OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 27 May 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 27 May 2025

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

16th Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Patrick Harvie (Glasgow) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Alison Fraser (Scottish Parliament)
Martin Reid (Scottish Government)
Douglas Ross (Highlands and Islands) (Con)
Maree Todd (Minister for Social Care, Mental Wellbeing and Sport)
Annie Wells (Glasgow) (Con) (Committee Substitute)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 27 May 2025

[The Convener opened the meeting at 09:06]

Interests

The Convener (Clare Haughey): Good morning, and welcome to the 16th meeting in 2025 of the Health, Social Care and Sport Committee. I have received apologies from Brian Whittle, and Annie Wells joins us in his place.

I welcome Patrick Harvie, who is replacing Gillian Mackay on the committee. On behalf of the committee, I send Gillian our very best wishes as she begins her maternity leave.

Our first item of business is to ask Patrick to declare any interests relevant to the committee's remit.

Patrick Harvie (Glasgow) (Green): Thank you, convener, and good morning. I do not think that I have any relevant interests to declare. My voluntary entry in the register of members' interests shows that I am a member of some organisations that might choose to give evidence to the committee, and I will mention that if it happens.

The Convener: As this is Annie Wells's first appearance as a substitute member, I also ask her to declare any interests that are relevant to the committee's remit.

Annie Wells (Glasgow) (Con) (Committee Substitute): Good morning, convener, and thank you for allowing me to join you today. The only interest that I have to declare is that I am the second signatory to the bill that will be discussed in this meeting.

The Convener: Thank you, Ms Wells.

Decision on Taking Business in Private

09:07

The Convener: The second item is a decision on whether to take items 6 and 7 in private. Do members agree to do so?

Members *indicated agreement.*

Right to Addiction Recovery (Scotland) Bill: Stage 1

09:07

The Convener: The next item is the conclusion of our oral evidence taking as part of the committee's stage 1 scrutiny of the Right to Addiction Recovery (Scotland) Bill. We will take evidence from the member in charge of the bill, Douglas Ross MSP, and I welcome him to the committee. He is joined by Alison Fraser, a solicitor in the legal services team at the Scottish Parliament, and Neil Stewart, a senior clerk in the Parliament's non-Government bills unit.

Before we move to questions, I invite Mr Ross to make a brief opening statement.

Douglas Ross (Highlands and Islands) (Con): Thank you, and good morning. As members know, I have attended all the public meetings that the committee has held on the bill and have listened to the evidence that you have received in the past two months. Although I might not agree with everything that has been said, I take the opportunity to thank those who have made contributions. Should the bill pass stage 1, I will work with the witnesses you have heard from to address their concerns where I can, and I extend that invitation to committee members and to Parliament as a whole.

The specifics of the bill are not before the committee at this stage. Instead, the question is simply whether the bill and the issues that it seeks to address are worthy of further consideration and whether this committee and Parliament should continue considering further measures to tackle drug and alcohol deaths in this country.

I know that the committee is aware of the statistics, but I believe that they bear repeating. The number of drug deaths in Scotland has more than doubled in the past 10 years, and the rate of deaths is 15 times higher in our most deprived communities than in the least deprived ones. Alcohol deaths in Scotland are at the highest level since 2008 and are four times higher in our most deprived communities than in the least deprived. Both of those death rates are the highest in the United Kingdom. This is a crisis made in Scotland and one that can, and must, be fixed in Scotland.

Members might disagree about the solution to this crisis, and we might have a range of views on the content of the bill, but we can all agree that the current approach is not working. That is not a view—it is a fact. Currently, a Scot dies every four hours because of drugs or alcohol. None of us can consider that a success. No one can look upon that fact with complacency. Put simply, we are not doing enough. Those are not statistics—those are real people who are being failed every day.

Deborah had struggled with addiction for more than a decade and was facing sentencing for shoplifting, which is a crime that she committed to pay for her addiction. At her drug treatment and testing order assessment, she begged to be put into rehabilitation, as she did not want to continue with methadone treatment. Her lawyer argued for her request to be met, but that was rejected as being out of scope of the DDTO and she was put back on to methadone. Deborah died of an overdose only a few months later.

Liam had a history of childhood trauma, homelessness and severe mental health issues. He asked for rehab after multiple arrests for drug offences but was placed on a four-month waiting list and told to engage with community services. It was while on that waiting list that Liam overdosed and died.

If the Right to Addiction Recovery (Scotland) Bill helps just one person to survive—if it helps just one more person live life to the full and not die a needless death—I will consider it a success, but I believe that it can do much more than that.

The bill sets out a procedure for a health professional to follow in determining what treatment is appropriate following diagnosis of such an addiction. That includes explaining the treatment options to the patient and encouraging them to contribute their views during the decision-making process. It also sets out a process and a right for a second opinion when a health professional considers that the treatment that the patient wants is not appropriate for them or when the health professional concludes that no treatment is appropriate.

The bill requires that, once a determination is made as to treatment, that treatment must be made available as soon as is reasonably practical and no later than three weeks after the determination is made. One of the key issues that was identified during the policy development process was the number of people who are referred for treatment who do not get that treatment or for whom receiving it takes far too long. The bill seeks to ensure that, in the future, they will receive that treatment—because it is provided at the right time for them and it is the treatment that suits them—and that the treatment they are referred to will be provided irrespective of cost and other considerations. The bill also requires the Scottish ministers to publish and lay an annual report on progress made towards providing the treatments for drug and alcohol addiction recovery.

Finally, the bill requires the Scottish ministers to prepare a code of practice that sets out how the

duty to fulfil the right to treatment will be carried out by health boards and others, such as integration joint boards. As the financial memorandum states, the bill would increase funding to alcohol and drug services by up to £38 million annually.

Crucially, the bill takes nothing away. It does not seek to change existing services; it only seeks to add to the treatment options available.

In the Parliament, we say time and time again that drug and alcohol deaths are a tragedy. Every year, the figures are published and the language gets stronger and stronger—there is talk of "crisis", "scandal", "shame", "national mission" and "priority"—but, beyond those words, the sad reality is that we are not doing enough.

The issue has not been given the attention that it warrants, but, by passing the bill at stage 1, we can give the legislation and other proposals the due consideration that they deserve, we can give some of the most vulnerable people in our society hope that their cries for help have been heard by their Parliament, and we can ensure that the deaths of Deborah, Liam and thousands of other Scots were not in vain.

The Convener: Thank you, Mr Ross. We will move straight to questions.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Good morning. I wonder whether you could respond to the cabinet secretary's evidence to the committee last week, in which we heard that providing a right to treatment in legislation that is not incorporated in any other aspect of health and social care is a potential challenge and could lead to a precedent being set.

Douglas Ross: I understand the uniqueness of what I am proposing, but, as I tried to explain during my opening statement, we are dealing with a unique set of circumstances and we will have to think outside the box. We cannot continue to do what we have always done and hope that solutions will be found in that way.

I think that what the cabinet secretary was alluding to last week in response to Dr Gulhane's questions is that what is being proposed is new because we have never specified a particular treatment in legislation. Of course, we do not specify a particular treatment. Section 1(5) lists a range of treatments, including

"any other treatment the relevant health professional deems appropriate."

Indeed, not providing treatment is an option.

09:15

As I said in my opening statement, it is for the individual, when they are not recommended for any treatment, to seek a second medical opinion, and that second opinion will look at the individual's circumstances. Therefore, yes, I understand that we are proposing something that is different and new, but, as other witnesses have said, we need something different and new, because the current approach is still leading to far too many people losing their lives due to drug and alcohol misuse each year.

Elena Whitham: Would the bill give other individuals who face other conditions the understanding that they would perhaps have the right to seek legal standing in their pursuit of treatment? If so, could that deprioritise spending in other areas, or does your bill seek to level the playing field?

Douglas Ross: It absolutely seeks to level the playing field, because, as the committee heard in evidence, too many people who are being recommended for a number of the treatment options that are set out in the bill are not receiving that treatment. We have introduced the bill to enshrine that right in law because, at the moment, people who are seeking that help are not receiving it.

With regard to the concern that that might move resources away from other areas in the health budget, as I said, there is a range of funding projections for the bill, from £28.5 million to £38 million, and I have been very clear that the uplift in funding for drug and alcohol treatment should come from the Scottish Government central fund. In my note to the Finance and Public Administration Committee, I suggested where I believe that that money can come from—by reducing the civil service head count in Scotland. I know that the Scottish Government is looking at that.

In my view, the bill would not take money away from other drug and alcohol services or from other health services. I have found the funds in other areas of Scottish Government funding so as to address the concern that Ms Whitham expresses about the need to not take the focus or funding away from other areas of healthcare in Scotland.

Elena Whitham: The committee heard quite a bit of evidence that requiring a diagnosis of a medical professional risks being exclusionary to those who are seeking treatment and potentially exacerbates feelings of stigma. How do you respond to that?

Douglas Ross: I want to speak about stigma first, because Ms Harper has spoken about that issue quite a bit, particularly in relation to people in rural areas. We will probably come on to talk about that, but the issue was also mentioned in the Audit Scotland report "Alcohol and drug services", which was published in October. I hope that the bill will

be passed by the Parliament, but Audit Scotland and the Auditor General for Scotland were already speaking about stigma in relation to drug and alcohol services, so we already have a problem to overcome.

I agree with the cabinet secretary's comments last week about our making positive strides to destigmatise those who are suffering from drug and alcohol misuse. I also agree with people who have commented on the bill that the very fact that the Parliament is looking at the Right to Addiction Recovery (Scotland) Bill means that we are shining a light on an area that has not had enough attention in the past.

I do not agree that the bill's provisions would be exclusionary. As I said, they would not take away from any existing services; they would simply add to the available treatment options. The bill looks only at a particular element of drug and alcohol misuse—the treatment element—and does not take anything away from any of the other great services that operate in Scotland or services that could be provided in the future, because it provides for a number of opportunities for Government ministers to add to elements of the bill, whether those are treatment options or other services.

Elena Whitham: You narrated how much stigma there is in health and social care. Would the bill help to break down the barriers to individuals accessing treatment? As opposed to adding stigma, does it have the potential to reduce stigma?

Douglas Ross: I really believe that it does, because it would give people an opportunity to have their voice heard. First of all, a person's voice is heard in the deliberation on the best treatment option for them. I welcome the fact that, last week, the cabinet secretary said to Ms Mochan that we need to

"go further ... in a co-ordinated way that works for individuals and how they wish to access services"—[*Official Report, Health, Social Care and Sport Committee*, 20 May 2025; c 31.]

and that we need to do that in a way that works for them.

There is a gap in the individual element of care that Ms Mochan was getting to and the cabinet secretary was agreeing with. Empowering people to be involved in their own treatment options helps. We have also heard from others that they hope that the bill will support compliance with individuals' human rights. It would allow them to feel that they have a voice in their own decision making and treatment options, and, crucially, if they disagree with those, they would have the right to a second opinion.

They might still disagree with the second opinion if it says that no treatment is right for them or if the treatment that they have asked for is not appropriate for them, but that is left to medical professionals. I am sure that we will get into that later on. I hope that that will further destigmatise those who are struggling with drug and alcohol abuse, because they will be empowered to get the treatment and support that they believe is right to get them on the road to recovery.

Elena Whitham: Finally, we have heard quite a bit from family members about the role that they play in supporting their loved ones when seeking access to support and treatment. What thoughts did you have about them when you were considering the bill? I understand that the scope of a member's bill needs to be quite narrow, so perhaps that was why they were not included in the bill as drafted. Is the role of family something that you would seek to look at going forward?

Douglas Ross: It is a crucial role, and that is why I met organisations that support and represent family members. That was alluded to in the evidence. Following the meeting, I know that they were disappointed that they were not specifically mentioned in the bill. However, I would say that nothing prevents an advocate or a family member from accompanying a patient to a consultation. My concern or fear was that, by putting that in the bill, I would be suggesting that that was not available or happening, and I did not want to give that impression.

I listened intently to what the representatives said to the committee. If I can do something by way of amendment, including amendments from organisations, to strengthen that role and make that clear in the bill, I would be content to look at that. It is a hugely important part of the recovery process that there is support not just for the individual who is going through rehabilitation and trying to get their life back on track, but for their family. I did not include them in the bill simply because I did not want it to seem as though there is a gap at the moment. They are very much part of the process and would be part of the process under the bill—that is crucial.

Finally, a number of committee members will be aware of the point about the narrow scope of the bill, because they have introduced their own non-Government bills. I praise the non-Government bills unit. As someone who had never been involved with such a bill previously, I had no idea of the work that Mr Stewart, Ms Fraser and their colleagues do. I had to take quite a narrow track with a non-Government bill in comparison with a Scottish Government bill. That is why, perhaps for some, the scope is quite tight and restricted, but that is simply because of the process.

The Convener: I have a couple of points for clarification, and then I will bring in Sandesh Gulhane, who has supplementaries on the same theme.

In response to Elena Whitham's question about whether the bill is exclusionary, you spoke about how the rights that would be conferred by the bill would be only for people who had been diagnosed as having an addiction.

Douglas Ross: Yes.

The Convener: Someone who had a drug misuse problem or was overusing alcohol—or however else you wanted to look at it—would not have the rights that someone who was covered by the bill would have.

Douglas Ross: They would have all their current rights. The bill would not take away any of the other rights that exist or that could exist in the future. The bill seeks to complement what we already have.

The Convener: It would not give them the rights that it confers.

Douglas Ross: No. That is what I was going to come on to. I know that the use of the term "diagnosis" has come up quite a lot, and I would be keen to look at that, depending on what your committee decides about whether elements of the language could be exclusionary. I think that the cabinet secretary even said that it would never be my intention, as the member in charge of the bill, for it to be exclusionary. So, if that is an unintended consequence, I will look to address that at stages 2 and 3.

At the moment, the bill is drafted as it is because any treatment starts with a diagnosis—that is why it was put in that way. However, given the evidence that I have heard, I am certainly willing to consider the point.

I should have mentioned to Ms Whitham, on her point about families being included that elements of that could be strengthened in the code of practice, which is also mentioned in the bill. The bill also allows for Parliament to consider the draft code of practice before it is published. I hope that that reassures those who have concerns relating to Ms Whitham's final point.

The Convener: I have another point for clarification, which I have asked about at previous committee meetings. I am keen to hear what you mean by the term "health professional"—that is, the person who would give the determination or the diagnosis. It is a very wide-ranging term. Should its scope be narrow or wide?

Douglas Ross: It means people who, at present, treat people with drug and alcohol addiction. It could be a general practitioner or a nurse practitioner—people who are authorised to prescribe any of the treatments that are listed in the bill. I picked up from the evidence from Dr Peter Rice and Dr Chris Williams that there are concerns that the definition might result in independently contracted GPs and pharmacists making treatment determinations—I think that that was your question, convener. Dr Rice said that he was relaxed and Dr Williams said that he was comfortable with the position because of the sound governance arrangements that would be in place.

The Convener: Are you relaxed about the position that it could be an independent GP or independent prescribing practitioner who would make the determination?

Douglas Ross: I am relaxed that the former chair of the Royal College of Psychiatrists and Dr Chris Williams from the Royal College of General Practitioners are relaxed and comfortable that there would be existing sound governance arrangements in place for that. That is why we have come up with the term "relevant health professional".

David Torrance (Kirkcaldy) (SNP): Good morning. On the implementation of the bill, what consideration has the member given to how the bill would operate in practice, and has he explored what duties and functions the Scottish Government would need to place on other bodies?

Douglas Ross: Mr Torrance, I know that you have a personal interest in the area—you have made that very clear—and are involved with the Fife Alcohol and Drug Partnership. Your interest has been very helpful to me during the committee's consideration of the bill.

Clearly, the bill puts an onus on Scottish Government ministers. There is a budget uplift that has to be delivered—we will get into that—but, when I spoke to the Finance and Public Administration Committee about the financial memorandum, concerns were raised about the role of social work departments and local authorities.

Ultimately, the desire is that, under the bill, the Scottish Government would deliver the rights in law. The Scottish Government would then work with ADPs, integration joint boards, councils and others to deliver them, and it would be for the Scottish Government to take that work forward. I think that it is right that the Government is given the flexibility to implement the bill in the way that it believes will deliver the outcomes that the bill seeks.

There is also an important reporting mechanism that allows ministers to be held to account in the Parliament—we will probably come on to speak about reporting. There is a huge deficiency in the

numbers that we are able to properly gather on those who are suffering from drug and alcohol misuse. Indeed, many people have spoken about a missing cohort of people who are not included in any official statistics. Having that reporting to Parliament, so that it could hold the Government to account on the elements in that process, would therefore be an important part of both the legislation's progress and how it is monitored in the years to come.

David Torrance: Did the member consider any options for redress in addition to the national health service complaint process or the need to take legal action?

Douglas Ross: There will obviously be opportunities for people to take legal action, but I know that the cost will be of significant concern for some. Legal aid options will be available. A number of standard options are in place to allow people to appeal any determination. I listened closely to what the Law Society and others said on the issue, and I think that it is right that, when something is enshrined in law and a guarantee is given to people, they should be able to appeal should the outcome not be the one that they are looking for.

I also hope that, ultimately, by enshrining the rights in law and by shining a light on the issue in your committee and in Parliament, we will send a very strong signal that the rights should be delivered and that, when medical professionals believe that someone deserves and is entitled to a certain form of treatment, they should get that. I hope that that would negate much of the need to take anything into the legal sphere, because people would understand that the right for people to get the help and support that they need and want had been enshrined in law by the Scottish Parliament.

David Torrance: The written and oral evidence to the committee has highlighted the importance of independent advocacy. Has the member given any consideration to the role of independent advocacy under the bill?

09:30

Douglas Ross: Yes. That is hugely important. It goes back to Ms Whitham's point that any family member or another advocate can come along with someone who is seeking help and support to overcome their addiction. It is vitally important that they are part of the decision-making process—I think that that is one of the most positive elements of the bill—and that they feel supported in seeking that support, because there will be concern. We are dealing with some of the most vulnerable people in our society, and individual advocacy plays an important role in people getting the rights that they deserve, which I hope the bill will enshrine.

Annie Wells: Just to expand on that theme, how would you ensure that Scotland's most deprived communities were aware of their rights under the bill?

Douglas Ross: That is hugely important. As I said in my opening statement, drug and alcohol deaths are, sadly, far more prevalent in our most deprived communities than in our least deprived communities. There is particular mention in the financial memorandum of a process that we would go through and funding that would be allocated to make people aware of their rights, should the bill be passed by the Parliament. That would be important.

The bill has been drafted by front-line experts. I am the person who will take the bill through the Parliament, because that has to be done by an MSP, but I have to pay special credit to Annemarie Ward from Faces & Voices of Recovery UK and Steven Wishart, who drafted the bill and have been the driving force behind the change that they hope it will elicit.

From discussions with front-line experts, I know that they are aware of what is happening in the Parliament, and they are aware of the possibilities should the bill progress and become law. Therefore, there is already awareness out there in communities and among front-line experts who deal with people with drug and alcohol addiction issues.

Beyond that, there is a financial element in the financial memorandum that would allow us to make it clear to people, particularly those in the most-deprived communities, that the new law would help and support them.

Annie Wells: Thank you.

Emma Harper (South Scotland) (SNP): Good morning. Thanks for being here today, Mr Ross. I will pick up on the rural issue, but my first question is about evidence that we have taken that the bill does not incorporate appropriately the principles of trauma-informed practice. We know that trauma can lead to somebody ending up making harmful use of alcohol or drugs. Will you address that issue?

Douglas Ross: I suppose that that goes back to the narrow focus of a member's bill. I can look at only one element of the drug and alcohol issues that people face. However, the bill does not step on the toes of any other issues. It does not supersede anything else that has gone before it or will go after it; it looks specifically at the treatment element. Anything around trauma-informed diagnosis or support would continue and would in no way be affected by what is in the bill that is in

front of us. It is an extremely important element of the overall package to help people to overcome their addiction issues.

Emma Harper: Another thing that came out of the evidence is the primary focus on a medical model of treatment rather than broader psychosocial factors. It is similar to the trauma-informed practice issue. Some of the concerns are about focusing only on a medical model, instead of including the wider psychosocial aspects.

Douglas Ross: Again, I would say that the wider psychosocial aspects would in no way be impinged on if the bill were to go through. A number of treatment options are specified in the bill, because we are taking a narrow focus on just this element of the drug and alcohol addiction journey that people go on. As Annemarie Ward said in her evidence, if there is criticism that the bill is too narrow in scope, perhaps that just means that the bill aims to do one small thing in the best possible way. That is quite a good way to look at it.

I understand those concerns, but I hope that I can reassure you, Ms Harper, and the rest of the committee that the bill would in no way diminish the other aspects of drug and alcohol rehabilitation for those who seek help and support but would simply add to them.

Emma Harper: Last week, as I am sure you heard, there was evidence about section 2, in which, on the procedure for determining treatment, there is a requirement that a meeting between the relevant health professional and the patient be "in person". Challenges have been brought up about people who are experiencing homelessness and people in rural areas. We know how technology has moved forward, especially post-pandemic, when it comes to getting appointments, for example. What are your thoughts on the requirement for an in-person appointment?

Douglas Ross: I heard that loud and clear. I put in that requirement to begin with because I wanted to give as much support as possible to an individual seeking help, and I felt that that face-to-face interaction would be important. Of course, you can still have face-to-face interaction in rural or island communities. As I represent the Highlands and Islands, I know—as does Ms Harper, as a representative of the south of Scotland—that those communities have built up resilience in relation to some of the challenges of meeting in remote and sparsely populated areas. However, I cannot disagree with anything that Ms Harper or the witnesses have said. That is why I am keen and would be happy to look at an amendment at stage 2 to widen the scope of that provision. To go back to the point that Ms Whitham and the convener made, I do not want anything to be exclusionary. It would be absolutely an unintended consequence of my trying to give an individual as much support as possible through having that in-person meeting if people from the islands or the more remote and rural areas were then excluded.

To go back—because I jumped ahead with Ms Whitham—there has been a strong theme throughout Ms Harper's questioning about the impact in our rural communities, which is why I looked again at the Auditor General's report of just last year. It says:

"Progress in providing person-centred services is mixed. Not everyone can access the services they need or is aware of their rights."

That is what is currently happening—it has nothing to do with the bill. The report goes on:

"People face many barriers to getting support, including stigma, limited access to services in rural areas, high eligibility criteria and long waiting times. People who already face disadvantage experience additional barriers to accessing services and there is more to do to tailor services to individual needs."

That sums up what I am trying to overcome through the bill. However, I accept and acknowledge that the stipulation that a meeting must be "in person" would exclude certain people, which is why I would readily seek to change that at stage 2.

Emma Harper: You spoke about the individual needs of people who are experiencing harm as a result of alcohol or drugs. Does the bill need to have a better balance that includes harm reduction strategies instead of taking only an abstinence-based approach?

Douglas Ross: I know that that has come across quite a lot from the witnesses. In section 1(5), there is a list of treatments, but there is also a catch-all at the end that states "any other treatment" that is deemed "appropriate". Although I can understand why some people think that the bill is heavily reliant on an abstinence-based approach, it is not exclusively so. Any other form of treatment could be added at any point—section 1(6) allows Scottish Government ministers to add to that list. I hope that that will reassure you that, although that may be a perception, it is certainly not the intent, and, in the detail of the bill, more options are available, and there may be further options in the future.

Emma Harper: Okay.

I have a final question. According to section 3, which is about the provision of treatment, the strategies that are to be determined are to be implemented

"as soon as reasonably practicable and ... no later than 3 weeks after the treatment determination is made."

When does the clock start and stop ticking? The nature of people who present for help might mean that they miss appointments or disappear. Homelessness is part of all that. How would that be monitored? When does the clock start and stop ticking?

Douglas Ross: It is important to state that section 3(1) contains a three-week ceiling—and it is very much a ceiling, because it also states that the treatment should be available

"as soon as reasonably practicable".

That can be on day 1, as soon as the person presents and has met with a medical professional and a treatment has been determined for them.

The point has been rehearsed in some of the evidence that the committee has heard and that it has received in submissions. The reason that the three-week period was chosen was because that is the national standard: 90 per cent of people should wait no longer than that three-week period for specialist treatment. It ties in with what we already have. However, I understand that, for some people, far more urgency is required.

On your question about when the clock starts and stops, it starts when someone seeks help—when they go to a medical professional to get a determination, when they are requesting a certain treatment or having a discussion about the treatment. It does, however, stop and restart if they are not satisfied with the option that is provided by the medical professional and want a second opinion, or if they are not happy or satisfied that no treatment has been suggested. The clock, and the three-week period, would start again when they sought a second opinion.

Joe FitzPatrick (Dundee City West) (SNP): I want to go back to your response to Emma Harper about treatment options. You said that there is a perception that the bill is about abstinence-based treatments. I ask you to reflect on the fact that your opening remarks might have made it sound as if the bill is about one particular abstinence-based treatment route. It was almost as if you were saying that, although there are other options, there is a hierarchy and anything shy of abstinence-based recovery and rehab is less good than any other treatment option. I think that your opening remarks today will have fed that perception. The challenge is that people out there who might support that would be disappointed if that is not what the bill is about.

Douglas Ross: First, on rehab, the Scottish Government's priority is to increase the number of rehab beds by March 2026. Indeed, the former First Minister, Nicola Sturgeon, wanted to take the percentage of people getting into rehab from 5 per cent up to around 11 per cent, which is the European average. If I stressed that option in my opening remarks, it was because it is an area in which we are currently seeing development. I know that you have a great deal of experience in this area, as the former Minister for Public Health, Sport and Wellbeing.

In many ways, I am trying to work alongside the Government's current strategies. The investment that the Government is making to increase the number of beds and its ambition to get us up to levels that are similar to those in other European countries can be complemented by the bill. However, section 1(5)(g) provides for

"any other treatment the relevant health professional deems appropriate",

so that opens up the opportunity for other options.

I take on board the point—I am not saying that it is a criticism—that you make, which is that the bill is looking too much at abstinence. There are a number of elements in it that would support that option, but there are also a number of elements that would allow other treatment options to be made clear and available.

Joe FitzPatrick: You are right in saying that the Scottish Government wants to increase access to rehab and is funding that. What would your bill do that the current process is not doing?

Douglas Ross: I will give some examples. Some of the funding would go towards ensuring that there are sufficient medical professionals available to make the determinations on treatment options. Another point is that the bill puts the person at the centre of the process; they would be involved at the very beginning, when they say what they would like. A person may say that rehab is right for them; other people may say that a methadone script is the best approach for them, and the bill would not prevent them from getting methadone and continuing with it.

It is about taking a patient-centred approach and enshrining in law a legal right so that people have more power, when they go into those meetings, to say what they want. Unlike Liam, who wanted rehab, they will not be told, "Probably not," and then go on to a waiting list for months. The bill would shut down the prospect of someone waiting for months or, indeed, years. We currently have examples of such waits. People who are offered rehab or a number of the treatment options that are listed in the bill are not getting that treatment—it is simply not happening.

I believe that the committee has had evidence from a number of people that there are too many people out there in Scotland right now who are seeking help and are not getting it. The bill would give them the legal right, in law, to get that treatment.

To go back to the point that I made to Mr Torrance, the Government would then be scrutinised on that. If Government ministers have to answer for that in Parliament—as you and Ms Whitham had to do, and, indeed, on different subjects, as Mr Harvie and Ms Haughey previously had to do—they will be held to account. They will then work hard with partners, be they ADPs, integration joint boards or social work departments in local authorities, to deliver it.

09:45

Joe FitzPatrick: To go back, I think that the bill talks about clinician-led decision making, but you suggested that the patient should be allowed to say, "I want this particular type of treatment." Are you, indeed, suggesting that, uniquely, patients should be able to dictate their treatment path?

Douglas Ross: Well, they are able to dictate what they believe is right for them, but, as you will be aware, the medical professional must still comply with the guidance in what is called the orange book and look at whether that treatment is right for the patient. I could be struggling with addiction and think that X was the right approach for me, and I would make a very forceful case for that, but if that did not meet the criteria in the orange book and the medical professional did not agree with that, they could say, "No, that treatment is not right for you."

An individual would have the right to a second opinion, which, as with the original determination, would be given in writing, so that the person would have something that they could scrutinise. We have spoken already about the vulnerability of many of the people who are involved here—it is important that they have something in front of them that they can look to challenge or accept.

It goes back to your point about what the bill would do, Mr FitzPatrick. It would provide an uplift of between £28.5 million and £38 million—between 17.5 per cent and 24 per cent—in the drug and alcohol budget. The national mission budget is £160 million to the end of this session of Parliament. It is hugely important and I want to see it extended. We need more resources going into the national mission, because this is still a national crisis with which we must get to grips.

Joe FitzPatrick: Obviously, budget decisions are normally made in the budget, and Mr Ross did not support the increase in that area this year.

Patrick Harvie: Good morning. I will follow up the same theme that Emma Harper started and that Joe Fitzpatrick continued: the list of treatments that you have made clear is non-exhaustive, not prescriptive and can be changed. Specific issues might have been considered for such a list but have not been included, such as harm reduction. There are those who make a case for heroin-assisted treatment not as a default, but because it has been shown to be effective in certain circumstances and successive UK Governments have allowed it. I am interested in exploring not only that but the question whether any list—even a non-prescriptive, non-exhaustive one—is the right way to go.

You said that the bill would increase the range of treatments that are available. Although you might be strongly of the view that it would increase the pressure on Government and public sector bodies to invest in capacity, it would not actually increase the range of treatments that are available. You also said that it would empower individuals to access the treatment that they believe is right for them, but the bill's achieving what you have described would not sit well, it seems, with the points that you have just made about clinical judgment in each case.

Surely, any bill that is composed of a list, as this one is, will place an emphasis on the things that are included in the list and risk de-emphasising others. Effectively, providing a list makes a political judgment in place of what should be a clinical judgment. By taking a list-based approach, are we not mistaking a political judgment for what should be a clinical one?

Douglas Ross: The point is very well made. I would not say that I had a dilemma, but I had the option of saying nothing in section 1(5) apart from the last point—that is,

"any ... treatment the relevant health professional deems appropriate".

The worry was that such an open approach would make scrutiny at this committee and the finance committee difficult, because it would not be specific enough. How would you then budget for the treatments and hold the Government to account for it? Reporting is extremely important, and the bill will deliver that, but it would have become far more challenging with a very open-ended section 1(5).

Therefore, we looked at a list of options, and those are the ones that I included, but I am very willing to look at amendments that add some of the points that you have suggested. If a strong case can be made that including other treatments would provide more balance—if that is the concern—we could add them to the list in section 1(5).

As for whether that makes the bill less clinical and more political, I do not believe it does. There are reasons for having the list of treatments as drafted—the treatments that have been included—and there will be reasons why people will wish to lodge amendments to add to the list. Ultimately, there is the catch-all of

"any other treatment the relevant health professional deems appropriate",

which takes away the political element.

That said, I go back to the point that I made in response to Mr FitzPatrick: there is already a political drive to increase the amount of rehab beds in Scotland, which I think we all support. When we get the increase in rehab beds that the additional funding coming through the bill will help to deliver, I want people to have the right to get them. At the moment, people are being recommended for rehab and are being told that it will take weeks, months or, in some shocking and unacceptable cases, years for them to get into the rehab facilities that they need to access.

Patrick Harvie: I do not disagree with your points about investment in capacity. Investment in public services is a political decision. However, do you understand the concern about what you have just suggested? It means that when we get to stages 2 and 3, we will be deciding ourselves, as MSPs, on the case for and against particular treatments and debating amendments to include them in a list. My worry is that that is not our judgment to make and that it would inevitably impact on the types of service that receive investment and, almost automatically, the types that do not receive increased investment.

Douglas Ross: The bill must have an influence on the types of service that receive investment. As we know, not enough money has gone into rehab facilities in the past, which is why some of them have closed. That is why, in the national mission, the Government has increased the amount of money going towards them.

As for your concern about debating particular treatments, so that we include some and do not include others, and about whether that takes away from the clinical decision, I would say that, no, it does not. I trust the doctors—indeed, one is sat next to you—to make the clinical decision that they think is right for the patient in front of them. They have to adhere to the orange book guidelines, and they will still have to adhere to them, regardless of what is in the bill and any future amendments.

They also have the option of choosing no treatment at all. Despite all the options being listed in section 1(5), the doctor could say that none of them was appropriate or suitable for an individual, and therefore no treatment would be provided. The doctor, medical expert or nurse practitioner would have the opportunity to say that no treatment was suitable for the patient.

Patrick Harvie: So, in fact, the bill would not empower individuals to access the treatment that they believed was right for them—to use your words from earlier.

Douglas Ross: I think that it would empower them in that they would be involved in that conversation. If you were the medical professional from whom I was seeking help, I could mention the options suggested in the legislation, and I could say, for instance, "I think that option 1 is the right one for me." We could then have a discussion, perhaps with a family member or an independent advocate present, and the medical professional would make their determination, based on their meeting with the patient or the person seeking support and on all their relevant medical training. The financial memorandum covers further training for medical professionals to deal with such situations.

Therefore, I think that the bill would empower individuals—it would empower them to know that, if the medical professional said that the person met the criteria for a given type of treatment, they would be entitled to it within three weeks. At the moment, you could tell me that I am entitled to something and I could sit on a waiting list for months. That is where the empowerment would come from.

The Convener: I am keen to hear the member's response to some of the things that he will have heard in the public gallery at previous committee meetings. For example, how do you respond to concerns that the bill does not sufficiently recognise the role of partnerships between health, social care and third sector organisations that currently deliver substance misuse and use services?

Douglas Ross: I heard that evidence, and it is a point that Mr Harvie's colleague Gillian Mackay raised a number of times, including last week. I am sorry to labour the point, but it bears repeating: the bill would not stop any of that multidisciplinary working, and it would not prevent any of the good working between the third sector and a number of different organisations. It would add treatment options in the narrow area of drug and alcohol addiction, but it would not prevent, stop or in any way diminish the work done by others; I hope that it would work in collaboration with it. It would simply add tools to the toolkit, so that people could seek the support and help that they were looking for.

The Convener: Do you think that there is a danger in having a stand-alone bill that deals with a specific group of patients who are seeking treatment and need a specific diagnosis and determination? Might that muddy the waters for the services that currently provide wraparound support to people who are seeking help with addiction?

Douglas Ross: I do not think so, and I can point to a number of ideas to support that view.

First, the budget required for the bill would represent a significant uplift. There would be an increase from £28.5 million to £38 million, which again shows that the bill would be adding something, not taking from other areas.

The bill would also be important in helping those in third sector organisations who work with people with addictions, because they would be able to see that an individual with whom they were working, and who needed one of the treatments listed in section 1(5), would get it. If the treatment was agreed by the medical professional, workers would know that the support would go to that individual and that they would not have to worry about someone such as Liam being put on a waiting list for four months and then taking an overdose and dying while on it. I think that the bill would help with the work that they are doing, and they would know that those individuals would be guaranteed the care that was deemed appropriate for them.

The Convener: For my next question, I want to take a step back. You will have heard the evidence from the Law Society of Scotland, which raised some concerns about the way in which the bill is currently drafted, suggesting that it does not particularly align with the medico-legal position on how treatment is provided. In that respect, the Law Society cited the McCulloch case. Do you want to respond to that?

Douglas Ross: The procedure set out in section 2 of the bill is bespoke for the treatment of alcohol and/or drug addiction. In my view, it is not inconsistent with the Supreme Court ruling in the case of McCulloch vs Forth Valley Health Board, which was the example cited.

The Convener: Can I just clarify that, Mr Ross? Are you disagreeing with the Law Society's interpretation?

Douglas Ross: I am saying that I do not believe that the bill is inconsistent with that judgment, and I will try to explain that if I can.

The Law Society has an opinion, which I have looked at with those supporting me. I do not believe that the bill is inconsistent, but I understand why the Law Society raised the issue. I think that the Law Society was raising a potential concern instead of guaranteeing that the bill would fall foul of that.

The Supreme Court decision sets out a specific scheme for people seeking help with drug and alcohol addiction. Under the bill, a health professional would be responsible for providing an explanation of each of the treatments listed and of any other areas that they considered appropriate, along with an explanation as to their suitability. The decision as to suitability would still rest with the clinician, so the bill would not require a health professional to say that a treatment would be suitable, nor to recommend a treatment as being the appropriate one. The Supreme Court decision basically looked at the question whether the doctor was negligent in failing to discuss an alternative treatment that she did not consider to be reasonable.

The Convener: Ms Fraser, do you want to come in?

Alison Fraser (Scottish Parliament): As the member has just said, it might be worth going through what the bill provides and what the Supreme Court decided in the McCulloch case, as those are different sides of the same coin.

The bill provides that the health professional must explain the various treatments and must consider all those that might be relevant to that person, including those on the particular list. It is the provision of the list of treatments that is unusual, as the member has already discussed. That is not disputed; it is unusual, but the reasons for taking that approach have been given.

The Supreme Court decision in the McCulloch case was not about alcohol and drug addiction; in that case, the question was whether the consultant was clinically negligent in failing to discuss a treatment option that they did not think was reasonable. The Supreme Court held that the consultant did not have to discuss a particular treatment that they did not think was reasonable for that patient and that they were not negligent in that decision. That set of circumstances is different to those set out in the bill.

The Law Society of Scotland has said that the bill takes a different medico-legal position, but I would say that it makes different medical provision, because it provides for a non-exhaustive list of treatments in the particular area of alcohol and drug addiction. The member's policy is that all those treatments should be explained to the patient, whereas in the Supreme Court judgment—I am sorry, but I cannot remember the condition from which the patient was suffering in that case—there was a question of clinical negligence in failing to discuss an option that the consultant did not think was appropriate.

10:00

The Convener: So, all the treatment options would be discussed with the patient, regardless of whether the clinician felt that they were clinically appropriate. Is that what I am hearing?

Douglas Ross: The patient comes in and can discuss the options that they believe are right for them. The clinician—the medical professional—can say, "I agree with you and I recommend you for it," "I disagree, and maybe another option is the

correct one," or, "No treatment is the correct option for you."

The Convener: How does that differ from a situation in which I present to my GP tomorrow and say, "I want this treatment," the GP then discusses the treatment options for my particular condition, I decide that I do not agree with them, and I seek a second opinion, as is my right?

Douglas Ross: Of course, a second opinion is your right at the moment. One of the biggest differences would be the timeline. This should happen as soon as is practically possible and with a three-week ceiling.

To go back to Ms Harper's point about the clock starting and stopping, I would say that this is about trying to get the process to happen as quickly as possible. It is also about enshrining that right in law, which brings me back to my points about holding the Government accountable for this. When the Government has to meet those standards and has to be accountable for doing so, there is more of a drive to get the investment into the various different options that we have discussed this morning.

The Convener: I am sorry to labour the point, but I want to make sure that I am absolutely clear on this. This is about enshrining the timescales in law.

Douglas Ross: The legal right to addiction recovery enshrines in law that it should happen as soon as is practically possible and within a maximum of three weeks.

The Convener: Thank you for that clarification. Before I forget, I should put on record my entry in the register of members' interests that I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

Emma Harper: As a former liver transplant nurse, I know that one of the treatment options for addiction is a liver transplant. If someone was seeking a treatment option and wanted such a transplant, would that be part of the list?

Douglas Ross: That is not my understanding, because that would be a consequence of drug—particularly alcohol—addiction, whereas the bill is looking at dealing with the addiction elements. I know that there were questions in some of the committee's previous sessions about addiction to things like nicotine—Mr Whittle even jokingly referred to chocolate and such like—but the bill is very specific about drug and alcohol addiction, and about dealing with the addiction part. In my view, liver failure is a consequence of addiction and would be dealt with in the normal way, through a transplant request.

Emma Harper: I have a wee supplementary question about the reference in the bill to "a second relevant health professional".

Is there a hierarchy of health professionals? I am thinking of what might happen if the first health professional was a specialist in alcohol and drug harm reduction, and a medical doctor, and the second was an advanced nurse practitioner, and their opinions were different.

Douglas Ross: No, there is no hierarchy at all. I should say that this is not stipulated in the bill—it is left to the Government. It could be in the code of practice, but I do not anticipate anything like that being stipulated in any way.

All the medical professionals, as is outlined in the bill and as was highlighted in my earlier discussions with the convener, are deemed to be medical professionals as per the terms of the bill and the accompanying notes; therefore, one does not take precedence, and their judgment or view is not deemed to be superior to that of any other.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising NHS GP. Sadly, I have had to treat people with drug and alcohol addiction, and I think that we can all agree that a Scot dying every four hours of drugs or alcohol is simply not good enough.

I would like to ask about data. What data are we lacking, and how would the bill help us in that regard?

Douglas Ross: There is a huge lack of data, which has hampered some of the deliberations that I have had on the bill. It certainly caused challenges when I went to the Finance and Public Administration Committee, because the members on that committee understandably want precise examples of and costs for everything. In his letter to this committee and the finance committee—it was a joint letter to both committees that are considering the bill—the Cabinet Secretary for Health and Social Care was open about how difficult it is to gather data on this issue and to assess the effectiveness or otherwise of some of the options that are currently available.

The reporting element of the bill would therefore provide much greater clarity going forward. There would be an onus on organisations to report, because a report would need to be laid annually before the Parliament and a Government minister would have to present that report and be held accountable for it. The report would allow politicians across the political spectrum to question the Government on how it is dealing with the proposals and the procedures that are set out in the bill and also the wider issues around drug and alcohol addiction and rehabilitation.

Sandesh Gulhane: Would getting that data and having it presented by ministers help us to tackle the issue?

Douglas Ross: Yes. As other witnesses have alluded to, it would shine a light on the issue and ensure that some of the most vulnerable and marginalised people in our society get their say within the Parliament. Good, sound, evidence-based policies need data, and there is currently a deficiency in such data. I do not think that that has been questioned by anyone you have heard from in your evidence sessions or in submissions, nor in the evidence that the finance committee took. There is a gap in the data. By improving that, we can surely improve scrutiny of the Government, health boards, integration joint boards and others, and also help our policy making in the future.

Sandesh Gulhane: In medicine, things change rapidly. Things that I was taught at medical school are no longer the case, and we all need to keep up to date. Would the bill prevent any future advances in medicine from being given to patients who present to health professionals?

Douglas Ross: No, it would not prevent that. That is a good point, because we often worry about provisions in legislation being timed out and things moving on rapidly. There is provision in the bill for Scottish Government ministers to add treatments to a number of different sections of the bill as they wish. The code of practice, which would be discussed, debated and agreed in the Parliament, can also be refreshed.

It is important that there are opportunities for the Government to add to what is in the bill, because the situation in 2025 will not be the situation in a couple of years' time or at the end of the next parliamentary session. Things will have moved on, both medically and, I hope, in the communities where there are drug and alcohol deaths. If the bill is passed, I would hope to see the number of deaths reduce, though the problem will sadly not be eliminated. There will be further challenges that the Parliament and the next Government will have to grapple with.

Sandesh Gulhane: I want to go back to the point about face-to-face appointments. Previous witnesses have talked about the difficulty of getting such appointments. What are the bill's requirements regarding the need for a patient to be seen face to face?

Douglas Ross: I think that that relates to section 2(1) of the bill. As I said to Ms Harper, I would be happy to amend that. Yes—it is section 2(1)(d), which states:

> "the treatment determination is made following a meeting in person between the relevant health professional and the patient".

In relation to being able to get an appointment, the uplift in the drug and alcohol budget would be to increase training, so that, hopefully, the number of medical professionals that are available to consider such cases would increase, meaning that there would be more availability. That would also ensure that there is full consideration and—to go back to Mr Harvie's point—that the patient feels that they are involved and that there is engagement with the medical professionals who are taking an important decision for that individual's future.

Sandesh Gulhane: My final question is about the wider multidisciplinary team that is always involved with anything that we do in medicine.

We have a situation in which an award-winning preventative drug service in Glasgow has been stopped due to a lack of funding. What are your thoughts on how the bill would interact with a multidisciplinary team that includes people whose work is to prevent drug and alcohol users needing to progress to treatment?

Douglas Ross: That is a very good point. It will be an extremely important issue locally. I go back to the point that I made earlier: the national mission has committed £160 million for drug and alcohol services, and the bill seeks to substantially increase that through an uplift of between 17.5 and 24 per cent. However, the funding from the national mission will continue only until the end of this parliamentary session. We cannot tie the hands of future Parliaments and Governments, but, by enshrining this in law, we are giving the strongest possible signal that it needs to be prioritised going forward.

I accept that the current Government has made strides in increasing the funding for this area. It accepts, as we all do, that we have not made as much progress as any of us wanted or hoped to see. Therefore, the funding increase is crucial, but it must be in place going forward, too, so that fewer—or perhaps none—of those facilities will have to close in the future. There is adequate funding, and funding is included in the bill. In my letter to the Finance and Public Administration Committee, I suggested where I would find that money. Between the Government and the 10 members sitting around this table, we could have 10 different solutions for where that money could come from, but it is vital that we see that uplift in those services.

Sandesh Gulhane: I have a final question. Are you clear that the bill would reduce the number of people dying?

Douglas Ross: Yes, but let me be clear: it is not a silver bullet. It must work in tandem with a number of other initiatives that the Government is operating and exploring and those that it will look at in the future. However, I think that giving people this right would ensure that people like Liam would not die while on a waiting list. Where it is deemed by a medical professional to be appropriate for

people to seek the help and support that is right for them, they should not be left on waiting lists, struggling to get the support and recovery that they want and need.

To go back to Mr FitzPatrick's point on residential rehab, I should probably have used this quote from FAVOR UK, which I cited to the Finance and Public Administration Committee, too:

"quality residential treatment can help improve mental and physical health, reduce offending, improve employability and enhance social functioning."

That is the real difference that rehab facilities can make for people. That is why there is a demand for them and why people who are seeking that help and support—and their families—are so frustrated when they are left on waiting lists for weeks, months and, in some cases, years.

Convener, if I can, I would like to make a final point, which came up more in the finance committee than in this committee. The Dame Carol Black report—which, I accept, is about NHS England—suggests that for every £1 that we, as a society, spend on drug and alcohol recovery services, we can save £4 in other services. It is money that can very much save lives and help our services going forward.

Sandesh Gulhane: Thank you.

Joe FitzPatrick: I have a couple of other questions in this area. The drugs landscape in Scotland is changing rapidly, particularly in relation to polydrug use and new substances. Is the bill suitably drafted to respond to those emerging challenges?

Douglas Ross: I believe that it is. I go back to the point that I made to Dr Gulhane: there are opportunities for the Government to amend the bill going forward and to increase the options that are available. Mr FitzPatrick, you will know that the issues that you dealt with a number of years ago, as the minister responsible for drugs, are different to those that the cabinet secretary who has that responsibility in their portfolio has to deal with now. It is an evolving issue. What is not changing is the large number of people who are dying every year from drug and alcohol misuse—that is why I feel so passionate about bringing the bill forward. However, that does not mean that there is no capacity for the bill to change in a few years' time, when there are changes in the drugs that people are using, how they are using them and so on.

Joe FitzPatrick: The bill talks about a three-week deadline for commencing treatment. I want to tease that out a bit. Sometimes, quite complex preparatory work is required, including psychological interventions and stabilisation, before folk can move on, particularly if they have chosen an abstinence-based treatment pathway. That can take much more than three weeks. How would we manage to square that?

Douglas Ross: The period of three weeks starts from the treatment being agreed with the medical professional—from the point at which the medical professional says, "This is the treatment you should get." Therefore, the medical professional would include that consideration in their determination. However, as I have repeated a number of times, people are being told by medical professionals and others that they are suitable for residential rehab—I am sorry to go back to that example—

Joe FitzPatrick: No, that is fine.

Douglas Ross: —but they are not getting a place, because the beds are not available and there is no capacity. Where the determination has been made that someone should get a particular treatment, they should not have to wait. I do not believe that they should have to wait even three weeks; they should be able to get treatment as soon as possible, but that is all part of the medical professional's determination of what treatment is right for that person.

10:15

Joe FitzPatrick: Let me clarify that. You are saying that, if the determination is that that pathway is suitable for someone, irrespective of everything else, they should get that treatment within three weeks and be in a rehab facility.

Douglas Ross: The medical professional will know what work has to be done by the patient, the third sector and others to get somebody ready. However, if, having gone through the process of meeting with the individual, remotely or in person, the medical professional is saying that the individual is ready for residential rehab, that person should get that treatment within three weeks. That is why it is part of the medical assessment.

Joe FitzPatrick: I am sorry, but I want to clarify that further. Someone for whom that is an agreed pathway should not expect to immediately—in three weeks' time—be in a rehab facility, because all that other process would need to happen.

Douglas Ross: Yes. The course of treatment should start within three weeks. Currently, if the course of treatment is X, there will be other work that needs to be done in advance of that. However, once the determination is made that the right approach is a particular treatment option listed in section 1(5) of the bill, that treatment will have to start within three weeks.

Joe FitzPatrick: That is helpful, because I think that some people would have assumed that they had a right to be in treatment within three weeks,

because, in their minds, they were ready for it. Thanks for that clarification.

Douglas Ross: The clarification includes the fact that three weeks is the ceiling. Some people will be ready and available to receive the treatment that is right for them on the same day, and that should be available, too.

Emma Harper: I know about the challenges of helping to support people to reduce harm from alcohol and drugs. It is really complicated. We speak about polydrug use, and there are issues with benzodiazepines being delivered to people's doors by taxi companies and people buying stuff off the internet when they do not even know the dosage of things such as blue benzos, as they are known. I am also thinking about the medication assisted treatment standards that have been implemented. There is the roll-out of heroin reversal agents such as naloxone, and research is being done on a reversal agent for benzodiazepine called Romazicon. A lot of work is being done, so is the bill sufficiently future proofed in its drafting to account for the evolution of the way that people are taking drugs—including nitazines, for example?

Douglas Ross: I believe that it is, because we have included in the bill the ability for ministers to increase some of its provisions. Section 9(1) says that a "drug"

"includes any intoxicant other than alcohol".

What is meant by "alcohol" is clear, but, because "drug" means "any intoxicant", if a new drug comes on the market that is deemed to be an intoxicant, it will be covered by section 9(1).

You also mention the MAT standards, which are important. Last week, we heard a lot from the cabinet secretary and witnesses about the standards. Again, the bill seeks in no way to replace the MAT standards but to work alongside them. The committee will be aware of this, but it is important that others understand that the MAT standards have no statutory underpinning. The bill would make statutory provision. That is the difference; the bill provides a legal framework. People have an ambition to deliver the MAT standards, but the standards have no statutory underpinning.

Emma Harper: The bill would not affect a single mum with two kids who cannot go to residential rehab but who is worried that her children will be removed from her. How would the bill support somebody in those circumstances?

Douglas Ross: It might be that residential rehab is not right for her or it might be that that is the best approach. In which case, efforts can be made with partners to look after her children while she is away, and then, when she comes out of residential rehab, the family can get back together again. However, it might be that other treatment options listed in the bill are right for her or that some of the other treatment options that are not listed but are available under that catch-all provision could also support her. The current support for a mum with two kids will be maintained and will continue to be delivered.

One of the other examples that I was going to use in my opening remarks was about a young woman who was pregnant. She was addicted to drugs and tried to get off them during her pregnancy. She was worried that her child would be taken away from her if she could not do so, so she wanted to get into rehab before she had her baby. She was not admitted to rehab, and, because of complications, she delivered prematurely. The baby was born with addiction issues and was removed from her, regardless. That individual has now totally disengaged from all the services. That is an example of a tragic case of someone trying to get help to turn her life around before she became a parent and it just not working for her.

Elena Whitham: When you were discussing residential rehab, a question came into my mind about the variety of provision across the country. A directory has been created that gives to people who are seeking residential rehab a little bit of information about what a particular rehab service provides. Have you thought about whether people's decision making also pertains to choosing to go to X rehab? There are rehabs that are faith based, rehabs that require abstinence before you attend, and rehabs that you can go to while you are still using and that will stabilise you in the facility. Rehab is not the same across the board, and I wonder whether you have given any thought to that.

Douglas Ross: I gave that quite a lot of thought. I am trying not to be overly prescriptive and I do not want to say too much in the bill. There are elements of that that could be included in the code of practice. It is important that people who are entitled to residential rehab, in the view of the medical professional, get it in some form.

Drafting the bill is difficult, because we have not achieved even the Scottish Government's target for additional beds—it is due by March 2026. We do not know where all the beds will be. Some will be with independent providers and some will be available through the health service. It was a decision not to include any specific choice. It is not like people will get their top three options, but I absolutely agree that services are very varied in what they offer and how they offer it.

That would go back into the discussion that the individual would have with the medical professional. The medical professional would

determine a course of treatment that people could follow to hopefully overcome their drug and alcohol addiction issues, not a specific destination that that person should go to. I would be happy to look at that, but I worry that it would add complexities that would make it more difficult to deliver the bill. We could certainly tease that out during future stages, because it deserves wider consideration.

Elena Whitham: At the moment, the reality is that ADPs commission rehab facilities to send their service users to, and that facility might not be local to where the person resides. There are a lot of competing issues for individuals, and I wondered whether people would have the right to make a specific choice. I take your point, though, that people could not have their top three or whatever.

Douglas Ross: It is a very difficult issue to balance. However, the treatment is the top priority. People would be told which treatment they were entitled to—hopefully, it would be the treatment that they were keen on—and then we would look at the options that were available to them. There would be more options should the bill pass, because we would have a significant uplift in the budget to deliver more facilities across the country. As you said, some ADPs provide out-of-area treatment, because a lot of communities do not have a local facility. Across the Highlands and Islands, we have very few facilities compared to the central belt and, particularly, the west of Scotland, where there are more facilities available.

Patrick Harvie: I joined the committee recently, so I am playing catch-up, but I think that Mr Ross's comments about the bill's definition of a drug as "any intoxicant" have clarified what I want to ask about. I was a bit confused when Mr Ross mentioned nicotine. My understanding is that the legal status of a drug would not have any bearing on the application of the bill. Does the bill cover nicotine addiction or addiction to legally available painkillers? Would it automatically cover a drug that was decriminalised in the future? Is the application of the bill disconnected from the legal status of a drug?

Douglas Ross: I mentioned nicotine because it came up in earlier evidence sessions. Mr Whittle discussed the idea that some people could be addicted to nicotine and some people could be addicted to chocolate. The definition in the bill relates to substances that intoxicate people and to which they become addicted. Someone can become addicted to prescribed drugs, so that would be covered under the bill.

Ms Fraser, do you want to add anything?

Alison Fraser: The definition comes from road traffic legislation. The idea is that someone is intoxicated or out of control, and that does not cover nicotine or caffeine.

Patrick Harvie: I see.

Alison Fraser: Under road traffic legislation, someone could be breathalysed for alcohol or drug use, but they would not be breathalysed to establish whether they had had too many coffees that morning.

Patrick Harvie: I can see why it is relevant to road traffic law, because you need to be in control of a vehicle. Could Mr Ross explain why intoxication is relevant to addiction recovery, whereas addiction to a legal or illegal drug that does not intoxicate would not be treated in the same way?

Douglas Ross: As Ms Fraser said, we chose that definition because it comes from section 11 of the Road Traffic Act 1988. Neither nicotine nor caffeine would cause a person to lose control, which is the issue here.

Patrick Harvie: Why is that relevant to the question of treatment for recovery from addiction?

Douglas Ross: I am not sure that there is particular demand from people to use the list of services in section 1(5) of the bill if they are addicted to caffeine or nicotine. There are other ways that they can overcome that addiction. I am not trying to minimise it in any way—I have never been a smoker, but I know how challenging it can be for people to overcome that addiction. However, they do not lose control. We based the determination of addiction and the substances that people can be addicted to on the element of control. The statistics that we are all concerned about are the number of drug and alcohol addictions that lead to people dying, which is where we see the biggest need.

Patrick Harvie: Nicotine can lead to people dying.

Douglas Ross: It can, through the act of smoking. The Minister for Public Health and Women's Health is in the opposite committee room at the moment, but I know that the Government is looking at other measures to tackle addiction to nicotine and, indeed, new substances that we thought only a few years ago would help people to overcome their addiction. The bill focuses on drugs and alcohol, and the definition is based on the definition in the Road Traffic Act 1988.

Patrick Harvie: Thank you for the clarity. I am still a little unclear about the rationale for saying that intoxication, as such, determines the right to access the treatment considered under the terms of the bill. New substances are coming on to the market all the time, and a drug could come along that is lethal and highly addictive but that does not

cause intoxication leading to a loss of control. I do not want to overstate the issue, as it may have been considered already during a previous evidence session, but it is a little unclear to me why intoxication—which is clearly a relevant safety issue in road traffic offences—is relevant to people's access to addiction recovery services.

Douglas Ross: It goes back to what people are seeking from recovery services and what they are not receiving from them. The largest proportion of the cases that I hear about involve people who have addiction issues with drugs and alcohol, so that is the bill's priority. That does not mean that we cannot look at Mr Harvie's point. Perhaps the Government or other members could consider introducing a bill that looks specifically at those issues.

Patrick Harvie: That would require further primary legislation.

Douglas Ross: Yes.

Patrick Harvie: Okay. Thank you.

10:30

Sandesh Gulhane: There seems to be a bit of inconsistency. Lots of people say that the current system is not working but that we should not interfere with the current system. Do you agree that there is that logical inconsistency?

Douglas Ross: I do. As I said in my opening statement, I have listened intently to all the evidence that you have received so far. I was encouraged to hear that, in the written evidence that the committee received, a majority of the submissions were in favour of the bill. We have heard a lot of people raising questions not about the general principles of the bill but about some of the bill's specifics, which I hope can be addressed through amendments—if we get to that stage. The majority of people who responded to your committee's call for evidence were in favour of the Right to Addiction Recovery (Scotland) Bill, and the response to my consultation was 70 per cent in favour of the bill.

With regard to your question on the inconsistencies, we have also heard a lot of positives. The cabinet secretary said that the Government supports "the intention" of the bill, and many others said the same.

However, Dr Sue Galea-Singer said that she does not believe that what the bill stipulates is required, because it is already being done. In response to Brian Whittle, who had suggested that the provisions of the bill are not already happening across Scotland, she said that she did not accept that. However, in the same evidence session, she said:

"the system is not working."—[*Official Report, Health, Social Care and Sport Committee,* 25 March 2025; c 25.]

I found that evidence session to have elements both of believing that the current system is working and of accepting on the record that the current system is not working. That is why I hope that, in making your determination, you will look at the raw figures, which tell us all that we are not doing enough. Some elements of current policy are working very well and suit the needs of some people, but a record number of people are still dying from drug and alcohol misuse, which shows that we are not dealing with the biggest issues.

I agree that some people have said that the bill is not required because things are working when it is very clear that they are not.

Sandesh Gulhane: I do not want to steal from the next theme, which is about cost, but I will go back to an answer that you gave me previously about not wanting to tie a future Parliament's hands. Do you think that the proposed budget uplift might create more money throughout drug and alcohol treatment from now on?

Douglas Ross: Yes, there is a very strong indication of that. I welcome the fact that the Government has remained neutral on the bill. It has not said that, because of the assumptions in the financial memorandum, the bill is simply unaffordable. It has waited to see your consideration and it has considered the Finance and Public Administration Committee's report, so it still has open eyes and ears about what the bill seeks to do and the costs of that.

It was important to get the bill to stage 1 to allow further consideration and tease out the details that all the members of this committee have raised. Some of those details have been in support of the bill, some have challenged it and some are about things that will have to fundamentally change. If we were to shut off the debate now, that would send a worrying and alarming signal—to people who seek to use these services today and in the future and, indeed, to wider society—that we have reached the peak of our ambitions to tackle drug and alcohol misuse in Scotland.

Carol Mochan (South Scotland) (Lab): You have possibly touched on some of the things that I was going to say about the workforce and the importance of supporting the workforce. We have heard some concerns that workforce constraints could limit the bill's implementation. Do you have any thoughts on that? Does anything additional need to happen so that the workforce can ensure that the bill's provisions are realised?

Douglas Ross: There is no doubt that there are considerable challenges within the NHS workforce. With a couple of NHS staff members sitting around this table, you will hear that on a

regular basis. However, in the financial memorandum there is specific funding for additional training of medical professionals for what will be an additional workload—I am in no doubt about that, which is why the cost is included in the financial memorandum's considerations. That puts the onus on the Scottish Government to deliver that training through its partners. I know that the Convention of Scottish Local Authorities raised concerns about finance, but the COSLA representative also said that he was absolutely supportive of the bill's intentions.

Our taking the bill to the next stage and the Parliament's ultimately passing it would indicate to the various bodies and the workforce that we must focus on the issue in Scotland, which I hope would start to drive down the appalling figures of drug and alcohol deaths in the country.

Carol Mochan: Is some of the specific training that might be required available at the moment, or do additional things need to be put in place to make it happen for healthcare professionals?

Douglas Ross: Obviously, some training is available, because people are currently doing those assessments, but there would have to be further training to increase the cohort of people who are able to do them, because demand would increase. We know that many people seek help and support through the various treatment options and do not get it—they are already assessed as being appropriate for the treatments that are listed in the bill, but they are not getting them. One element of that is the capital costs and such like. Hopefully, others will be encouraged by the bill.

I am sorry, but I cannot remember who—it might have been Ms Wells—talked earlier about people in our most deprived communities becoming aware of what is in the bill and their legal right. I will see it as a success if we improve that awareness and if there is more demand on our hard-pressed health professionals because more people feel comfortable about coming forward to discuss the recovery journey that they want to take to overcome their addiction issues. I hope that that is backed up by adequate support in the financial memorandum.

Joe FitzPatrick: My questions cover costs and resources, but I think that you have covered most of that theme as we have gone through. We have talked about the Law Society in relation to the McCulloch case. In addition, the Law Society highlighted the potential risk of "significant litigation" arising from the bill. Might you take the opportunity to comment on that?

Douglas Ross: If people have a right to action in the courts and qualify for assistance, it is only right and proper that justice should be allowed to take its course. Enshrining that in law allows people to take it to the next level. I know that, in submissions or oral evidence, people were concerned about the costs of judicial review, and I accept that going to the lengths of a judicial review is extremely complex and financially burdensome, but other areas and avenues, such as legal aid support, would be available. As I have said, if people have the right to that assistance and qualify for it, they should be able to use it.

Joe FitzPatrick: The Law Society's specific concern—which it suggested was about an "unintended consequence"—was that, if someone did not get the treatment and something then happened, their surviving relatives or partner could sue. Your financial memorandum does not include that litigation cost, but it is obvious that it could be significant.

Douglas Ross: It is a potential consequence at the moment. If someone has been told that they are the right fit and their circumstances mean that residential rehab is the right approach for them but they are on a waiting list for months or years, do not get into residential rehab and then overdose—as in the example that I gave—or die through further complications, their family is, at the moment, entitled to take a civil action against a health board or other authority.

Joe FitzPatrick: So, you have not included any cost for that.

Douglas Ross: I hope that, by putting the issue in law and raising it in that way, we avoid, in the future, getting to the point where people are denied the treatment, as they currently are. A consequence of the bill would be the reduction of that risk, because people would get the treatment within a far more constrained period of time than is currently the case. That goes back to the capital increase that is mentioned in the letter to the Finance and Public Administration Committee. The Government is already doing a lot of work, and there would be the uplift in the budget. Currently, it is a risk, but I hope that the risk will be reduced if there is more availability.

Joe FitzPatrick: Can you remind me what the uplift in the budget would be?

Douglas Ross: It would be 17.5 per cent from the low end and 24 per cent from the high end—so, from £28.5 million to £38 million.

Joe FitzPatrick: Rather than bring forward this bill, why did you not lodge an amendment to the Budget (Scotland) (No 4) Bill last year to say that it should include that additional spend?

Douglas Ross: The additional spend on its own is important, but, to go back to the very first point that was made by Ms Whitham, we are dealing with a unique situation here. In the past, we have increased the budget for drug and alcohol

rehabilitation, and we have also reduced it, and things are getting marginally better, if at all. Therefore, it is not just about budgeting but about the legal framework, this right being enshrined in law, and reporting. None of those things would be improved or enhanced by adding to the budget alone. In the round, the bill provides a number of mechanisms to deal with this unique problem that we have not looked at so far, and it could make a big difference.

The Convener: You have mentioned several times that the bill must include a budget uplift but that you cannot tie the hands of future Governments. I am not sure how those things marry. Will you explain that?

Douglas Ross: Once the budget uplift is enshrined in law, the Government will accept it going forward. To go back to Mr Harvie's point, the Government would have to introduce primary legislation to take away the right.

The bill would send a very strong signal and indication that this is an area that we should be focusing on. Although it is not a small amount of money, it is not an unachievable budget uplift for an area that every party leader, politician and representative in the Parliament agrees needs to be tackled. We are talking about spending an extra £38 million in Scotland to deal with an issue that is uniquely bad in Scotland. That is not to say that people do not die in other parts of the UK or across the world from drug and alcohol misuse, but more of them die here every year. There are historical reasons for that, as well as reasons related to developing drugs, which Ms Harper discussed, but it is our national shame. If we cannot deal with it through this bill and with an increased budget, I am not sure that we will ever truly tackle the issue and get those numbers down, preventing people from losing their lives and their families from being left distraught over the loss of a loved one.

The Convener: We have explored a lot of the issues around that. I am putting them all aside and looking purely at the finances here. Would putting that uplift into the Scottish Government's budget outwith a budget bill not be tying the hands of the Government, given that it would create a legal commitment to have that increase in drug and alcohol budgets going forward regardless of the party that is in Government and the budget that it has?

Douglas Ross: What I am saying is that the bill does not tie the hands of future Governments, because, if it is passed, the Government can pass legislation to remove it from the statute. Sorry—I probably did not explain that well.

The Convener: So, if this legislation is passed, would it then need to be repealed before a budget paper was passed for that budget line to be taken out of the budget?

Douglas Ross: Yes. That is why it also enhances the provision of the national mission—again, something that we all support. The £160 million funding will continue only until the end of this parliamentary session. If the bill is passed, it will send a very strong signal that the funding should continue beyond that—but another Government could repeal the bill.

The Convener: That is the clarification that I was after.

Douglas Ross: "Repeal" is the word that I was looking for during the past 10 minutes—apologies that I did not find it as quickly as you did, convener.

The Convener: That is all right. It is not easy sitting in that chair.

Douglas Ross: It certainly is not.

Elena Whitham: You have clearly stated that you do not think that there is a hierarchy of the services that somebody should be able to go for, so your bill encompasses all the different options that are available to individuals. I have listened to you speak about a budget uplift of up to 24.5 per cent, which is significant in this area. I would always argue that we need more money in this area. However, having previously signed off on allocations towards the creation of new residential rehabilitation provision, I know that just one facility costs tens of millions of pounds.

How would we not see a reduction in the money that goes to other areas where we need all the provision that is available to people—namely, harm reduction, the community rehabilitation model that we have in community facilities, psychosocial support and substitute prescribing? Knowing the cost of residential rehab, stabilisation services and crisis services—all of which we do not have enough of—I wonder how we can square that with ensuring that all options are available for individuals.

Douglas Ross: The capital cost of the increased residential rehab provision will already be covered by the Government in the national mission. In drafting the bill, I have taken the Scottish Government's ambition to increase the number of residential rehab beds as being delivered. Therefore, the uplift in the drug and alcohol budget that would be required under the bill does not need to account for that increase in beds, because that is already in process and is happening up to March 2026. I agree that the costs of that provision are significant, but the Government has already committed to meeting them. Therefore, the bill looks at spending over and above that.

That is why one of the submissions to the Finance and Public Administration Committee said that I had understated the capital costs. I had not understated them; the costs are already being met through the Scottish Government's ambitions to increase the availability of those beds in residential rehab. We did not need to double count the cost of that provision in the financial memorandum for the bill.

The Convener: So, an increase in the use of those beds—or, rather, in the availability of those beds—

Douglas Ross: The capital cost of increasing the availability of residential beds is covered by the Scottish Government's target to increase that availability by March 2026. The cost of running those beds and such like is then included in the bill. The difficulty in trying to find a figure for that is due to the length of time for which someone can stay in residential rehab. Some people stay for a matter of days and weeks—the longest time someone spent there was 156 weeks—so it is very difficult to pin down a precise cost. Going back to Ms Whitham's point, the capital element has not been understated but is in a different element of the budget. Therefore, it was not required in the financial memorandum for the bill.

The Convener: Mr Ross, I thank you and the officials for attending. I will briefly suspend the meeting to allow for a changeover of witnesses.

10:46

Meeting suspended.

10:52

On resuming—

Employment Rights Bill (UK Parliament Legislation)

The Convener: Our next agenda item is further oral evidence on a supplementary legislative consent memorandum on the Employment Rights Bill. At last week's meeting, we took evidence on the supplementary LCM from a panel of stakeholders. This morning, we will continue our scrutiny by taking evidence from the Minister for Social Care, Mental Wellbeing and Sport and supporting officials. I welcome to the committee the minister, Maree Todd. The minister is joined by Stephen Garland, unit head, fair work division; Lucy McMichael, head of branch, social care legal services unit; and Martin Reid, unit head, adult social care workforce and fair work, all from the Scottish Government.

We move straight to questions.

David Torrance: Good morning, everyone. Minister, will you outline the work of the fair work in social care group in recent months?

The Minister for Social Care, Mental Wellbeing and Sport (Maree Todd): There is a great deal of on-going work on fair work in the social care sector. We have overseen a significant increase in investment in social care, and specific workstreams of activity are well under way to progress actions to improve fair work in the adult social care sector. The workstreams are being taken forward in partnership with key stakeholders through the fair work in social care group.

Workstream 1 has enabled a minimum rate of pay of at least the real living wage for workers who are delivering direct care and commissioned social care services, as well as enabling annual uplifts to be delivered quickly into workers' salaries.

Workstream 2 has developed a framework of proposed minimum terms and conditions, reflecting fair work principles and initial priority areas to be progressed. Due to budget constraints, we are currently unable to implement those proposed minimum standards.

Workstream 3 has developed an effective voice framework. The first phase of that delivery programme has been rolled out through a volunteer cohort of organisations from across the sector in Scotland. That will undergo a comprehensive evaluation before progressing to national deployment.

Through workstream 4, progress has been made on voluntary sectoral bargaining with key stakeholders. That work is complex, as there are

more than 1,000 employers in the social care sector. Once developed and introduced, it will help to underpin improvements in pay and terms and conditions across the social care workforce.

David Torrance: Are staff representatives, small care homes or care-at-home providers represented on the group? Can you expand on who sits on the group?

Maree Todd: The group has quite broad representation. Martin Reid might want to talk a little more about it.

Martin Reid (Scottish Government): Care providers are represented principally through the Coalition of Care and Support Providers in Scotland and Scottish Care. Trade unions are represented through Unite the Union, Unison and the GMB. The Scottish Government, the regulators and the Convention of Scottish Local Authorities are also at the table.

Those organisations make up the core membership. We can bring in additional expertise, which we have done during the past 18 months or so to support sectoral bargaining in particular. The trade unions lobbied hard for someone with academic expertise to join the group. We listened to that and acted directly on their specific recommendation about an expert they had identified. Their involvement has made a significant difference to the progress of our sectoral bargaining work.

Maree Todd: To expand on that, the CCPS tends to represent not-for-profit providers and Scottish Care tends to represent private providers of varying sizes. Both organisations represent very large and very small organisations. It is complex to set up a sectoral bargaining organisation, especially as so many different parties are involved, including a large number of employers, COSLA, the Scottish Government and a variety of trade unions. The academic input has been crucial to unlocking the challenges that we face. We feel as though we are motoring and that we are pretty close to reaching an agreement; we just need to dot the i's and cross the t's on the sectoral bargaining proposal.

David Torrance: Can you describe in detail the tripartite arrangements that have been agreed to and that, according to stakeholders, are ready to be implemented?

Maree Todd: They are not quite ready to be implemented. We are still trying to achieve consensus, but the evidence that the committee has taken has been absolutely correct: we have made massive progress and we are significantly ahead of other UK nations, because we have been working for many years on the voluntary sectoral bargaining tool.

I will let Martin Reid say more about the detail.

Martin Reid: I probably do not need to add too much. As the minister said, we are close to finalising our draft constitution. We need to work with our legal colleagues to ensure that it is robust, but that conversation is on-going to ensure that we are on the right side of the line for a voluntary arrangement in Scotland.

The stakeholder engagement has been interesting. Whenever there is delay, people tend to think, "Oh, it's the Scottish Government's fault," but, at times, both trade unions and provider organisations have needed a significant amount of time to go back to their members to discuss things, as they are at the table in a representative capacity. We are also conscious that, although Scottish Care and the CCPS represent a significant number of organisations, they do not cover the totality of the sector. Sometimes, it is also necessary to talk to others. There have been periods when there has been what probably looks like a small hiatus in the progress that we have been making, but that has mostly been when trade unions have been talking to their members about where we are.

11:00

The issue of effective voice is a particular challenge for the trade unions, because they see themselves as the voice of the workers, but the effective voice work goes a bit wider than that. We are looking to management structures to ensure that organisations that are not unionised can also have a voice at the table, so that we do not limit ourselves. There has been quite a lot of in-depth conversation with the unions about how we strike the right balance.

It is fair to say that we encourage union membership, and the minister has been very active in having conversations with providers to say that the Scottish Government encourages union membership. Having a unionised workforce certainly makes it easier for us when we engage with the sector. Historically, the unionised workforce has been just below 20 per cent. I think that the level of union membership in the sector is a wee bit better now, but that gives an idea of the level that it is at. The percentage is not particularly high, so we are conscious that, when we talk to the unions, we need to have an awareness of other mechanisms, and the effective voice framework is the other mechanism that we are looking to use to ensure that we hear what workers are saying.

To draw a distinction between Scottish Care and the CCPS, Scottish Care already has a negotiating mandate for its member organisations, because it negotiates under the national care home contract,

whereas the CCPS does not. Constitutionally, those organisations are in a different place. The CCPS needs to ensure that it has got itself sorted out to be able to come to the negotiating table to undertake sectoral bargaining and legitimately represent its members at the table, and it is undertaking on-going work on that.

Maree Todd: I will add a little more detail. One thing to be aware of about unionisation levels across the sector—which we are keen to increase, because we see that as a means of improving the pay and terms and conditions for the workforce—is that, as well as being relatively low, with around 20 per cent of the workforce unionised, union membership is concentrated in local government employees. Do not misunderstand me: we are keen to listen to and work with unions, but a large part of the workforce is not represented by the unions, so we need to ensure that we capture the voice of that workforce.

Another thing that has disrupted progress, in a good way, during the past few months is the issue that I am here to talk about today—the Employment Rights Bill, which we have had to take time to examine. We have been working on that through a voluntary arrangement in Scotland. The Employment Rights Bill is going through the UK Parliament because what it covers is largely reserved. We have had to take time to take stock and have a look at that proposal, which we broadly welcome, which is why I am here today.

Emma Harper: Good morning. We heard last week from the CCPS and Scottish Care that the terms “collective bargaining” and “sectoral bargaining” are both used. Both involve negotiations between workers and employees, but they differ. Can you put on the record the difference between collective bargaining and sectoral bargaining?

Maree Todd: Do you want to have a go at that, Martin?

Martin Reid: Yes, I am happy to do that.

Maree Todd: My very first conversation with the unions was on exactly that topic. The language used varies round the table, and one of the first things that needs to be done is define that in your sector.

Martin Reid: In simple terms, sectoral bargaining is what it says on the tin. It means that we look at the entirety of the sector. In this case, sectoral bargaining is being developed for commissioned services, which are not the services that are delivered by local authorities. When we talk about sectoral bargaining, we are talking specifically about commissioned services, and about the entirety of commissioned services across Scotland.

Collective bargaining is a much more localised arrangement. There could be collective bargaining between a management team and a single organisation. A single care home that is totally independent of other care homes could have a negotiation that takes into account whatever sectoral bargaining might say should be delivered—a rate of pay and certain terms and conditions, for example—but its local collective bargaining could, in theory, go beyond that. Nothing that we are doing on sectoral bargaining would prevent such localised arrangements from being used. Better pay and terms and conditions could be introduced locally—the two things do not prevent each other from operating in the same space.

Maree Todd: The reason for focusing on commissioned services is that there are already arrangements in place for local authority employment.

Martin Reid: Yes. There is a sectoral bargaining arrangement in place that covers local government staff in the totality and includes staff who deliver social care services and who are directly employed by local government.

Emma Harper: Thanks.

Sandesh Gulhane: I declare an interest as a practising NHS GP.

I want to go back to what Martin Reid just said. Is it possible that collective bargaining could be worse than the sectoral agreements?

Martin Reid: As we are discussing it now, sectoral bargaining has to be a voluntary arrangement. In order to deliver commissioned services as part of the deal, you would have to meet the minimum standards through the contracts—you could not drop below the sectoral bargaining standards to deliver commissioned services and access the contracts. The simple answer is no. Collective bargaining allows you to go further, if you wish.

Sandesh Gulhane: To go back to the FWISC group, is there any reason why minutes have not been produced?

Maree Todd: I did not know that minutes had not been produced.

Martin Reid: Minutes are produced. Sorry, I should make a distinction between different meetings. The fair work in social care group is the strategic representation of our four workstreams. Pay, terms and conditions, effective voice and sectoral bargaining are four distinct workstreams that drop out from the fair work in social care group. Representative members from the fair work in social care group meet to discuss those four workstreams. Those meetings are all minuted and

the details are available for anybody who wants to see them.

The fair work in social care group meets far less frequently. It was originally envisaged that it might meet two or three times a year. In reality, it has not met for quite some time, but that is because the focus has been on the workstreams. It has not been necessary to convene the group.

However, the minister engaged directly with Andy Kerr, who was the chair of the fair work in social care group when the Employment Rights Bill was published, to ask for the group's feedback. Andy engaged with the group in its totality to ask for feedback on the group's response to what was in the Employment Rights Bill, and he then wrote directly to the minister. The group is accessible, but it has not met in that format for some time.

Sandesh Gulhane: Thank you.

Minister, in relation to workstream 2, which is about minimum standards of terms and conditions, you spoke about cost and being able to afford things. In last week's evidence session, we heard that local authorities pay themselves almost three times as much to deliver care as they pay independent care homes. There has also been a significant hike in employer national insurance contributions. The evidence that we took said that a huge or significant uplift in pay would be totally unaffordable for the sector without significant money going in. Is the Scottish Government considering putting in significantly larger sums of money, or can you foresee there being a way to give people more money and still have a care home sector that works?

Maree Todd: Over the years, our track record in delivering at least the real living wage to people who are employed in social care has been strong. That has been possible to deliver because we have put in extra money. That policy of investing sufficient funding to ensure that everyone is paid at least the real living wage now costs between £900 million and £1 billion.

The workforce tells us that, if we were to bring in improvements on terms and conditions, its priorities would be maternity and paternity pay, as well as sickness pay. Yes—we would have to invest extra money to ensure that those changes were delivered into the system.

Sandesh Gulhane: My final question on terms and conditions is about whistleblowing, which is an issue throughout the health service. People who whistleblow lose their jobs and are ostracised. I absolutely accept that there is existing legislation, but that does not translate to the reality on the ground, given the number of people who have come to me to talk about the issue.

Although there is legislation on whistleblowing, are you looking at something in social care to ensure the safety of people who want to say that what is going on is unacceptable?

Maree Todd: Largely, people can raise issues with the Care Inspectorate, and there are protections in place, so those discussions are confidential. The identity of the person who raises concerns does not have to be in the public domain.

Martin Reid: The work on effective voice is intended to address those kinds of issues. It is intended not to take the place of legislation but to make its provisions more accessible and ensure that people know how to raise concerns. We would signpost people towards the effective voice framework for exactly those kinds of issues. That work is being piloted at the moment. As I said, it is intended not to take the place of existing mechanisms for people to do that but to make them more visible and accessible, so that people know where they can raise concerns.

In addition, through the fair work in social care group, we have less formal troubleshooting mechanisms. For example, if people have concerns that their pay uplift has not come through in sufficient time, the fair work in social care group can be alerted through a troubleshooting mechanism that we have introduced. Through the effective voice framework, we are looking at what else, in similar terms, we could do to introduce a mechanism that feels like a safe space for people to raise concerns.

Maree Todd: That troubleshooting mechanism was introduced because there were significant delays between our putting the money into the system for the uplift to the real living wage and people actually receiving the real living wage. That mechanism appears to have largely sorted the issue.

Elena Whitham: Last week, the witnesses expressed a sense of urgency about devising a sectoral negotiating body, but their perspectives slightly differed. A union representative was quite relaxed about and supportive of the LCM and stated that it would not threaten the progress that the fair work in social care group has made. Other witnesses felt that the bill had already created a delay and that refocusing on it would further delay implementation in a sector that urgently needs a means to ensure parity across the sector. Given that there does not appear to be total agreement on the way forward for sectoral bargaining in social care, will the Government consider further consultation on the issue?

Maree Todd: I do not think that we are planning further consultation, but, once the legislation is passed in the UK Parliament, we definitely need to

pause and reflect on whether we will pursue the process with statutory underpinning or continue with our voluntary process as envisaged.

The fair work in social care approach was specifically brought in for Scotland, and, when we consulted the fair work group, it clearly liked the work that has been done so far. We will need to pause and reflect. I do not think that we need to consult too much more, and we have the mechanisms in place to ensure that we hear from the sector.

The UK Employment Rights Bill, as it is amended at the moment, includes provisions to establish a social care negotiating body, but we do not have to do that. We can choose not to implement that part of the legislation in Scotland, but we might find that it is more effective.

Elena Whitham: Does the minister recognise the concern among some of last week's panel members about what they perceive to be delays in implementing what has been agreed?

11:15

Maree Todd: Yes. As we have illustrated with our answers, things are not quite agreed, although we are very close to agreement. I absolutely understand the frustration of people working in the sector that their terms, conditions and pay are not improving fast enough. That is the concern that was outlined to the committee last week. I agree—I would like to go further and faster. A number of limits are in place. We have just about managed to work out a mechanism that can help us to navigate what is a complex landscape. The other challenge will be finding the money, but we are keen to do that. We are committed and we have a track record.

Emma Harper: On having a sectoral negotiating body, our briefing papers say that the bill is in the House of Lords at the moment, so it is reserved legislation. It would be better if employment law was devolved to Scotland completely, as that would give us more control over what we do with employment throughout Scotland. If the legislative consent motion is agreed to, what will be the next steps to establish a sector-wide negotiating body?

Maree Todd: You are absolutely correct that employment law is reserved. The bill is required to devolve some power to the Scottish ministers to make changes. We saw the bill coming on the horizon and recognised the opportunity to underpin much of the work that we have done on sectoral bargaining by seeking to extend the bill's scope to Scotland.

When the bill was introduced, it was intended to be for England only. Scotland and Wales in particular were pretty keen for its scope to be extended. That will give us the option to regulate for negotiated fair pay agreements for the sector as an alternative to the voluntary process, which we think will be useful.

On your point about the reserved nature of employment law, the Scottish Government, much of civic Scotland and trade unions are all keen for employment law to be devolved. Under the mechanism that is in the bill, there is an issue that, despite the area being devolved, UK ministers will still have to consent. It is fair to say that we would have preferred not to have that. At the moment, relations are very positive with the UK Government, but there have been times in the recent past when we have had very different views on how we should proceed. Having to ask the UK Government for permission to implement fair work is not my choice.

Emma Harper: It is good to hear that relationships are better at the moment. I am sure that that makes negotiations with our UK Government partners easier.

I have another question. If the Scottish Government were to proceed with establishing a national negotiating body, how would you ensure that the mistakes that were highlighted in the Strathesk Resolutions report on collective bargaining in the college sector were not repeated?

Martin Reid: I will be honest—I am not particularly familiar with that report, but I can say that we are working closely with UK Government colleagues on how we move forward with implementing the negotiating body. As the minister said, we have done quite a lot of work on developing a model that is based on voluntary participation in sectoral bargaining.

The UK Government is in a different position, as the bill is its first go at doing this. It is seeking to move quickly to a statutory route, which is not a mechanism that has been available to us, and it has been able to move quite rapidly to this stage. We are in regular consultation and conversation with the UK Government on the steps that need to be taken to set up the negotiating bodies—we are dealing with issues such as the membership, the voting rights and ensuring the participation of the sector and of people with lived experience, for example, so that their voices are heard around the table.

We are working jointly with the UK Government and Welsh colleagues to understand the structure of the negotiating body and what it would do. I absolutely agree with your point about lessons that need to be learned from other work that has been done. We have already told UK Government colleagues that we will feed in anything that we can in order to avoid any missteps and to ensure

that any learning that is picked up along the way can be shared. I am happy to take away the point that you made, look a wee bit further into the report and pass on our thoughts to UK Government colleagues.

We are at the early stages of the process. As ministers consider which option they want to move on with—whether it is a voluntary approach, a statutory approach or a transition from one to the other over a period—it will be important that we pick up any learning that we can along the way. I am happy to make the commitment to consider the issue.

Emma Harper: Minister, you talked about the low rate of union membership in the care sector. I know that there might be geographical challenges in that regard in rural areas such as your constituency and Dumfries and Galloway and the Borders in my region. How will you address the geographical challenges to increasing union membership in the various areas across Scotland? How will you support people to join a union in a context in which some providers are not very sympathetic to that?

Maree Todd: The issue of geography is always challenging. In the Highlands, we have always been quite keen on virtual options for meeting, because the distances involved are vast, but that has become much more of a factor since the pandemic, and now people can go online to gather together, work together and network virtually in a way that was not commonplace a few years ago. Therefore, issues of geography should not prevent union membership.

On the hostility towards unions, it is important that we remind people of the benefits of union membership. That includes reminding employers of the benefits that their organisations will realise if their workforce has union representation, an effective voice and better terms, conditions and pay.

We have worked really hard to work in partnership with the sector, despite the low unionisation level, which exists for all sorts of reasons. However, we are pretty keen on unionisation in the sector. I see union membership and increasing unionisation of the workforce as being strongly beneficial to the workers and to the sector as a whole.

Emma Harper: Some of the benefits could involve things such as access to skills development, competence enhancement and support for clinical advancement. I say that as a former clinical nurse educator who taught people across the care sector.

Maree Todd: Absolutely. Unions are brilliant at providing professional leadership. We have a professional workforce in social care in Scotland, which is a slightly different approach from that in the rest of the UK. The situation in the rest of the UK has led to some of the narrative over the past few weeks around immigration. Keir Starmer talked about the social care workforce being low skilled, which I absolutely rail against.

Our workforce in Scotland is professional. Staff are regulated by and registered with the Scottish Social Services Council and are either qualified or working towards qualifications. A great deal of support is available to maintain the level of skill and increase pathways to progress in our social care sector. The situation is significantly different in England, which has perhaps led to some of the misunderstanding over the past few weeks.

As I have said clearly in the chamber, the announcement on immigration is potentially catastrophic for particular geographies, including Scotland's rural areas, such as the ones that you and I represent. It is a result of a fundamental misunderstanding of the different approach to social care in Scotland.

Carol Mochan: You have answered quite a lot of the questions that I was going to ask, so I will have a wee look at the scope of the proposals and the funding. Can you clarify why the proposed negotiating body will exclude children's social care staff? Is there a particular reason for that?

Maree Todd: We have negotiated a change to that. The arrangements were introduced in that way for England, but we and Wales are both keen on including children's social care staff, and that will be the position in Scotland.

Carol Mochan: That is a helpful clarification—thank you.

On funding, have you done any cost analysis of sectoral bargaining and fair work arrangements? Could we look at anything on that?

Martin Reid: We have done broad costings around the areas of the terms and conditions that were prioritised by the fair work in social care group that the minister referred to, including maternity, paternity and sickness pay. It is hard to produce costings on sickness pay, as that is quite a variable area, so we have arrived at a range of estimated costs for delivery.

Equally, on pay, we know the approximate costs of increasing wages by, say, 10p an hour, so we have ballpark figures for that. For example, this year, the Scottish Government invested £125 million in increasing pay by 60p an hour—you can probably do the rough arithmetic from there to work out the costs. That work has given us indicative costs for introducing the policies.

Carol Mochan: Is that information publicly available?

Martin Reid: It is not something that we have made publicly available. I am trying to think of any reason why we could not do so.

Maree Todd: We can probably furnish you with some costs. I have spoken before about the on-going costs of the increase in employer national insurance contributions, which we think will cost social care in Scotland between £84 million and £100 million a year, every year, from now on. We are trying to regularly update people and help them to understand the situation, because some of the figures are enormous. We will gather some costings together and provide them to the committee.

Carol Mochan: On the options appraisal of the models that will apply after the UK bill comes into force, do you veer towards a voluntary model?

Maree Todd: The Scottish Government welcomes the introduction of the bill. I am positive about the part that we are discussing today in particular, which is a real step forward. We need to spend time working with the sector to bottom out whether people in Scotland would prefer the arrangement to be voluntary or to have a statutory underpinning. However, I am absolutely delighted that the legislative consent motion will give us both options—it does not mean that we will have to introduce one option over the other. We have done a great deal of work towards the voluntary arrangement—as I said, we are nearly there—and I do not want to lose the progress that we have made, but I absolutely want to have both options, and that is why I am recommending approval.

The Convener: I thank the minister and her officials for their attendance. I apologise for keeping you waiting as our previous session ran over slightly.

At next week's meeting, we will take oral evidence on pandemic preparedness from stakeholders including the chief medical officer for Scotland. Following that, we will undertake our periodic scrutiny of the work of the Mental Welfare Commission for Scotland.

That concludes the public part of our meeting.

11:30

Meeting continued in private until 12:14.

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