the Scottish Drugs Forum, the SRC, Scottish Families Affected by Alcohol and Drugs and Alcohol Focus Scotland, but they are all based in Edinburgh and Glasgow. We are based in the north-east of Scotland, and from a national point of view, I feel that we miss out on the representation and engagement of national organisations. I am always advocating that we have local control over how we engage with people. As taxpayers, the people deserve that.

From my perspective, “national” often means the central belt. We need to ensure that if there are national resources and frameworks and so on, there is local flexibility. That is not simply about distributing things equally—there has to be equity.

We have hugely rural areas in our neighbouring local authority, with pockets of deprivation, and we have a large city with unique issues. Obviously, a lot of today’s discussion has been about Glasgow and the drug consumption room there, but equally there are other challenges and harms in other parts of Scotland that do not necessarily get the air time and that colleagues here represent in terms of the work that they are interested and involved in.

Roz McCall: I understand that. Thank you. I have no more questions.

The Convener: We are coming to the final part of our session. Does Collette Stevenson want to come in?

Collette Stevenson: I am fascinated by the input from all the witnesses. As you are probably aware, I have my own lived experience with a family member who took drugs and lost his life to a heroin overdose. However, although I have found it fascinating, I have also found it really frustrating, because a lot of jargon has been used. At the heart of it, users and addicts just want that wraparound support.

I would like to know more about whether those with lived experience, their families and key partners—I have previously worked with the Beacons in South Lanarkshire—have been adequately included in the work on national specification.

When I was involved with my brother, one of the things that I used to be told was, “He’s not hit rock bottom yet. You allowing him to stay with you—you’re actually feeding his habit.” That was some of the worst advice that I ever got. One of the things that my brother used to say was that the worst thing that could ever happen to him would be if he had no family to turn to.

I am just wondering whether all that lived experience and work by families is being taken into account. I put that to Tracey McFall first.

Tracey McFall: Time and again, I have heard the phrase, “You’re colluding with his behaviour,” or “You’re colluding with their behaviour.” I completely understand and that resonates, so thanks for sharing that.

One of the points of the national commissioned organisations and the people around the table here is to press the Government to make sure that that lived experience voice is around the table and we need to continue to do that.

We are having the same discussions across justice and mental health—and a range of different policy areas—about how you get lived experience voices around the table in a way that is representative, not tokenistic. It can be done and it is being done. It takes time and it takes energy.

I hope that you do not mind, but I will share my bugbear. We are asking a lot of people with lived experience to come around the table for free and to volunteer on their own time. We are placing a value on that lived experience. If we are asking people to share their time and experiences, we should be valuing that time. I want that approach to gain traction. Telling people that we value their lived experience is a massive message for me to give. That is not about simply asking someone to come to two meetings, taking all the information that they have and then not needing to talk to them again. The approach needs to be embedded in the system. We are not quite there yet, because it is difficult to do. In the meantime, we are trying to save people’s lives and to get them into treatment.

We need to turn the approach on its head. As the national Drug Deaths Taskforce said,

“services must be person-centred, not service-centric”.

We need to challenge ourselves in that regard and we have all got a role to play in that.

Wez Steele: Although there is definitely a place for the lived experience voice at the table—that is really important—it is really good and useful to include the living experience voice as well. That refers to those people who are trying to access support right here, right now, because the landscape that the two experience is very different. I have not problematically used a substance for about six years, but the treatment landscape and the substances that are out there are quite different now.

We need to make sure that we do adequate groundwork with people before including them, especially in strategic meetings or anything like that. I can often feel out of place at strategic meetings, so how must someone who is very new to the whole environment feel? We must ensure that there is adequate support.

We also need to think about what we are asking for and what we want to hear from the people we are inviting to such meetings to try to get their input. Often, they will come out with things that we might not want to hear, if that makes sense. How well equipped or ready are services or strategic boards for that? If they really want to do it, we need to be quite bold and brave in our approach, because sometimes the truth hits hard. I know that people in forward-facing roles are working really hard to try to help and support people. Sometimes,

people criticizing or critiquing that work can be quite difficult to hear.

I echo Tracey McFall's about paying people for their time, expertise and insight. Vouchers do not pay my mortgage. We should not be asking people to turn up and provide such input for free.

Collette Stevenson: I have no further questions.

The Convener: Okay. We have covered a lot. I really appreciate your forbearance, because we have gone quite a bit over time. Thanks very much to all of you for a very helpful session.

We were hoping to have the Minister for Drugs and Alcohol Policy, Elena Whitham, join us on a second panel to give evidence. Unfortunately, she is very unwell and not able to attend the meeting. We wish her a speedy recovery.

10:59

Meeting continued in private until 11:58.

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