OFFICIAL REPORT
AITHISG OIFIGEIL

# Public Audit Committee

**Thursday 21 November 2024**

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

# Thursday 21 November 2024

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## PUBLIC AUDIT COMMITTEE
**29th Meeting 2024, Session 6**

**CONVENER**

*Richard Leonard (Central Scotland) (Lab)

**DEPUTY CONVENER**

*Jamie Greene (West Scotland) (Con)

**COMMITTEE MEMBERS**

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*James Dornan (Glasgow Cathcart) (SNP)
*Graham Simpson (Central Scotland) (Con)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Stephen Boyle (Auditor General for Scotland)
Ray Buist (Audit Scotland)
Cornilius Chikwama (Audit Scotland)

**CLERK TO THE COMMITTEE**

Joanne McNaughton

**LOCATION**

The James Clerk Maxwell Room (CR4)

# Scottish Parliament

## Public Audit Committee

*Thursday 21 November 2024*

*[The Convener opened the meeting at 09:02]*

## Decision on Taking Business in Private

**The Convener (Richard Leonard):** Good morning. I welcome everyone to the 29th meeting in 2024 of the Public Audit Committee. James Dornan MSP is attending the meeting remotely.

The first agenda item is a decision on whether to take agenda items 3 and 4, on further consideration of alcohol and drug services, in private. Are we agreed to take those items in private?

**Members** *indicated agreement.*

## "Fiscal sustainability and reform in Scotland"

09:02

**The Convener:** Before we move to item 2, I invite the Auditor General for Scotland to make a short statement on his report "Fiscal sustainability and reform in Scotland", which was published earlier today.

**Stephen Boyle (Auditor General for Scotland):** Good morning, committee. As you know, this morning Audit Scotland published a report on fiscal sustainability and public service reform in Scotland. I look forward to briefing the committee in more detail on the contents of the report in the next couple of weeks.

Among the key messages from today's report, which focuses first on fiscal sustainability, is that the Scottish Government could do more to be clearer with both the Parliament and the public about the scale of the fiscal challenges in Scotland's budget.

We note that, over the past few years, the Scottish Government has delivered a balanced budget—as it is required to do at the end of each year—by using a range of short-term measures. However, that has not yet translated into a longer-term approach of clear fiscal sustainability.

The report also looks at the Government's progress on making arrangements for public service reform, which is identified as a key plank of delivering changes to public services and achieving fiscal balance. I note that, although there have been some important small-scale changes, that reform has not yet moved at the scale and pace necessary to deliver public services that are affordable in the longer term. Our report includes recommendations for the Scottish Government to that effect.

**The Convener:** Thank you very much. As you say, we will return for a detailed evidence session on that report in a fortnight.

# “Alcohol and Drug Services”

09:04

**The Convener:** The next item on this morning’s agenda is primarily about Audit Scotland’s report on Scotland’s alcohol and drug services.

As well as the Auditor General, we are joined by Cornilius Chikwama, who is audit director, and Ray Buist, who is audit manager, at Audit Scotland, both of whom worked on this report.

Auditor General, we have quite a number of questions to put to you this morning. However, before we get to those, I invite you to make a short opening statement on the alcohol and drug services report.

**Stephen Boyle:** Good morning. I am presenting to the committee a joint report by me and the Accounts Commission for Scotland on alcohol and drug services in Scotland.

The number of people in Scotland losing their lives to drug misuse or to alcohol-specific causes remains among the highest in Europe. In 2023, 1,172 lives were lost to drug harm, and the number of drug misuse deaths has risen significantly over the past two decades. Also in 2023, 1,277 people lost their lives to alcohol-specific causes—the highest number since 2008.

The numbers of lives lost to alcohol-specific causes and drug misuse have increased, despite the announcement in 2021 of a national mission to tackle drug harm and to significantly increase Government funding for tackling both alcohol and drug harm.

In Audit Scotland’s 2022 briefing, “Drug and alcohol services: An update”, we highlighted

“a lack of drive and leadership by the Scottish Government”

and a need for

“clear accountability across all partners”.

The leadership has improved since then, but progress in delivering some of the key national strategies has been slow. The Scottish Government urgently needs to make progress on the delivery of those plans.

Local accountability arrangements remain complex. Alcohol and drug partnerships co-ordinate the delivery of alcohol and drug services, yet they have limited powers to influence change or to direct funding. Accountability needs to be clearer across the wide range of services that collectively contribute to improving outcomes for people who access treatment.

Many barriers remain to accessing services for people in need. They include stigma, waiting times, limited services in rural areas and high eligibility criteria. The workforce is also under considerable strain, and it often feels undervalued and that it lacks job security.

Currently, most of the funding goes towards national health service specialist treatment for those at the highest risk of harm. High demand leaves limited capacity for alcohol and drug partnerships to shift the focus towards early intervention and prevention arrangements. The Scottish Government needs to develop more preventative approaches that offer people help before they reach a crisis point.

The national mission has increased funding for tackling alcohol and drug harm by £50 million per year from 2022 to 2026, but annual budgets and short-term funding make longer-term planning for services difficult. The Scottish Government has not yet undertaken an evaluation of the cost and effectiveness of the services to determine whether they are delivering value for money. This is a vital part of directing funding to where it is most effective.

Ray, Cornilius and I will do our best to answer the committee’s questions.

**The Convener:** Thank you very much indeed. Your report opens with some very harrowing figures, not just in terms of the absolute numbers of deaths and of the lives that are affected by them, but also in showing how bad the picture in Scotland remains in relative terms. It draws on figures from August 2024, so they are very up to date.

Even in paragraph 2 of the introduction, you say that the drug-induced death rate in Scotland is

“27.7 per 100,000 population”

and that

“The next highest rate was Ireland with a rate of 9.7”

per 100,000 people. That is almost three times the incidence of drug-induced deaths in Scotland compared with Ireland, and it puts Scotland way out in a wholly worse place than anywhere else in the rest of the United Kingdom, as well as in relation to the European examples that you draw on. You talk about the death rate from drug poisoning being twice as high in Scotland as it is anywhere else in the UK.

Those figures do not seem to be getting better, even over time. What is your reading of the reasons that lie behind the record that Scotland has, compared with other parts of the United Kingdom and other parts of Europe?

**Stephen Boyle:** In a moment, I will bring in Cornilius Chikwama, who can share with the committee some of the work that we did to draw out the statistics that we have captured in the report.

You rightly referred to our comparison of the impact of Scottish death rates on the lives of people and their families with the impact of rates in comparable jurisdictions. Exhibit 1 charts the trend in alcohol-specific and drug misuse deaths in Scotland over the past 24 years, and you can see the rate of growth—it is not quite exponential, but there is a significant upward trend in deaths from the turn of the century to where we are now.

There is no doubt that there are complex factors behind that. Some factors are societal; some cover Scotland's relationship with alcohol, certainly, but also increasingly with drugs. As we touch on in the report—Cornilius can say more about this—changes in the nature of the substances that are being used and abused mean that the treatments that are in place have evolved. Those substances have ranged from opioids, initially, to synthetic opioids, which have been introduced in recent years, and there is now dual consumption of different substances. Those things all contribute to the rates.

Our report looks primarily to assess the arrangements that Scotland's public sector has in place to tackle the challenges that people face in accessing drug and alcohol services, and it seeks to assess whether the public money that has been invested is, fundamentally, being used effectively and having an impact.

I will pause for a moment, because it would be useful for the committee to hear some of the statistics that Cornilius and the team drew upon to arrive at some of today's judgments.

**Cornilius Chikwama (Audit Scotland):** The totality of the evidence in the report tells us that a number of factors are driving what we are seeing in Scotland compared to other countries.

The personal and social circumstances that people find themselves in seem to be quite a big driver. The evidence in the report around equalities shows that people in low-income situations are particularly affected. The availability of and access to drugs and alcohol, along with the culture around that, also play an important role in some of the outcomes that we are seeing in Scotland. Of course, the treatment and recovery services are important as well.

Scotland is obviously different from other countries in many respects, such as personal economic circumstances, availability, access and treatment. However, more important is how those factors come together in specific circumstances and have the potential to produce different outcomes. That is probably the main driver behind what we are seeing in Scotland.

**The Convener:** I am reading the report again and looking at the section titled "Alcohol and drug harm disproportionately affects people already facing disadvantage". That is a recurring theme, is it not? You cite in the report that people from Scotland's most deprived areas are

"seven times more likely to be admitted to hospital for an alcohol-related condition"

and that

"almost half of all patients with a drug-related hospital stay lived in the 20 per cent most deprived areas of Scotland."

It is clear that there is a link between deprivation, poverty and inequality and alcohol and drug dependency, as well as the seriousness of that dependency and where that leads and has led.

However, is there not multiple deprivation in parts of England, Wales and Northern Ireland? Why is the situation so acutely bad in Scotland?

09:15

**Stephen Boyle:** Yes, you are right on those points, convener. Before I address your question, I note that the report states that, if a person lives in one of the most deprived parts of Scotland, they are more likely to experience drug or alcohol harm than their more affluent neighbours.

That is a revelation not only from today's report. We cite, for example, the "Hard Edges Scotland" report, which we also referenced in our briefing paper in 2022. There is a consistency: a person experiencing socioeconomic deprivation is more likely to experience harms from alcohol and drug misuse.

The principal thrust of today's report, however, is that support tends to be given at a point of crisis for people who need access to services rather than asking how the system is operating. It is a very complex system that, as we set out in the report, tends to focus more on making interventions than on taking a preventative approach.

You asked about why Scotland is so much worse than other parts of the UK or elsewhere. Complex socioeconomic factors, along with the availability of substances, will be part of it, but that is probably not that much different from elsewhere in the UK. We have not drawn a definitive conclusion on that question in the report.

I can say a bit more about the comparability of the data. However, as we set out in the report, it is hard to draw definitive conclusions about why the death rates, particularly for drugs, are so much worse in Scotland than they are in other parts of the UK.

I will touch briefly on alcohol before passing over to Cornilius Chikwama. Regrettably, we are seeing more of a convergence in other parts of the UK towards some of the high alcohol death factors in Scotland. The Covid-19 pandemic seems to

have been something of a catalyst for additional consumption and increased death rates elsewhere in the UK. However, there is such complexity that it is hard to make definitive judgments or correlations about why Scotland's rates are so much poorer than those elsewhere in the UK.

Cornilius has more expertise on that, so I will pass over to him to see whether he wishes to add to that.

**Cornilius Chikwama:** It is really difficult to be definitive and to say what the factors are that explain why Scotland is different in that way. It is about the factors that I outlined, but what is probably more important is how, and in which geographic areas, those factors come together. Behind deprivation, for example, is worklessness, low income and poor housing. When all those factors come together, in particular localities, that is when we see the impact being so pronounced, which might not be the case in other parts of the UK or Europe.

That underlines the importance of looking at other experiences and seeing whether we in Scotland could learn from policy developments elsewhere. Although we do not mention it in the report, countries such as Denmark tend to do relatively well and, over time, have managed to bring down some of the death rates.

There is an opportunity to learn. That is probably the key message that we would give to policy makers.

**The Convener:** Earlier, you mentioned changing patterns of consumption and so on. One of the things that stood out for me in the report was where you talk about the influence of cocaine in deaths. You say that, in 2008, around six per cent of drug misuse deaths included a cocaine element. That has now gone up to 41 per cent. What does that tell us?

**Stephen Boyle:** I will pass that over to Ray Buist, who can say a bit more about people's experience and the nature of consumption. I would certainly use the word "stark" to describe things in relation to the influence and availability of substances and the use of multiple substances.

Before I pass over to Ray, I will point out something that I am sure that we will discuss further, which is that, although we do not draw definitive comparisons with other jurisdictions, we make judgments on Scotland's arrangements for the provision of drug and alcohol services, and on the complexity of the system and the new funding arrangements that are in place. However, you are right that the pattern of supply of different drugs is one factor that influences the statistics that are before us today.

**Ray Buist (Audit Scotland):** Convener, you are right to draw attention to paragraph 6 of the report, in which we make specific reference to the changing environment where we see different patterns of drug use. That change is one of the complexities that we face. The challenge is shifting over time.

As you said, there has been an increase specifically in the use of cocaine, but there has also been an emergence of synthetic opioids, which present slightly different challenges, and an increase in poly drug use, which is more problematic and carries a greater risk of harm. All those things are relevant.

That is why we highlight the importance of good data. We will perhaps come on to that. Specifically, a pivotal part of the process is looking at how useful the data is in understanding what is emerging and being able to adapt and react to the changing circumstances. In the report, we set out the arrangements that are in place to keep track of changing drug-use patterns.

**The Convener:** Okay. I think that Colin Beattie will come in with questions about that.

I will move on to a point that is rather more bureaucratic, which is about the architecture of the delivery of services, such as the alcohol and drug partnerships. You have mentioned before, and again in this report, the extent to which those are, or should be, autonomous, and whether the Government's arrangements are "mature" and so on. Will you explain why that makes a difference? In your estimation—as somebody who has been talking about public sector reform this morning—what reforms would you like to see in this area, as an example? Where should the balance of funding, responsibility and powers rest for interventions to have the best outcomes?

**Stephen Boyle:** In a fairly sizeable part of the report, we set out the landscape of how the system for the delivery of drug and alcohol services operates. I direct the committee's attention to exhibit 2, in which we set out—it takes us a full page to do so—the many different players that are involved in delivering those services. We say that landscape is very complicated. That is part of the experience that users have told us about; they have said that it is hard to navigate the system. We also need to bear in mind that people need to navigate it, or their families need to navigate it on their behalf, at times of crisis.

The question that arises from that is whether that the best way to deliver drug and alcohol services. Does it deliver a preventative approach, which will help people at a much earlier part of the process, or—albeit that it was designed with good intention—does it reach people much later in the process? That is where we have got to, convener.

We also set out something about how the system operates and the role of alcohol and drug partnerships. Rightly, you referenced public service reform—that is the subject of another report, which was published this morning. Alcohol and drug partnerships are not statutory bodies. That means that they do not have a direct line of reporting into either local government or the Scottish Parliament. I do not audit alcohol and drug partnerships. For the avoidance of doubt, I am not advocating that I should do so. It is not for me as Auditor General to set out how the structures should operate; ultimately, that is a policy decision for the Scottish ministers.

We draw on the Scottish Government's assessment, which we set out in paragraph 21 of our report. In the Government's view, alcohol and drug partnerships are not sufficiently mature in terms of their governance and their financial and performance reporting. That tends to operate through integration authorities—integration joint boards—which are statutory bodies, reporting jointly with national health service boards and local authorities.

That illustrates the complexity of the system. We make a recommendation in our report that the Scottish Government has to

"Clarify accountability of alcohol and drug service providers and other statutory service providers"

so that there is a collective understanding about who is responsible for what with regard to improving outcomes. The involvement of non-statutory bodies, the lack of clarity about outcomes and the flow of funding through ADPs or to third sector providers do not help the delivery of effective services to users.

**The Convener:** Before bringing in Colin Beattie, I will ask you about that final point. You made a series of recommendations in your 2022 report. Two years later, in this report, you say:

"The Scottish Government has made progress in implementing our previous recommendations, but delivery of some key national plans has been slow."

The word "slow" crops up a few times in the current report. Has the Scottish Government given you a reason as to why it has been tardy in addressing some of the recommendations in your previous report?

**Stephen Boyle:** Our judgment is that both things are true. I will turn to colleagues to set that out in more detail and particularly to address the points about the Government being slow and what is still awaited. I draw a distinction between drug services and alcohol services, and note, as we do in the report, the pace of improvement and focus on drug services relative to alcohol services.

The appendix includes an assessment of the Scottish Government's progress against the recommendations in the 2022 report. There has been progress on some very important parts of the model, and we note the national mission. The medication-assisted treatment standards for the delivery of drug services have been a step forward. Cornilius Chikwama might want to say something on that.

There is a slower pace of improvement on the workforce and on the strategy for the workforce. With regard to workforce delivery, we talk in the report about the strain that people are under. Ray Buist might want to say more about the relative pace of improvement in alcohol services and drug services.

Our broad assessment is that there has been progress on some things but that other really important parts of the work still need to be done.

**Cornilius Chikwama:** On the specifics of where we have seen improvement, we would highlight leadership. Previously, we had a Minister for Drugs Policy, but, in April 2023, that role changed to the Minister for Drugs and Alcohol Policy, so the Scottish Government has responded and tried to align the policy for drugs and alcohol and to provide clear policy leadership.

We have seen progress on minimum unit pricing for alcohol. The evaluation of that policy has taken place and the Scottish Government has sought Parliament's support to extend the pricing policy and to increase the minimum price for a unit of alcohol.

There are some areas of innovation. We have seen progress in Glasgow on safer drug consumption rooms. There is also the national collaborative, which applies human rights-based approaches to accessing services. We have judged those areas to be moving in the right direction.

We have seen a lack of progress on mental health-related support. The mental health and substance use protocol has been published, but delivery is not where we would expect it to be.

The Auditor General mentioned the role of stigma and how it gets in the way of people accessing services. The Scottish Government published its stigma action plan in 2023, but when we look at the progress of its implementation, again, it has been slow.

09:30

There are a number of areas—workforce is another—where the practice of annual budgeting is leading to one-year short-term contracts, which results in high churn within the workforce, which then impacts on the delivery of services and on

the experience of those accessing services. Progress has been made in some areas, but it is also lacking in some very important areas. Maybe we can get into more detail on some of those areas later on.

**The Convener:** I am sure that we will.

**Ray Buist:** I will add a bit of information, convener, in response to your question about the slow progress that we describe in the report. A couple of things are contributing to that. One of them is in the capacity of resourcing, even within the Scottish Government itself, to deliver on some of its actions and strategies. The second is the complexity of those strategies. We heard from the Scottish Government that there was a need to make sure that it gets it right and that the strategies are implementable locally.

The Government gave the mental health and substance use protocol as an example of where it had to make sure that it got it right by engaging with Healthcare Improvement Scotland to ensure that the protocol could be adapted for use in each locality. Those are two of the main reasons for the slow progress.

In the report, we highlight slow progress specifically on the workforce action plan and the stigma action plan. There are a couple of reasons for that. First, those two recommendations came from the Scottish Drug Deaths Taskforce, which said that the strategies needed to be developed and rapidly implemented. That emphasised the urgency with which those strategies are required.

Secondly, as we say in the report, there is a need to shift towards earlier intervention and a more preventative approach. Those are two of the key strategic initiatives that can have an impact on that. Tackling the workforce challenges, making services more readily available and more attractive to people who need to ask for help, and tackling stigma, which prevents people from coming forward to ask for help, are key parts of getting support to people at an earlier stage before they reach crisis point.

**The Convener:** As you point out in the report, stigma is a huge factor in things such as suicide. It is a huge factor in the reason why people are in prison. It is a huge factor in driving why people are homeless. There are much wider implications of our competency in dealing with the challenge that we face as a society.

**Stephen Boyle:** I recognise that important point. Although we might have set out at exhibit 2 the apparent boundaries of the system, tackling drug and alcohol harm in Scotland will require the system to operate more effectively than it currently does, even in a public sector context. I am sure that the committee will explore some of the data-sharing aspects of why the system is not operating to best effect.

For balance, the report contains some positive examples of the system stepping into more difficult territory. We give case study examples of the Scottish Ambulance Service's role in tackling people in crisis and how that can help.

It will absolutely take the justice system, housing services, health and, perhaps most fundamentally, communities to give support and ensure that we have that balance right. This is not a justice system issue as it might have been seen historically, and perhaps, as we have set out to a degree in the report, it is not about medicalising drug and alcohol misuse; it is about looking at where the preventative approach to support for people and communities is.

**The Convener:** It is certainly a public health crisis, is it not?

Colin Beattie has some questions to put to you about data and the information that is, or is not, available.

**Colin Beattie (Midlothian North and Musselburgh) (SNP):** Good morning, Auditor General.

Data is something that has come up just once or twice in the past in connection with the public sector. I am looking specifically at the drug and alcohol information system—DAISy—which is supposed to capture all the information from the services that are being delivered. Paragraph 32 on page 18 of your report states that there have been problems with uploading information to the system, and that it would appear that the figure for cases submitted is now down to only

"66 per cent of cases."

That would appear to indicate that the Government is using limited figures in order to create policy.

What progress is being made to sort out those difficulties in uploading data? The issue seems so basic. The system was launched in April 2021, and we are now three and a half years on. What has been done?

**Stephen Boyle:** Good morning, Mr Beattie. You are right. The DAISy system—or, for completeness, the drug and alcohol information system—is Public Health Scotland's system. The intention was for a national database to collect information from drug and alcohol services. As we set out in the report, and as you referenced, it has run into some difficulties with data recording and the ability of statutory and third sector providers to upload information, which has led to a degree of incompletion. Ray Buist might want to say a bit more about where that goes next.

The Scottish Government and Public Health Scotland have recognised that there is more to do here, and they have a review of the system under way in order to get it right.

You are no stranger, Mr Beattie, to reports that the Public Audit Committee has considered over the years with regard to the need both for better data recording and for better use of data to inform policy implementation.

Regrettably, we do not have a system that is operating to best effect. In some respects, it is unfortunate when any data system in the public sector is not operating to best effect, but given how critical this information is at the point of intervention in people's lives, it is fundamental to get the system right. There is considerable need for progress from Public Health Scotland and the Scottish Government to get a system that operates to give people who are working in the sector vital information, in life-and-death circumstances, exactly when they need it.

I will bring in Ray Buist to develop that point and say more about what happens next.

**Ray Buist:** I do not have an awful lot more to add. Mr Beattie's question was around what happens next. We know that the Scottish Government has recognised that there are problems with the DAISy system in the way that it allows service providers to both upload and download data to inform service planning.

As we say in the report, at paragraph 32,

"A review is under way and due to complete in 2025."

**Colin Beattie:** Two thirds of cases are uploaded, and one third is not. It seems extraordinary that some bits of the system are okay, and some people have no problem with it, while others have great difficulty. Has any analysis been done of why that is?

I come back to the question whether the Scottish Government is basing its policy decisions on the limited data that is being uploaded.

**Stephen Boyle:** With regard to the functionality of the system, there is a limit to the extent to which we are able to give the committee effective insight into how it is operating.

**Colin Beattie:** Has it been a problem from the beginning?

**Stephen Boyle:** The system is from 2021—as you mentioned, and as we set out in the report—but we have seen a slight reduction in the extent of usable data from it.

The Scottish Government—again, this is Cornilius Chikwama's field of expertise—is making an assessment that two thirds of the data is of sufficient quality to allow it to draw conclusions across the country. I am not a statistician, Mr Beattie, but I recognise that there is a degree of confidence that allows the Government to make general assessments of how far that sample reflects experience across the population.

Each case in isolation absolutely matters. Decision makers interacting with people whose information is recorded on DAISy need to have confidence across the piece. To give the Scottish Government due recognition, I think that it has noted that the system is not functioning or operating as intended—Public Health Scotland is now conducting a review, and we hope that that will progress as intended and be published next year—but I do not think that anyone would say that the system is currently operating as designed.

**Colin Beattie:** What concerns me about the situation is that, if a problem in the system is systematically affecting certain data that is input and if that data is excluded from consideration, because it has been rejected for some reason or is not working in some way, you will have only a partial picture of what is happening out there.

**Stephen Boyle:** That is exactly our assessment, too. The only distinction that we would make is whether reasonable conclusions can be drawn from the reliable information that the system is populated with to cover the information that it does not have. The Scottish Government's view is that it can reasonably do so, based on the size of the sample that has been entered. Cornilius might want to say how reasonable a judgment that is.

**Cornilius Chikwama:** There is definitely a data gap in DAISy, but it is also worth reflecting on the other data systems that the Scottish Government and its partners that operate in this space have tried to set up to help with information. There is, for example, the rapid action drug alerts and response—RADAR—system, which is co-ordinated by Public Health Scotland; it mainly tracks drug use trends and uses the information generated from that to flag up areas of risk. That information is then passed to those who provide services to give them an understanding of where the risk might be or where it might be changing. There is also a surveillance study of illicit substance toxicity—or ASSIST—which is more of a toxological study of substances that are being used; it captures data from accident and emergency settings and uses that information to inform the planning of what services may be needed. It is therefore worth recognising that there might be other data that covers the data gap.

However, DAISy is all about the data of people who access services, and probably the biggest risk of that data not working well is that you miss individuals who could have accessed specific services. It is more on the service delivery side of

things—that is, the interaction with people—where I think that having incomplete information in DAISy presents the most risk, rather than the policy development side.

**Colin Beattie:** Still on the data theme, I note that there is a problem with data sharing. Indeed, in paragraph 33 on page 18, you raise the issue of

"NHS and local authority patient information"

being

"held on different information technology systems"—

we have heard about that before—and the inability of workforces to share data in a joined-up way. What is happening with that? What action is being taken? Again, it seems fairly basic. I guess that third sector providers are caught up in it, too.

09:45

**Stephen Boyle:** Yes, they are. Ray Buist looked closely at that issue in preparing the report, so I will bring him in too.

On information sharing having been a recurring theme of the committee's consideration of public services, I would start off by saying that, if that issue were easy to resolve, it would have been resolved by now. I recognise that there is complexity—by design, in some respects, because of the number of participants involved in the provision of services. That in itself brings a degree of challenge.

However, we also recognise that some very confidential personal data exists in connection with the people accessing these services, and you have to go through appropriate gates and ensure that those who are providing the services at different points in the system have gone through the right processes. Full compliance with the general data protection regulation is often cited as a barrier—and it is a barrier by design. However, the judgment that we are left with in the report is whether the system is satisfied that it has done everything that it can to overcome the issues with information-sharing arrangements—which, I should point out, are also vital to get right—and that, in times of crisis, the people who provide the services can access information as necessary. There is more work to do in that respect.

Ray can speak to this, too, if he wishes, but—and I go back the case study in the report that I mentioned a few minutes ago—sometimes the information sharing works well. It happened in the Scottish Ambulance Service's role in working with third sector providers such as Women's Aid in the example that we reference, but it does not happen regularly enough. Information sharing—and getting through and overcoming the various barriers—needs to happen more consistently and more effectively.

**Ray Buist:** As the Auditor General has just set out and as you yourself have alluded to, Mr Beattie, some of the barriers include GDPR compliance and information being held on disparate systems across health, social care and justice. However, as the Auditor General has mentioned, we have highlighted in the report some of the ways forward, particularly with regard to information-sharing agreements. In the case study that has been mentioned, we highlight an example of where having an information-sharing agreement can make a real difference to the experience of people accessing services.

Secondly, we highlight the Glasgow intelligence hub, which was initially set up as a sort of Scottish Drug Deaths Taskforce-funded pilot. It has been able to create a dashboard that includes processed and therefore anonymised data on service users, where they are, what they are using and, therefore, hotspots and gaps in where services are being provided, and it uses that information to inform the forward planning of future services.

Those are the two key things that we could perhaps look to as possible ways forward. The information-sharing agreements, as I have said, follow the Glasgow intelligence hub model.

**Colin Beattie:** Are the legacy systems that are in place simply not flexible enough to be able to share data, or is it a question of layering something on top to permit data sharing to happen? I am thinking of the technical side of things rather than the more artificial side that we can deal with.

**Stephen Boyle:** There are bound to be technical issues—there is no question about that. As we say in paragraph 33 of the report, when people leave prison, information on whether they have a drug or alcohol dependency is retained on prison system records instead of being passed on to the NHS or drug and alcohol services. IT infrastructure will inevitably be an issue, and, indeed, the system will not have been designed to be interoperable between different providers. Inevitably, there will be some sort of conduit by which information can be shared safely between different providers, but you can just imagine how that information will arrive. It is going to be on a spreadsheet, or whatever, that is safety protected, and it is not going to be as accessible—at people's fingertips—when they need it.

I think that there are going to be a number of parts to the solution, Mr Beattie. It will involve the effective information-sharing protocols that Ray Buist mentioned as being the first important step, with the right safeguards. I suspect that a second-order issue will be designing a full IT system across the various players, and we would want to look closely at how feasible that might be.

**Colin Beattie:** In your second key message on page 4 of the report, you say:

> "Better information is needed to inform service planning and where funding should be directed and prioritised. This includes data on demand, unmet need, cost-effectiveness, and spending on early intervention and community-based support models."

What improvements are required to achieve that aim, and to what extent is it being addressed?

**Stephen Boyle:** I will bring in colleagues to say a bit more about the steps that need to happen, but before I do so, I want to note a couple of things. First, spending on the provision of drug and alcohol services has increased significantly, and we drift into some of the detail of that in key message 3. For example, there has been a step change in funding from £70.5 million 10 years ago to £161 million now. We also refer to the additional spending that has come through the national mission since 2022.

However, what we have not seen yet is any evaluation or assessment of whether that spending is making a difference or whether the system is delivering as intended. Do we have the sorts of preventative approaches that we know are more cost effective and deliver better outcomes, rather than the crisis-point interventions that tend to be how the system operates in Scotland? We need good data on that. We also know that such evaluations will allow policy makers and the Scottish Government to assess where best to target resources in order to deliver better outcomes. Those are the next steps.

Before I pass to Cornilius Chikwama, who might want to say a bit more about this, I should also say that, in two years' time, we face a significant milestone with the end of the current national mission. That will mark not just a period of uncertainty but a period of opportunity, in which we can set out how Scotland wishes to provide drug and alcohol services and tackle the challenges of misuse for the rest of this decade and beyond.

Again, I guess that that is our high-level judgment, but Cornilius might want to develop the point a bit more.

**Cornilius Chikwama:** I probably do not have much more to say, Mr Beattie, except to highlight that what we need here is a system that works efficiently. When we think about designing data systems, we must recognise that data supports the system, so any approach to data must reflect the system's thinking, and how, if we are going to have different systems, those systems interact. Perhaps we need just one system to cover all the parties that provide services.

That would probably be our headline message on data. There needs to be a recognition that the data supports the system, which means that, whatever we do, we must ensure that the data arrangements are aligned with the system's approach to delivering services.

**Colin Beattie:** Following up on some of the points about what needs to be done to get data on demand, unmet need, cost effectiveness and so on, you highlight on page 43 how we lack information on the cost effectiveness of services and do not know whether we are spending the right amount in the right place. How does that work? What is happening in that respect? It just seems so basic that we need to align outcomes with the spend that we are making.

**Stephen Boyle:** Another recurring theme of Audit Scotland's reporting and the committee's consideration of public spending is the need for clear, intended outcomes at the start of policy implementation that can be tracked and evaluated during its life. Paragraph 43 refers to the £100 million that the Scottish Government has made available for the provision of rehabilitation services. There are two factors in that respect, the first of which is, as you have referred to, whether it will make a difference and whether it is the best way of providing the service in order to deliver better outcomes.

Also, if that is the policy intent, is £100 million enough? Is that the way in which it should be spent to address the demand for the service? As we set out in the report, there is a target of 1,000 publicly available rehabilitation places by 2026, but we are not clear whether that will be enough to meet demand. In some places, it feels that there is a mismatch between the policy intent and whether the policy's ambitions can be delivered, and a question whether the funding available to meet that ambition is enough, given the demand.

**Colin Beattie:** I think that you have just answered my second question on this subject. Given that this particular lack of data across the public sector has been highlighted before, to what extent has the Scottish Government now got the data to assess the cost effectiveness of alcohol and drug services? You seem to be indicating that it still does not have it.

**Stephen Boyle:** We refer in the report to assessment work that is being carried out by Public Health Scotland, particularly a baseline review of this particular programme that it undertook in February, which noted that there had been an increase in placements. Moreover, it has also explored the demand for residential rehabilitation services. However, as we have been discussing, we are not clear whether 1,000 places—which feels like quite a round number—will be sufficient to address the demand for services. As we have set out in various places in the report, Public Health Scotland is undertaking a

range of evaluation approaches, together with the Scottish Government, and those conclusions will be vital to making an informed assessment during 2025—and especially with the conclusion of the current national mission the following year—of where drug and alcohol services in Scotland go next to deliver the outcomes for people who so dearly need them.

**Colin Beattie:** I just want to finish up with a question about young people and prevention. Your report says:

"More work is required in schools to engage with pupils and to understand which approaches are most effective in helping young people understand the risks associated with substance use."

To what extent is good practice—something that we do not talk about as often as we should—such as the North Ayrshire alcohol and drug partnership's engagement with young people being shared across Scotland?

**Stephen Boyle:** I agree that a very interesting part of the report is the balance between crisis-point intervention—and its prevalence in the system—and preventative approaches. I will bring in Ray Buist, because I think that a key part of our own approach to and understanding of this issue has been through the experiences of people who have lived this system, whether or not at crisis point, as well as through engagement with our youth panel, which has informed our understanding of the system through their eyes. I would also highlight North Ayrshire's approach to engaging with young people and, indeed, the Scottish Government's own approach through Planet Youth, which draws on the Icelandic experience of a community approach to ensuring sustainability of drug and alcohol services with regard to young people.

Before I pass to Ray, I just want to highlight the fact that education clearly plays a vital role in that balance between crisis and prevention, and, in that respect, I note the role that Education Scotland was asked to play as part of the national mission to develop materials for schools. Notwithstanding the views of young people that the current approach to drug and alcohol services in schools felt quite traditional or stigmatising, we have not yet seen any pace with regard to Education Scotland's development of some of its learning materials, and we expect that to be picked up in short order. I am sure that Ray has more to say on this point.

10:00

**Ray Buist:** As the Auditor General has mentioned, we have engaged with our youth advisory group on this. As auditors, we are keen to get views from as wide a range of voices as possible, so over the past year, starting with our scoping, we have engaged with that particular group to find out which areas they really cared about and which issues they were seeing and hearing about in their schools and communities. They made it very clear to us that the way in which they were being educated about the risks of substance use was not working; it was very simplistic, it was not trauma informed and it was having no impact. They were not engaging in those classes, and they felt that a change was needed. We then had an opportunity to follow up those questions in our fieldwork.

We have highlighted in the report the North Ayrshire example, where the ADP has taken a similar approach and engaged with young people across the North Ayrshire high school area. It heard that there were different ways of doing this sort of thing, and its opinion was that engaging with people with lived and living experience to understand the circumstances was helpful. There are conflicting studies that suggest that this might not be the most effective way, but for us, the key point is to at least have that engagement with young people to understand where they are coming from and to work with them on a revised set of approaches that can be more effective.

**Colin Beattie:** Is there any sort of robust system for picking out areas of good practice in this field and making use of them or, at least, making them known elsewhere?

**Stephen Boyle:** Clearly, there is a key role here for the multiple partners that are involved. For example, there are the networks of alcohol and drug partnerships. Undoubtedly, there is, as we have set out, variation in the approaches that are being taken, given the scale and size of different ADPs. As well as highlighting good practice in North Ayrshire, we have cited some examples of good practice in Glasgow.

It is the issue of consistency that we are unclear on and which we might highlight in answer to your question whether there is a robust system in place. It is undoubtedly a complex issue, but there is a key role for Public Health Scotland and the Scottish Government to play as conduits for sharing good practice. We are keen to do so in our own reporting, too, but this is much more about the internal networks that the system has in place to ensure that the issue can be addressed satisfactorily.

**Colin Beattie:** Finally, in paragraph 68, you talk about

"little evidence of tier 3 and 4 (acute) services addressing the specific needs of young people."

Did you identify any reasons for that?

**Stephen Boyle:** Ray Buist might want to say more about this, but I think that this takes us back to the convener's point at the start of the meeting about the variation in people's experience. This came through quite strongly in our 2022 briefing, too, but there are barriers to accessing services, depending on one's circumstances. Some of them will be geographical. For example, 18 of the 32 local authorities in Scotland have rehabilitation services, four of which are in Glasgow and three of which are in Inverclyde. Therefore, if you are living in a different part of Scotland, your access to services will be impacted.

We also talk about the variation in and shortage of gender-specific services for people who require alcohol and drug treatment support. Similarly—and to address your question, Mr Beattie—I note that, according to the Scottish Government's own assessment, the provision of services for young people is skewed.

As part of the Scottish Government's approach to making a wider assessment of what is making a difference, consideration must be given to whether—Ray Buist might want to say more about this—there is equity in that regard for different groups in society. It is a complicated situation, but considerable public money is being invested, and evaluation of what is making the most difference is a key part of what the Scottish Government needs to do.

**Ray Buist:** There are two different types of services that we are thinking about when we talk about young people. First, there are services for young people who have problems with their own substance use. Secondly, there are services for young people who are affected by the substance use of a family member. We are seeing examples of both of those, but there are limitations in relation to a particular group of young people—those who felt that they were too old to be able to access children's services but who also felt that the services that were available in their area for adults were not appropriate for them, either. They did not feel that there was a space for them to access services.

That is why there is a key role for third sector grass-roots organisations—we highlighted the role of the Corra Foundation in funding such organisations—to play in providing services where gaps have emerged. That was one particular age group where we saw that.

**The Convener:** Thank you. I will move things along by inviting the deputy convener to ask some questions.

**Jamie Greene (West Scotland) (Con):** This is an important and difficult subject. Many of us will have lots of lived experience of this subject matter—I certainly do—so I am very keen that we try to get to the bottom of things. I have read your report, which is excellent. Unfortunately, it repeats much of what has been said in the past. I want to dig into that.

We all know the top-line statistics: we know that Scotland's drug death rate is three times higher than that of England and double that of Wales, and that, arguably, it is the highest in Europe. We also know that spending on drug and alcohol services has increased, more or less, over the past decade, although it has flatlined a little over the past year or two. The Government acknowledged that there was an issue and started to pump cash into addressing it. It created the specific role of a drugs minister and it established a national mission—the media attention and the world's focus on the issue pushed the Government to do so. The drug deaths situation is described as our national shame, and rightly so.

I do not understand—and I still cannot answer this question—why the drug and alcohol death rates in Scotland are so high relative to those of our neighbours. I simply cannot get my head around that. The report identifies many areas where improvement is needed, but I do not think that it answers that question.

**Stephen Boyle:** All those things are true. In relation to the scope of our work, we did not seek to get into the depth that you might be looking for with regard to some of the societal factors and the specifics of different types of drug consumption. Ray Buist mentioned poly drug use, which has been cited by experts in the area as being one of the variety of factors that are driving the awful death rates that Scotland is reporting, primarily in relation to drugs but also in relation to alcohol, which has consistently been the case over decades.

The intention of our report was to take stock of what has happened, certainly in the past two years but perhaps in the past four or five years, with regard to the use of public spending to deliver drug and alcohol services. That has coincided with the development of the national mission, the focus on the issue and the change in ministerial responsibilities to address it. There will be people who are far more credible and better placed than auditors to inform the committee about why Scotland's drug misuse death rates are as they are.

You will see from our report what will be invested in the future. Providing a step change in investment in drug and alcohol services, improving leadership and providing clarity on the medical treatment standards are all policy matters.

However, is that making a difference? That is the key next step. We need a full and thorough evaluation of how the system operates, what

public spending is achieving and what the fundamental drivers are, so that the trajectory of death rates can be downwards rather than upwards, as it is today.

**Jamie Greene:** I appreciate that clarification. I respect the role that Audit Scotland plays, and I know the limitations of what such a report can do. Nonetheless, Audit Scotland and you, as the Auditor General, chose to do the report, and this is not the first time that Audit Scotland has commented on the issue, so there is clearly an interest in the subject matter. Others will have their own views and comments on the issue, but they will often come from a specific angle in representing a specific organisation or sector.

Ultimately, we cannot answer my question. We cannot pinpoint the reason, and that is part of the problem. If we in this room—the Auditor General and members of the Scottish Parliament—cannot answer the question of why we have such a problem, it will be very difficult to fix. That is one of my concerns.

I do not downplay the importance of addressing the issue of those who, sadly, lose their lives to drugs, but does the focus on drugs come at the expense of talking about Scotland's problem with alcohol?

**Stephen Boyle:** Yes, we made that judgment in our report. I apologise for continuing to reference exhibit 1, but it perhaps illustrates the point. I do not want to overly focus on deaths, because there are wide-ranging personal and societal harms from drug and alcohol misuse, but it is the case that necessary interventions such as the provision of drug services and the creation of the national mission have, in part, come at the expense of a focus on alcohol deaths and alcohol services. I will bring in colleagues in a second, but that point is perhaps best illustrated by the fact that the focus of alcohol and drug partnerships is their work on drugs. Audits of alcohol deaths have become a far-reduced feature relative to the focus on drug services and the implications of drug use.

In relation to the timeframe of next year and the following year, it is clear that Scotland has had an unhealthy relationship with alcohol for decades, so we must consider the implications of that in relation to loss of life, as well as the economic, societal and family implications.

**Jamie Greene:** Is that because alcohol is legal and commonplace? You would not need to walk very far from this room to buy alcohol this afternoon—arguably, the same could be true for drugs—but my point is that we have a different view of alcohol. Drugs are illegal, for want of a better term, but there is societal acceptance of everyday drinking—the phrases "acceptable norms", "social drinking" and "safe levels of drinking" are all used. Is it just the case that we have a different take on alcohol? If the law suddenly made alcohol illegal, perhaps everyone would have a bigger focus on it, and if drugs were legalised in some shape or form, perhaps there would be a different societal view. Is how we perceive the harms just relative?

**Stephen Boyle:** I am not an expert on the subject, but I recognise the characterisation that you have made. Clearly, cultural distinctions between alcohol use and other drug use are prevalent across Scottish society.

It is worth pausing for a moment so that Cornilius Chikwama can say more about the Government's view on the steps that it has taken on consumption, such as minimum unit pricing and the marketing strategy, which is one area that we identify in the report. That been one of the strategies that have not progressed at the same pace relative to other progress, so it might be worth developing that point a bit.

10:15

**Cornilius Chikwama:** The fact that alcohol is legally marketed means that it will be more readily accessible, and there is a recognition that that presents challenges. In 2018, the Scottish Government published the alcohol framework for preventing harm, which was supposed to tackle exactly some of the things that Mr Greene highlights. It looked at affordability and availability, and particularly the role that licensing plays, and how that might help to manage easy access to alcohol, as a substance that can cause harm.

Work should have been done on developing positive attitudes and supporting people to make positive choices. That was about retaining alcohol as a marketed product but ensuring that people make the right choices around it. More important was the work on supporting families and communities where alcohol becomes a difficulty. That work has not progressed, which might partly explain why there is that gap.

That is one of the factors that lead us to conclude that there might have been more focus on tackling the drug challenge at the expense of making progress on some of the things that the Government had already committed to do to address challenges around alcohol. That framework work could have tackled the challenges that you highlighted, if it had progressed.

**Jamie Greene:** Based on some of the focus group work that you did and your conversations with stakeholders, would you say that the issues are massively underreported? Back in 2014, public health research showed that only one in four people who were dependent on alcohol or drugs was engaged in services. I believe that we are

waiting for updated figures for the past decade to see whether access to and take-up of services have improved.

Do you think that alcohol issues are massively underreported? With alcohol, it is more difficult to spot problematic behaviours and to identify people who have dependency issues until they present with an extreme issue, whereas people with drug dependency issues perhaps present more quickly and sooner to health services and in a much graver or more extreme condition. Is the Government on top of that? Is it identifying the undercurrent of underreporting and the problem that exists in society but that is not being helped in any way by a public service?

**Cornilius Chikwama:** There is definitely something there. We highlight in the report—I am trying to find the specific figures—that the number of people who are seeking support for alcohol-related harm has been declining, but that is in a period when we have near-record levels of alcohol deaths. There is definitely something of a disconnect, in terms of people needing support but not getting the service that they need, which then results in the horrendous outcome of people actually dying.

In short, the point that you make is something that we try to highlight in the report.

**Jamie Greene:** Exhibit 4, which shows the barriers to accessing support, sums up the issues. It covers alcohol and drugs, but it talks us through the user journey very nicely, from the point of someone seeking help as an individual through to their getting help and then staying on the path to recovery. The list of barriers is unbelievable. There are so many barriers to people getting from the point where they identify that they have a problem to coming out the other side and being supported and in a better place in life.

I find the barriers that you have identified and the way that you have presented them to be quite extreme and quite shocking, to be honest. Perhaps that identifies the problem, because some people will engage with one or two of those issues on their journey, and others will face them all. Is that part of the problem? Perhaps that is the answer to my first question about why Scotland has such a big issue.

**Stephen Boyle:** Without being definitive on whether it goes back to your earlier point, I say that people will face a complex set of circumstances in managing addictions and functioning in other parts of how they lead their lives. The system is also very complex, and we have spoken about some of the governance. To be honest, most people who access services probably do not really care about the governance around it, but they will care about their experiences and the perceptions or the reality of barriers.

At exhibit 4, as you mentioned, we have looked at the journey, and we have drawn on the lived and living experience of people who interact with the system and what they told us during the course of the audit. I think that that reflects—it is not scientific analysis, but it is what people have shared with us—that the system feels very difficult to navigate.

Perhaps it goes back to the roots of the evidence on why Scotland's relationship with drugs and alcohol leads to much worse outcomes than is the case in other parts of the UK and the wider world. The Scottish Government does not know what is making the biggest difference. Is the system operating as intended? We have not done that evaluation. Are we spending enough? Are we spending too much? Are we spending too little? How should we structure ourselves? Should we have statutory organisations or non-statutory organisations?

It has already been alluded to that many third sector providers operate in this service area. They operate vital parts of the system, but there is uncertainty about their funding arrangements and data sharing. Many factors lead to this situation. Fundamentally, the Government needs to carry out a full evaluation of what is making a difference and what is not.

**Jamie Greene:** You will probably not answer this question, but in that case, what is the point of having a Minister for Drugs and Alcohol Policy at all if we do not have that bigger picture? All the questions that you have just raised are completely valid. They are in the report, and you have reiterated them today. We get the same feedback time after time about the lack of governance, lack of structure and lack of ambition, about knowing whether the money is going to the right people at the right time and whether it is being spent in the right way, and about getting best value.

The governance arrangements seem to be all over the place in relation to who those lines feed back to. Ultimately, you could argue that they all feed back to the minister who is in charge of it all and who is tasked with delivering progress, but it is clear that we are not seeing progress. Things are going in the wrong direction, not in the right direction. I am not asking you to comment on the policy, but you have analysed the outcomes and they do not look great. Anyway, that is perhaps a statement rather than a question, which is a bit unfair.

I want to talk about residential rehab, which is an important issue. It comes up frequently in Parliament, and I am trying to get my head around it. I have done a lot of work in this space, asked a

lot of questions of Government and met a lot of stakeholders, but I still cannot work out whether we are heading in the right direction on residential rehabilitation for alcohol and drugs. There are instances where residential rehab is required for people with both those addictions, because sometimes people present with both addictions. You talk about the £100 million for residential rehab in your report, but you state in bold and big letters that you do not know whether that is enough. How will we know whether that is enough? How many beds do we need?

**Stephen Boyle:** We set out in the report that there has been an increase in residential rehab services. Leaving to one side for a moment the balance of spending on preventative approaches rather than on crisis intervention—clearly, residential rehab is at the other end of that spectrum—we have seen a significant increase in the provision of residential rehab services in Scotland.

I will repeat the points that came up in discussion with Mr Beattie earlier. Progress is being made towards the target of 1,000 residential rehab beds, but there are two points to make on that. First, will that be enough to meet current and estimated demand? We are not clear on that and nor are Public Health Scotland and the Scottish Government. Secondly, that sets a particular path with regard to service provision and the model of residential rehab. Again, I am not exploring the boundaries of the policy choice but, although residential rehab services are vital, they are at the other end of the spectrum and, in some ways, they are evidence of a failure, in that people have not been provided with the support that they needed at much earlier stages.

Therefore, the overall position is that progress is being made towards the Scottish Government's target and tens of millions of pounds is being spent on that, but it is not yet clear whether that will address the problem or whether it will stoke additional demand for rehab.

**Jamie Greene:** Residential rehab will not be suitable for everyone for lots of the reasons that you identify on page 33 of your report. From a practical point of view, services are not meeting people's needs, whether that is because of where they are located or the type of service that is offered—for example, for mothers or for people who have additional issues that mean that they need mental health support alongside rehabilitation or detoxification services. Therefore, there are reasons why the service is not suitable for everyone.

However, it seems that you are saying that by planning a huge increase in residential rehab, you are admitting to failure much earlier in the system, because people should not have to get to the point where they need to spend eight, 10 or 12 weeks in a residential care setting. Their addiction problems should be treated much earlier, which would negate the need for increased bed capacity. Is that what you are saying?

**Stephen Boyle:** What we hope that we have set out in the report is that preventative approaches will deliver better outcomes in a more cost-effective way. Residential rehab will undoubtedly always be a necessary component of services, but it is a crisis service and an intervention service in order to give people life-saving support. However, whether that is the best approach is questionable, so a fundamental evaluation is needed of whether investing in residential rehab on the scale and in the places that the Government has invested and with the targets that it has is the best approach. Perhaps that evaluation ought to have happened before that target was set, in order to ask whether that is the right model of service provision for drug and alcohol services.

**Jamie Greene:** Despite the target, I am aware of a number of providers that are really struggling to access public funding to deliver the expansion. Cornilius Chikwama spoke about the Corra Foundation funding. However, I have visited rehab centres that have had applications knocked back for funding from the residential rehabilitation rapid capacity programme from Corra and other pots of cash. The situation with regard to access to public money to expand capacity is a real pick-and-mix picture. One facility had planning permission to expand its capacity by a third, from 24 to 32 beds. However, the charity is having to raise the money privately by going out with a begging bowl in order to get enough cash to build the beds. Given that there is apparently a big national push and a Government mission to increase capacity, it seems to be incredible that so many providers are struggling to access the money for that. There is now a huge freeze on capital investment anyway, and the money for the expansion does not seem to be ring fenced. Increasing bed capacity is not ideal, but even those who are trying to do that are struggling. Have you come across that situation?

**Cornilius Chikwama:** Increasing the number of beds is one thing, but there is an issue with regard to the way that residential rehab then works.

In the report, we identify a number of factors around referrals, such as how well they are working. Where a system for referring people to residential rehab was already established, that seems to be working well. However, in areas where the systems are still developing, challenges remain. The point that I am making is that it is all very well having beds in institutions, but you actually need the system that moves people into those institutions to be working well.

10:30

The report highlights the issue of the standards of the services that are being provided by the residences, and there might be a role there for governance to ensure that quality standards are being adhered to.

On what you have just mentioned, Mr Greene, we highlight that securing funding for placements from ADPs can be difficult. The beds can be there, but you then need funding so that the bed can be used. If that funding is not available, the bed might not be of use.

Earlier, we talked about workforce challenges, and you highlighted the fact that, in some cases, the residences that are available might not be suitable for specific people. The issue of geography is also important, in that regard.

It is important to look at the number of beds, but there are qualitative aspects that we also need to be focusing on that determine how well beds are being used and, ultimately, the outcomes that we can deliver for people who are seeking help.

**Jamie Greene:** We are short of time, Auditor General, but if you had one key message for the Government off the back of the report, what would it be?

**Stephen Boyle:** I hope that you will forgive me, but we have five key messages.

**Jamie Greene:** I know what is in the report; it is here in black and white. However, if the ministers are sitting watching this committee meeting—I know that everyone watches the broadcast of the Public Audit Committee on a Thursday morning—what is the overarching theme that you want them to take away from your report?

**Stephen Boyle:** I will not repeat the key messages in the report, but I will summarise the position. We have seen improvements in leadership and focus, and we have seen additional spending on drugs and alcohol services. However, we have not got the balance between alcohol and drugs services right, and we have not got the right balance between taking an interventionist approach and a preventative approach. The evaluation work that will take place over the next six, 12 or 18 months will be vital in terms of setting the direction of travel so that we do not just sustain a system, but see vast improvements in the outcomes, in the way that the country is looking for.

**The Convener:** That felt almost like a valedictory statement, but I am afraid that we have several more questions to put to you this morning, starting with James Dornan, who, as I mentioned earlier, is joining us by videolink.

**James Dornan (Glasgow Cathcart) (SNP):** Auditor General, I think that the report is good and highlights exactly the job that the Government has to do to try to make people aware of what is required and get the service working to its maximum.

The problem that we are addressing is a historical one and every political party in Scotland has struggled badly with it. However, this morning, we have not mentioned at all the fact that drug policy is a reserved issue, which means that it is more difficult for the Scottish Government to do things than it necessarily should be. We had to fight tooth and nail to be able to establish safe consumption rooms, which Cornilius Chikwama mentioned earlier. I am not asking you to say what should be done, but there has to be a recognition that, at times, things are a bit more difficult for the Scottish Government than they necessarily should be.

Earlier, the rise in cocaine use was mentioned—I think that the convener brought it up, and it is in the report. Is that not just down to the fact that cocaine went from being a drug that was for a certain niche of society to being cheap enough for almost anyone to be able to use it?

**Stephen Boyle:** Good morning, Mr Dornan. There are a couple of points to recognise. Clearly, Scotland does not operate in isolation in what is a worldwide trade in illegal drugs, and the changing market for those drugs will influence both consumption and the health implications of that consumption—there is no question about that.

On your other point about the extent of devolved and reserved powers, just for absolute clarity, our work in Audit Scotland is on the Scottish Government's responsibilities. However, we recognise that the differing views between the respective Governments have been a factor in the delay by Glasgow City Council, NHS Greater Glasgow and Clyde and the Scottish Government on the creation of safer consumption rooms or the Thistle facility, as we set out in the report. Those differing views have been a factor in relation to taking forward the new approach.

It is true that the system is complicated, both as it is structured within Scotland and in relation to the need for both Governments to work closely and effectively together.

As Cornilius Chikwama touched on, we have seen slower progress on what is a UK-wide alcohol marketing consideration. Publication of what is happening with that next year will be a really important milestone, diverting focus back to the important parity between drug and alcohol services. The latter has not been the feature that we might have expected it to be over the past few

years, when there has been much more focus on drug services.

**James Dornan:** Okay—I appreciate that.

You talk about alcohol and drug service providers beginning to take a human rights-based approach, but people are often unaware of their rights. In your view, what steps are needed to ensure that people are aware of those rights relating to support and access to services?

**Stephen Boyle:** In Audit Scotland, we have tried to broaden our own approach to auditing to better understand people's rights to services, how those are being reflected and how services are designed and then implemented. Human rights was a feature of this audit, too. I will bring in Cornilius Chikwama on that point and then Ray Buist, if there is anything that he wants to add about our approach and judgments.

**Cornilius Chikwama:** The Scottish Government will be publishing a charter of rights in relation to this area. It has approached that through a national collaborative, which is about integrating the human rights approach into alcohol and drug policy development and service provision.

If people understand that it is their right to get treatment if they need it, it helps them to step forward to access services. It also shapes how services are designed if there is a recognition that it is about people claiming their rights. That is a key point to recognise.

The challenge has been in raising awareness so that people understand that this is an area where they have rights. A range of advocacy work is being done on that, but one of our conclusions in the report is that progress on and the resourcing of that work has maybe not been as sufficient as we would have expected it to be. My colleague Ray Buist can add more.

**Ray Buist:** Our approach is to engage with an equalities and human rights advisory group. We engaged with the group during the scoping of our audit to get a sense of the key issues in this space that we should explore, which allowed us to consider those in our fieldwork.

To highlight a couple of things from the report, as the Auditor General and Cornilius Chikwama have mentioned, the draft charter of rights, which is due to be published in December in final form, is key to helping people to understand their rights and to starting to tackle the specific issues around stigma and accessibility of services. If people know the level of service that they are entitled to, that helps to break down those walls of stigma and makes services more accessible.

In paragraph 52 of the report, we highlight the role of Reach Advocacy. We heard that, through ADPs, it is engaging with members of the workforce and helping them to become more educated in relation to helping people who access services to be aware of their human rights and the services that they should be entitled to. That is where we see progress being made.

**James Dornan:** Following on from that, do you think that enough is being done to integrate human rights into policy development for alcohol and drug services?

**Stephen Boyle:** As we set out in paragraph 53, ahead of the proposed new human rights bill, the Government established a national collaborative in an attempt to better integrate human rights into alcohol and drug policy development, and a draft charter of rights is being developed for people affected by substance use. That is due imminently—I think that the intended publication date is next month. It is important to see what comes of that and what is provided to alcohol and drug partnerships. Will it adequately reflect those rights and the role of service users in drawing on their lived experience to shape services?

The report goes on to say that progress with regard to the extent to which people who have lived experience are able to inform and shape that work has been variable across alcohol and drug partnerships. There is much to come in that area. I am keen to see what comes through in the Government's publications next month.

**James Dornan:** It will be interesting to see what happens at that point.

How do you think that the services are responding to people's needs? What do you consider to be the main barriers to people accessing the alcohol and drug services that they need?

**Stephen Boyle:** The position is really variable. There is variability when it comes to the work of individual alcohol and drug partnerships. At various points this morning, we have heard about the extent to which there are barriers for different groups in society and regional variations. There are also the issues that people told us about, which are referred to in exhibit 4. They have to go through a variety of different steps; it is a complicated system. As we set out, people face a wide range of barriers in accessing a system that is incredibly difficult to navigate at some of the most challenging times in their lives.

**James Dornan:** The issue of best practice was touched on earlier. Are you finding that best practice is being shared? Is the practice in areas that are doing things better than others even beginning to be rolled out in other areas?

**Stephen Boyle:** Colleagues will be able to say more about that. We found that there are many

routes through which examples of good practice can be shared—they can be shared through the Government, through the networks that exist and through Public Health Scotland. Therefore, I do not think that there is a lack of awareness of what is considered to be good practice.

However, the nature of the set-up, the structure and the resources that are available are such that some of the alcohol and drug partnerships are very small teams. Some of the services are operated by only a handful of people, so they might simply not be able to apply in their area an approach that might work incredibly well in another part of Scotland. There is regional variation. Aspects of Scotland's geography can act as barriers.

An assessment needs to take place that considers whether the system is set up in a way that will deliver the best outcomes for people and whether public spending is taking place to best effect to deliver the prevention-based outcomes.

I have no doubt that best practice is being shared. The heart of the matter is how easily that best practice can be replicated in different parts of the country.

**James Dornan:** So you are saying that the use of best practice is not flexible enough to take into consideration the different requirements of different areas.

**Stephen Boyle:** Yes. It is a question of policy, is it not? Fundamentally, what matters as the Scottish Government moves forward with its approach to alcohol and drug services will be its intent and the applicability of its approach. There will always be a place for innovation, and that should be the case in different parts of Scotland. It is a question of tailoring services to the needs of the population that they serve. That will be at the heart of delivering a successful model in future.

**James Dornan:** On that point, what needs to be done to tailor the requirements of the services to individuals and particular regions?

10:45

**Stephen Boyle:** We make a number of recommendations in today's report, and I suppose that we will get to the personalisation and tailoring of services.

If you will allow me, I will repeat the point that the evaluation of spending is the most important part that needs to happen now, to make the biggest difference in service provision and achieve a system that is flexible, gets the right balance between drugs and alcohol services and is preventative at its heart. Working with a wide range of partners in this system will give people the best chance of getting better outcomes than we see now.

**The Convener:** Auditor General, before we leave that question and I bring in Graham Simpson for a final round of questions, can I take you to exhibit 5 in the report, which is a graphic representation of performance by health board? You make the point that we cannot compare rural Scotland with urban Scotland and so on, but, if I look at the performance as depicted in the graph of, say, NHS Greater Glasgow and Clyde, as I read it, that health board has met its targets on alcohol and drug treatment service performance measures in every single one of the past 10 quarters. However, if I look at NHS Lothian, which has at its centre Scotland's second biggest city, I see that performance targets have not been met in any of the past 10 quarters. Why is there such huge variation from one end of the M8 to the other?

**Stephen Boyle:** You are right, convener, that there is stark variation between different parts of Scotland in terms of meeting the quarterly target for drug and alcohol services. To answer your question quite directly, we do not know why there is such variation.

However, it is not just in alcohol and drug services that we see variation in performance across Scotland's health boards; the variation that depends on which part of the country you live in is a feature of the experience that people get from NHS services. Not to deviate too much from today's report, but I note that we will soon publish our latest annual report on NHS Scotland, which will get into that territory in a bit more detail.

We are seeing variation in key performance indicators. Fundamentally, for those who live in the NHS Greater Glasgow and Clyde area, they are being met, but, elsewhere in Scotland, it is kind of just your luck as to whether they are met.

**The Convener:** It should not really be down to luck, should it?

I invite Graham Simpson to put some final questions to you.

**Graham Simpson (Central Scotland) (Con):** Thanks, convener. On the previous point, I guess that you would expect the Minister for Drugs and Alcohol Policy to be all over this and to be able to answer why there is such wide variation across Scotland. Has having a Minister for Drugs and Alcohol Policy made a difference?

**Stephen Boyle:** We have not made an assessment as to the benefits provided or difference made by an individual minister, Mr Simpson. Our work evaluates the work of the Scottish Government more generically; the role of local authorities, given that this is a joint report by

me and the Accounts Commission; and, principally, in this structure, the integration joint boards.

However, we do talk about leadership. Indeed, in today's report, we make the judgments that there have been improvements in leadership and that there has been more focus on alcohol and drug services and outcomes since our briefing paper in 2022. However, we do not get into the specifics of the merits or otherwise of ministerial structures.

**Graham Simpson:** In terms of leadership, are we or are we not clear about what this minister is doing or is responsible for in this space?

**Stephen Boyle:** At the risk of repeating my previous answer, I point out that we do not make an assessment of the work of individual ministers; rather, the report is about the work of the Scottish Government in the round. We primarily interact with officials and we draw on the experiences of people in making judgments. That is where we get to in the report. As I mentioned, we have seen some improvements in leadership and focus, and there has been progress in addressing recommendations from our 2022 briefing, but there is still considerable work to be done.

**Graham Simpson:** Earlier, you said that the Scottish Government does not know what is making the biggest difference. Does that include minimum unit pricing? I think that Cornilius Chikwama mentioned that.

**Stephen Boyle:** Cornilius might want to say a bit more about minimum unit pricing—

**Graham Simpson:** Just before he does, I will add one point. Paragraph 18 of your report refers to a report by Public Health Scotland that

"estimated that the policy had reduced the number of deaths directly caused by alcohol consumption by 13 per cent".

It was an estimate. I do not know whether you have looked at the issue in any detail, but can we say with any certainty that there has been that reduction?

**Stephen Boyle:** Cornilius can give you the detail on that.

To address your first point, and to repeat, one of the key judgments that we make in the report is that the Scottish Government does not have a clear enough understanding of what is making the difference in spending on drug and alcohol services. The Government needs to evaluate how the system is working, how it is being funded and where it is getting best value for public investment in drug and alcohol services and the vital impact that they have on people's lives.

I was going to say a bit about the minimum unit pricing report, but Cornilius might be better placed to talk about the reliability of that. The Scottish Government's reporting and its use of statistics is a regulated area, so it is subject to overview by the Office for National Statistics and the statistics regulator, but Cornilius can develop that.

**Cornilius Chikwama:** The Auditor General is right about the point on what works. When we look at the spectrum of services that are required—such as housing and the medical treatment side—we find a whole host of things that could happen in the prevention space.

Minimum unit pricing is one area where the Scottish Government and Public Health Scotland have done some focused evaluation work to understand how well the policy has worked. I am not giving a formal peer review of that work but, when I look at how it has been presented, it seems like a credible evidence base on which to make a judgment on how well the policy is working. There are clear caveats about areas where the evidence is tentative and uncertain, and there is a clear articulation of where there is confidence in what the data that informs the evaluation tells us.

The 13 per cent reduction in alcohol-related deaths is the figure that has come out. With such studies, there will always be a margin of error but, when I look at the methodology that was used and at other things that have also been evaluated as having changed as a result of the policy, it feels like a credible evidence base on which we can make a judgment on the success or otherwise of that specific policy.

**Graham Simpson:** All right—we can look at that if we get the Scottish Government in. It is not fair to ask you about it.

I want to ask about an issue that has come up previously about the alcohol and drug partnerships. Do we know what they actually do?

**Stephen Boyle:** Yes, we do. As we touch on in the report, they are not statutory bodies; they are partnerships between local authorities, health boards and other bodies. For example, the police are commonly represented as members of the partnerships.

On the question of what they do, colleagues might want to say a bit more about the specifics but, essentially, they provide a range of co-ordinating drugs and alcohol services. They set out a report each year on their performance, typically through the integration joint board—the integration authority for health and social care partnerships—that records their work and sets out what they have achieved, or otherwise, during the course of the year.

I will repeat a point that I made earlier, as it is important. In spite of all of that, the Scottish Government's view is that they are not yet mature enough as entities, in terms of what they are doing and what they are providing by way of services, to be given full autonomy in relation to the wider provision of drug and alcohol services in the various parts of Scotland in which they operate.

**Cornilius Chikwama:** As the name suggests, the ADPs are partnerships. Basically, they bring together local authorities, NHS boards, integration authorities, Police Scotland, prison services and third sector organisations—those are the groups that form the partnership.

Their primary role is to co-ordinate services. Each ADP will have a set of services that they provide within a community to support people who are trying to recover from drug and alcohol harms. Their primary function is co-ordination; bringing together the package of services that are offered to a community.

The funding for the work that they do comes from the integration joint boards, as the Auditor General has said. The partnerships are supported by a team, and, as we highlight in the report, the evidence on the sizes of those teams relative to the work that they are being asked to do shows that, in many cases, they tend to be small and are often stretched.

ADPs are a way of joining together services in communities. That is how I would put it.

**Graham Simpson:** I raise the point because, as you say in the report,

"the role of ADPs is not always widely known across other services."

If the people who are meant to be providing those services do not know what ADPs are meant to be doing, what are they there for?

**Stephen Boyle:** In the report, we mention the role of housing officers. They interact regularly with their tenants, going in and out of their homes, and they will see whether those people have drug and alcohol issues. In an ideal world, they might think that they should refer those tenants to an ADP, which could direct them to services. However, if that visibility is not there, there is a clear gap in how the system can operate.

What we are saying is that it is a complex system but, fundamentally, if a service is not operating to the best effect, there needs to be a review of its role to see how it can operate better.

**Graham Simpson:** You also say that there has been a real-terms decrease in funding for the partnerships in the past two years. Does that suggest that there has been a loss of confidence in them?

**Stephen Boyle:** I am not sure that that is a conclusion that we have reached. We are generally more factual, and we illustrate that there had been a significant upturn in spending on drugs and alcohol services, but ADPs' funding provision has been impacted by the rates of inflation and, in recent times, by the fact that they have received flat-cash settlements.

I do not think that we have seen any evidence to suggest that there is a loss of confidence in ADPs. Rather, the funding issue that you mention is more symptomatic of the funding and inflation environment that we have been in over the past couple of years.

**Graham Simpson:** Okay. I have a final question, which you might or might not be able to answer. Are we getting value for money from all the money that we are spending on drug and alcohol services?

**Stephen Boyle:** The Scottish Government does not know that. Indeed, one of the fundamental conclusions in our report is that, without an evaluation of drug and alcohol services and the spending that goes with them, we are not in a position to answer that question yet. We think that that evaluation needs to happen—it is one of today's key recommendations.

**Graham Simpson:** So, the Scottish Government does not know that, but what is your assessment?

**Stephen Boyle:** We are not able to give that judgment, either, until that evaluation takes place. We are seeing improvements in services, but there are still fundamental gaps, and the totality of the problem is not being addressed. Scotland is still operating with significant deaths, even with drug and alcohol services, and all the societal impact that comes from that.

**Graham Simpson:** I think that you have summed it up very well: we do not know what is making a difference, and we do not know whether we are getting value for money. I will leave it there, convener.

**The Convener:** Thank you very much indeed, Graham.

We have run right out of time, so I am going to conclude this evidence session by highlighting a couple of areas that we might wish to follow up on. For example, we never really got a chance to pursue the issue of staff turnover, which was mentioned earlier, so we might write to you with some follow-up questions on that.

Notwithstanding that, I thank Ray Buist, Cornilius Chikwama and the Auditor General for giving us so much of their time this morning to answer our questions on what I think all of us on the committee agree is a really important report.

We recognise that it is follow-up work, and that you are continuing to keep a very close eye on this area of public policy, not least because of the outcomes. Clearly, people are being let down. Our record on drug and alcohol-related deaths is shameful and needs to be addressed as a matter of public priority. Thank you for your evidence this morning.

We now move into private session.

11:01

*Meeting continued in private until 11:29.*

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