OFFICIAL REPORT
AITHISG OIFIGEIL

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

Thursday 2 November 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 2 November 2023

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CONVENER

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

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Alex Cole-Hamilton (Edinburgh Western) (LD)
Michael Crook (Scottish Government)
Orlando Heijmer-Mason (Scottish Government)
Susanne Millar (Glasgow City Health and Social Care Partnership)
Elena Whitham (Minister for Drugs and Alcohol Policy)

CLERK TO THE COMMITTEE

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

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

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

Thursday 2 November 2023

[The Convener opened the meeting at 13:01]

Decision on Taking Business in Private

The Convener (Clare Haughey): Welcome to the third joint meeting in 2023 of members of the Criminal Justice, the Health, Social Care and Sport, and the Social Justice and Social Security Committees to consider the progress made in implementing the recommendations of the Scottish Drug Deaths Taskforce. We have apologies from Gillian Mackay, and Paul O'Kane will be arriving a little late due to another commitment.

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

Members *indicated agreement.*

Drug Deaths and Drug Harm

13:01

The Convener: Our next item of business is an evidence session on tackling drug deaths and drug harm. I am pleased to welcome our witnesses. Elena Whitham is the Minister for Drugs and Alcohol Policy; Orlando Heijmer-Mason is head of the Scottish Government's drugs policy division; Michael Crook is drug policy team leader in the Scottish Government's harm reduction team; and Susanne Millar is chief officer of Glasgow city health and social care partnership.

I refer members to papers 1 and 2, and I thank the witnesses for their written submissions. I invite the minister to make some brief opening remarks, for no more than three minutes.

Elena Whitham (Minister for Drugs and Alcohol Policy): Thank you, convener. I thank all three committees for coming together to focus on this issue, which cuts across all your portfolios.

We are now at the midpoint of the national mission and we have seen significant progress in many areas. There has been a huge increase in naloxone distribution, improvement in our surveillance and early warning systems, progress on the implementation of medication assisted treatment standards and an increase in residential rehabilitation referrals and capacity.

As a Government, we have taken a truly whole-systems approach to tackling drug deaths and the underlying drivers. Our response to the Scottish Drug Deaths Taskforce set out bold actions, including in mental health and oral health, community pharmacies and developing a concessionary travel pilot. We recently published our second annual report, which I hope members have had a chance to read to see the depth and range of work that is being delivered.

That progress is not just due to our increased investment. It is very much due to a huge, concerted effort by people and organisations right across the country, and my respect and thanks go out to them. This truly is a national mission.

In 2022, we saw the first annual reduction in drug deaths since 2017. Although I welcome that record fall, I reaffirm my commitment to continuing the national mission and recognise that we still have a lot of work to do. I will never underestimate the scale of the challenge that we continue to face, which includes responding to new threats such as synthetic opioids and the ever-increasing use of stimulants. We will continue to implement evidence-based policies to reduce deaths and to improve the lives of people affected by substance use, and we are continuing with our commitment

to put people with lived and living experience at the heart of everything that we do.

We recently had a debate in the chamber that was focused on drug law reform. That debate highlighted the limitations and the barriers that we still face. A key facet of drug law reform is the ability for Scotland to implement actions that we know will save lives. One example is safer drug consumption facilities, and I again welcome the position from the Lord Advocate and the confirmation from the United Kingdom Government that it will not seek to block or prevent the proposals in Glasgow.

Safer drug consumption facilities are important, but they are only one small part of a much wider picture when it comes to supporting people wherever they are. I look forward to the opportunity to provide wider updates through this evidence session.

The Convener: Thank you very much, minister. We move straight to questions, and the first question comes from Audrey Nicoll.

Audrey Nicoll (Aberdeen South and North Kincardine) (SNP): Thank you for that update, minister. The previous meeting, which, unfortunately, you were unable to attend, was a very positive one. Given the timing of that meeting, the focus was very much on the recent announcements on the safe consumption room pilot facility in Glasgow. We very much welcomed that, as did the members of our panel. As an Aberdeen MSP, I am interested in the proposals to extend the provisions that are being developed in Glasgow to drug-checking facilities. Could you provide some details on the expected timescales for that? What exactly would a drug-checking facility look like?

Elena Whitham: Thank you very much for your question. I echo your recognition of the work that this joint committee does. I think that joint committees are invaluable, and that we should be doing more where we can.

On drug checking, a two-year study was funded by the Drug Deaths Taskforce to look at what Scotland's drug-checking facilities look like and what we need. One of the things that the study told us was that we need them to be situated in some of our bigger cities. Aberdeen city is obviously one such area. The study also told us that, on top of Dundee, Glasgow and Aberdeen, there is a need for a national hub. Hopefully, that will be sited within the University of Dundee. We recognise that, although we need to have the drug-checking facilities in communities within easy access of individuals, we also need to have a national facility that will allow for robust checking of the results that are found at local level. Perhaps, at one point, we will be able to move to the model that exists in Wales—the Welsh Emerging Drugs and Identification of Novel Substances, or WEDINOS, service—through which people can post in drugs to be checked.

When it comes to timescales, we have had some clarification from the Home Office regarding some of the information that will need to be supplied and submitted by local authorities with their applications. One of the issues that we are trying to work through concerns the legalities surrounding the transportation of substances. I think that, once we get into a position where that is nailed down, the applications will go in as quickly as we need them to go in.

Audrey Nicoll: I am sure that the minister will be planning to keep the committees updated on that. It is good to hear that that work is under way.

I turn to the issue of evaluation. At the previous meeting, a range of views were expressed about evaluation, including when it should begin. Obviously, the evaluation process will continue, now that things are under way with the Glasgow service. There has been comment that, in the meantime, work could be taken forward at other locations and facilities, and there is a range of views on what that might look like.

I am interested in your views on whether or not the evaluation should be undertaken before we consider the lessons learned and make decisions as to how we move that work forward.

Elena Whitham: I gather that you are talking about safer consumption facilities.

Audrey Nicoll: Yes.

Elena Whitham: We need to have a robust evaluation process, which needs to be flexible and agile. At the same time, I do not believe that that should stop us exploring the possibility of other pilots that could be proposed while the initial Glasgow pilot is being undertaken. As is set out in information that I submitted to the committee, we have had conversations with the Crown Office and Procurator Fiscal Service about what it would be willing to consider.

It is clear that the Lord Advocate would consider a robust application from an area, provided that it followed the parameters of the initial Glasgow pilot. An application would need to be precise, detailed and specific, underpinned by evidence from that area and supported by those, such as Police Scotland, that would be responsible for policing such a facility. Any area that sought to make an application for a pilot would need to ensure that it satisfied the Lord Advocate in relation to everything that Glasgow did.

Conversations have already been undertaken in the city of Edinburgh about whether the council there would seek to have such a pilot in the offing.

Officials in the Scottish Government are supporting that area to explore what that pilot could look like.

We do not need to wait for the full evaluation of the first Glasgow pilot before applications are put forward by other areas.

Roz McCall (Mid Scotland and Fife) (Con): Good afternoon. I will ask a couple of questions on stigma and my particular raison d'être of being trauma aware. That is something that gets me out of bed in the morning.

Can the minister provide an update on the work that has been undertaken with regard to part of the stigma action plan? I will roll the two questions together to save time. Can the minister outline the engagement that has taken place with the third sector to assess its experience of attitudes and whether that assessment has indicated any improvement in those attitudes over time?

Elena Whitham: Like you, I am very passionate about being trauma informed and ensuring that services are trauma responsive.

We need a full systems and cultural change if we are truly going to tackle stigma. Part of the Government's response to the Scottish Drug Deaths Taskforce's report was to launch a tackling stigma action plan. However, while we are in the process of rolling that out, we need to co-design what it looks like. Therefore, we are making sure that we work with our partners in the third sector, local government and the health and social care partnerships but also with the people who are experiencing the services. It is important for those people to be supported, by and large, by the third sector.

It will take a little time for us to co-design what the stigma action plan will look like, because co-design is not simple or easy. To do it effectively, we need to take a bit of time to ensure that we really hear from the voices of lived and living experience. With regard to our processes just now, I think that, sometimes—as you probably heard from witnesses last week—we can design stigma into our services by accident. We need to make sure that we hear what people who are living through substance use are telling us.

We also need to ensure that we think about some of the groups that are often not thought of when it comes to the designing of services. I am thinking about people from black and minority ethnic groups, who face substance use issues in the same way as everybody else, and I am thinking about services that we need to ensure are there for women and their specific needs. All too often, stigma can drive people away from services, so I am keen that we hear from all those voices. A lot of the time, the voices that we talk about as unheard are actually talking very loudly and we are just not listening to them. Therefore, for me, the co-design process is vital in getting that right, and it is going to take a wee bit of time.

Roz McCall: Thank you very much for that very full answer. My only concern is that, when anyone says that we have to take time to do something, the process becomes never ending, and it cannot be never ending when it comes to trauma. Are you willing to give an indication of how long you anticipate that process taking? I am not trying to hold anyone to a date, but I do not like the idea of it being a never-ending process.

Elena Whitham: Absolutely. I anticipate that, by the time we go into the spring, we will have a lot more information about what the stigma action plan is going to be. We are co-designing a voluntary accreditation scheme that people who are working in services can sign up to. That means that they, as practitioners, and their service will adhere to looking at how they can reduce stigma and drive it down. That is really important.

We are also supporting organisations to launch campaigns such as "See Beyond—See the Lives—Scotland", which is run by a few partner organisations, to get the stories behind the people. We have heard powerfully from MSP colleagues about the stigma that they and their families have faced. There is a lot going on in the background, but I will keep the committee and the chamber up to date on that.

Roz McCall: Thank you, minister.

13:15

Sue Webber (Lothian) (Con): Minister, you mentioned the evaluation methodology. I am glad that the chief officer of Glasgow city health and social care partnership is here today, because you talked about the methodology needing to be robust, flexible and agile, and I am looking for some reassurance that it will also be very independent.

Elena Whitham: That is a really good point, because we need challenge and scrutiny of, and independent eyes on, some of these things. I will probably pass over to Susanne Millar to help us with understanding the evaluation process from a Glasgow perspective. Obviously, things will look slightly different from a Government perspective, as my scrutiny will be of the evaluation that Glasgow will take forward.

I am happy to hand over to Susanne at this point.

Susanne Millar (Glasgow City Health and Social Care Partnership): The evaluation process is being led by the director of public health at NHS Greater Glasgow and Clyde, Dr Emilia Crighton, but we are also working with an expert

academic group, and two universities are working together on a bid in relation to having an entirely independent evaluation. In fact, that was how we operated the enhanced drug treatment service, so we have experience of that kind of independent evaluation. As you can imagine, there is a lot of interest in the evaluation of the safer drug consumption facility, and I am confident that the universities will be successful in their bids and that we will work with them on the evaluation.

Public Health Scotland has already been funded to carry out some baseline study work prior to the service opening to ensure that, when the service comes into operation, the evaluation can start almost immediately. That was a learning from the enhanced drug treatment service evaluation, which found that we had had to spend quite a bit of time on the baseline once the service was open. That is something that we can do as part of our preparation, and Public Health Scotland is doing it on our behalf to ensure that that element is independent, too.

Sue Webber: It is not a hidden fact that our party's perspective on safer drug consumption facilities is different from that of others. We are very much looking forward to seeing the evidence before we take a position on consumption facilities being set up more widely across the country.

I am aware that the City of Edinburgh Council is considering such things, and I am also aware that the service in Glasgow is funded by the Scottish Government. Given that the integration joint board in Edinburgh is in critical financial strife, I would have grave concerns if any consumption facility were to be funded from its existing budget. I am therefore looking for a bit of assurance on that.

Recently, the minister and I have shared some correspondence on the priorities that I think that some of the IJBs and alcohol and drug partnerships need to have with regard to the medication assisted treatment standards. I would just highlight the case of a constituent from my area, who was on Buvidal in Edinburgh prison, and when he presented at the south-west office in Edinburgh, he was told that he could not have that and that he would have to come back in two weeks, which potentially meant that he would have to go back on to methadone. There is a mismatch here between harm reduction and the embedding of that approach and the investment that is needed at local level to really help our individuals. I do not want the cart to be put before the horse here; I want us to have services that help people to recover before we have services that prevent harm.

Elena Whitham: On your first point, the resourcing of any other safer consumption project would be an on-going process between my officials and officials at Edinburgh council. That is not something that I can foresee, but I take your point about how pressed the budgets are.

Sue Webber: I would hate to see a safer drug consumption facility being funded at the expense of other critical services in Edinburgh, because we cannot afford to cut any of those. That is my main point.

Elena Whitham: Yes, and I absolutely take that point.

As for the case that was brought to our attention on social media, I asked officials to start looking into it straight away, because the story of the individual's journey that it told did not reflect what an individual's journey should be in that setting. Let us zoom out from that one person and think about the journey as it should happen. When someone transitions from any setting, whether it be a hospital setting, a prison setting or whatever, a cohesive plan should be in place to ensure that their medication or anything else does not fall between the cracks, that they do not present as homeless and so on. The individual in question should have had a seamless transition from the prison facility into the community setting.

I am still waiting to find out what some of the difficulties in that situation could have been. We know that Edinburgh has a named person standard operating procedure in place, which means that a specific patient is able to have the medication follow them, because you need to have a Home Office licence to store Buvidal. At the point of transfer, the person should have been able to have long-acting injectable buprenorphine set up for the next time that they were due to have that, so there must have been a breakdown in communication somewhere.

There has to be learning from that case, because it cannot be something that happens regularly across the country. That also harks back to the sustainable housing on release for everyone—SHORE—standards. When somebody makes that transition from a prison setting back into a community setting, their healthcare should follow, as well as support for their needs in relation to housing, access to welfare benefits and so on. I am happy to keep the member informed.

Sue Webber: I would be grateful for that.

Elena Whitham: I will also keep the committee informed about what can be learned from that case once I get a fuller picture back.

Sue Webber: That is very helpful. That way, we can make sure that no other person falls through the system like that. Thank you very much.

Orlando Heijmer-Mason (Scottish Government): I have something to add to the earlier point about evaluation. Obviously, we would all want any evaluation of the consumption

room trial in Glasgow to be so robust that, regardless of whether you are sceptical or passionate about it, you will be able to recognise its findings. The committee should know that, at official level, we have been speaking to the Home Office as well, and I have offered to make the introduction to Glasgow so that any questions that it has—there is a lot of interest across the UK, including in the Home Office, about the outcome of the pilot—are reflected in the evaluation, so that it gets from it what it would like to see as well.

Sue Webber: That is very helpful. Thank you.

Collette Stevenson (East Kilbride) (SNP): I want to touch on one thing in relation to the safe consumption rooms and the pilot scheme, then I will move on to the national specification.

One of the recommendations from the Drug Deaths Taskforce says:

> "Currently, many drug services do not operate in evenings or at weekends. We must provide emergency care 24/7 with out-of-hours referral points for people to access if needed."

However, I note from that the pilot scheme service is available only from 9 am to 9 pm. Is that something that is being looked at, or will it be looked at in the evaluation that you touched on?

Elena Whitham: I will answer part of that and then see whether Susanne Millar wants to come in.

If we consider the running costs of such a facility, we can see that staffing it within that timeframe is reflective of the tariff that we know it will cost us. However, I recognise that people will use drugs at all times of the day, so there is need to look at how we can assess, as the pilot develops, what the real-time information is telling us about individuals' habits and how individuals are engaging with the service. It is something that I have certainly thought about and I am sure that Glasgow has thought about it as well.

Susanne Millar: The facility will be open from 9 to 9, seven days a week, 365 days a year. One of the pieces of work that we are doing just now is specifically on the facility's connection to the wider services. Going back to the earlier question, we very much see the safer drug consumption facility as part of the wider offer in Glasgow city, where there are a number of integrated addiction services. A couple of them that are specific to your question are the crisis outreach team and our mental health assessment units, which operate 24/7 and also have an alcohol and drugs component to them.

We are currently working on the pathways for people using those existing services. However, the minister is right to say that running the facility for 24 hours, seven days a week and 365 days a year was not suggested. It is not how the other safer drug consumption facilities across the globe operate, either. We have looked at the evidence base from other places. However, you are entirely correct that the pathways into the other services that we have in place need to be really clear for people. That is something that we will work on.

Collette Stevenson: That is pretty reassuring, especially for people with addictions being signposted outwith those hours.

I turn to the national specification. The committee has heard about the difficulties that people face in accessing services. Can the minister provide an update on what is happening with the national specification and provide any details on what it will include?

Elena Whitham: That is in the Drugs Death Taskforce's report, which speaks to the variation of services throughout the country and perhaps the need to roll some things into the national specification. Work is on-going with stakeholders, through the various working groups that are in place, to consider what type of more formal service specification would benefit people who rely on services, but we are pushing ahead with the roll-out of the medication-assisted treatment standards, which is one part of the national specification of treatment.

We are thinking about residential rehabilitation and we are working towards a national commissioning protocol for that, so that we can make sure that local areas are able to effectively get people on their journey into residential rehabilitation and then back into the community. It has proven to be quite difficult for local areas to do that. Scotland Excel, which those of us who have been in a local authority know—I see a lot of wry smiles here—is a body that helps with that kind of procurement work.

We are now at the point where we will be looking to go out to the tendering process, and organisations that provide residential rehabilitation facilities will be able to get themselves on to a national framework. That will provide a directory for local areas, but also a directory for individuals. As it stands, people do not know what residential rehabilitation is out there for them. They do not know what each type of service might provide for them, and we hope that bringing that under national oversight will mean that individuals' journeys and their access to those facilities will be easier.

On the governance structures around that, a national specification, when we get to the point of understanding what the working groups are telling us, will help us to read across both spheres of government and all the partners and their individual responsibilities. That will help us to

quantify what a national specification should look like in practice, with clear lines of accountability. I obviously have accountability on a national level, but we also need to look to local partners' accountability, and a national specification will help us to do that.

Collette Stevenson: That is very helpful.

Elena Whitham: I do not know whether Orlando Heijmer-Mason has anything to add.

Orlando Heijmer-Mason: The only thing that I was going to add was about the service directory that we will launch shortly, which is a website where people can find out what residential rehab services are available to them.

Russell Findlay (West Scotland) (Con): We have around five minutes and I have three or four questions, so I will try my best to rattle through them. Suspected drugs deaths were up again in the first six months of the year, by 7 per cent, which I think equates to 600 lost lives. It is absolutely correct that we treat this as a public health issue, but there remains a serious problem with organised crime groups preying on vulnerable people. I have raised concerns about organised crime influencing mainstream sections of society including football and boxing, which I find obscene and outrageous. I seek from the Government some kind of explanation or assurance that the police will continue to have the resources that they need to tackle those parasites.

Elena Whitham: I think that everyone in the room recognises that serious and organised crime is very harmful to our communities and is insidious. It is in every level of society, including places where people do not think that it will be. Although it would be for the Cabinet Secretary for Justice and Home Affairs to comment on the police's funding situation and look at the issue across Government, I would seek to make sure that the police are resourced to respond in the areas that I am responsible for.

We need to recognise situations where we can interrupt county lines activity and, where we can, take vast quantities of drugs off our street by interrupting those gangs. We must also recognise when our police in Scotland can work with UK serious and organised crime professionals, and indeed those across Europe and beyond.

As the minister responsible for drugs and alcohol policy, I need to be aware of where the harms transfer to when supplies are interrupted. In my experience, when a huge quantity of substances is taken off the streets, we end up with harm being diverted to a different area. There is a dual aspect to that. I absolutely support the Cabinet Secretary for Justice and Home Affairs and colleagues in making sure that the police are resourced, but I also think about the unintended consequences.

13:30

Russell Findlay: I have a quick question about the drug consumption room pilot in Glasgow. Dr Saket Priyadarshi told the BBC that crack cocaine and any other substances that are smoked or inhaled were removed from the original plan because of the smoking ban. As far as I can see, that has had little pick-up.

Is that being reviewed? Are substances of that nature likely to be included? If so, does that raise potential questions about staff safety?

Elena Whitham: That is an interesting question. There are a few parts to the issue. The smoking ban plays a part in terms of smoking indoors, but the Misuse of Drugs Act 1971 prevents people from supporting the consumption of smokable substances. That shows how outdated it might be, because that was based on thinking about opium.

We know that there will be a challenge with how the consumption facility will operate, because more and more people are using crack cocaine and freebasing it. That will not be able to happen in the facility as it stands, but we also know that a lot of people are injecting cocaine. People who are injecting it would be able to do that in the facility.

I ask Suzanne Millar to say whether she has anything to add to that.

Susanne Millar: I will be careful about what we say publicly, but Glasgow City Council had detailed legal advice on that. As the minister said, including smokable substances would have made the proposal far too complex to get Scottish Government support and get the outcome from the Lord Advocate that we did. Also, the population that we are most concerned about is far more likely to inject cocaine.

Russell Findlay: The Scottish Fire and Rescue Service has secured an agreement with the Fire Brigades Union for, in principle, all firefighters to carry naloxone. There has been some resistance, but some firefighters are doing so voluntarily. That proposal is with the Scottish Government. What is happening with it?

Elena Whitham: There are some complexities with regard to how broadening the firefighters' role would operate in practice. We will consider the SFRS's proposal on firefighters carrying naloxone. I am grateful for those firefighters who are carrying it voluntarily. Like the police force before that, there were a lot of things to work through to get the confidence of front-line workers to carry it. The nasal spray of naloxone has made that much easier for them to do.

Russell Findlay: The police have been doing that for some time. The fire brigade has not yet reached an agreement. Do you have any sense of when an agreement might be reached or otherwise?

Elena Whitham: I do not know. I do not have any insight into that at the moment. Michael Crook might.

Michael Crook (Scottish Government): It is not something that we have information on at the moment. We have been working with the Scottish Fire and Rescue Service for a while, and we have provided it with funding for the carriage of naloxone. We can certainly check back on that and come back to the committee with further information.

Russell Findlay: Thank you. I have a final question on drug checking services. Audrey Nicoll has already talked about them.

In a recent debate, you correctly said, minister, that there is no such thing as a safe consumption room—it is a safer consumption room. Some of the substances are inherently dangerous and there is no getting away from that. What I do not understand—this may be naivety on my part—is what the purpose of a drug testing or checking facility or service would be. Are you checking for the purity or the identity of the substance? If you then tell people that it is the substance that they believe it to be, is that essentially giving them a green light to take it when, in itself, it could pose a danger to them? What happens if you give a red light?

It all seems very confusing and a bit of a legal minefield. What work is being done to establish what the purpose of those services would be?

Elena Whitham: I am very clear in my mind about the purpose of drug checking: its purpose is furnishing people with information. All of us recognise that information is power in every aspect of our lives.

Russell Findlay: If a person intends to take a substance that they have bought thinking that it was a particular substance, and then they get it tested and they find out that it is indeed the substance that they thought it was, the authorities are potentially directing people to take something that could harm them.

Elena Whitham: We are giving people information about what a substance contains. We are seeing an increasingly toxic supply out there, and what an individual might think is Etizolam—street benzo—might come back showing that it contains some synthetic opioids.

I take your point about whether it actually contains the substance that the individual thought that it would, but it allows people to make decisions about whether they will continue to use a substance and how they will use it.

Russell Findlay: That might be beneficial to people—

The Convener: We have to move on. If we have time at the end, we will come back to you for a supplementary question.

Russell Findlay: No, it is fine. Thank you.

The Convener: I bring in Alex Cole-Hamilton.

Alex Cole-Hamilton (Edinburgh Western) (LD): Thank you, convener, for allowing me to join the committees' deliberations today.

Minister, you know that I am supportive of the Government's approach to harmful substance use and deaths caused by the same. However, my question is about a topic that you and I have not discussed before. You touched briefly on the topic in your opening remarks, and in an answer to Russell Findlay—synthetic opioids.

I have a graph in front of me from the United States. It says that in 2012, just over 2,500 people died from synthetic opioids, predominantly from fentanyl, but that last year that number had jumped 73,500. There is an epidemic of synthetic opioid misuse in the states that has not yet been realised on our shores, but that may be changing.

The metrics speak for themselves. When the Taliban took control of Afghanistan in April 2022, it instituted a national ban on the growth and sale of the opium poppy. As a result, opium exports from Afghanistan have dropped right off, and stakeholders are concerned that there may be only 18 months' worth of heroin left in the illicit global supply chain. The vacuum that that will create might well be filled by synthetic opioids—predominantly fentanyl, but also Captagon, which is coming out of countries such as Syria.

First and foremost, what work is your Government doing to prepare for surveillance of what people are taking so that we can get an early warning if synthetic opioids hit our shores? The death rates from fentanyl are far worse than those from heroin.

Elena Whitham: Absolutely. I recognise everything that Alex Cole-Hamilton outlined. We invested in our rapid action drug alert system because we needed to know what was happening in real terms on the ground. The most recent rapid action drug alerts and response—RADAR—report talks about the fact that we are seeing synthetic stronger opioids making their presence felt in the UK and in Scotland. That gives me huge cause for concern.

Just this week, I was on a call with some of our international experts from Canada and the States to talk about what they would do differently now if

they were able to do it again, and to ask about what we are doing in Scotland and what we could do that would help us to address what could potentially be coming down the line.

Thinking back to Russell Findlay's question about serious and organised crime, it is far easier to get hold of and transport synthetics than it is to cultivate a crop that is dependent on so many other factors—never mind geopolitical ones. I am really worried about what we could potentially see, and that is why we need to ensure that we have the ability for drug testing and checking to be done.

People need to know what is in substances, and the Government also needs to know what is happening. The ASSIST—a surveillance study in illicit substance toxicity—project pilot, which is on-going at the Queen Elizabeth university hospital in Glasgow, does routine testing of individuals when they come in to find out what substances are at play. That information and surveillance will help us, but we need to ensure that we speak to the global leaders that are already dealing with the issue.

Shortly, I will convene a round table with other international experts on the issue, and the hope is that once that work progresses it can be opened up to allow other parliamentarians to be part of it, so that the whole Parliament can ensure that we understand what the threat is that is coming down the line and how quickly it could take hold.

Alex Cole-Hamilton: Are we confident that the processes and interventions, such as naloxone, that we have at our disposal for crisis response and overdose mitigation are applicable to the synthetic opioids that are coming in? Are we learning from our North American colleagues about what interventions have been efficacious in those countries and are we ready to adopt those quickly? Things could happen very quickly. Are you confident that we are in a good place?

Elena Whitham: We have been rolling out our national naloxone programme for more than a decade, which is standing us in good stead already. We know that naloxone works on synthetic opioids. There may be a need for multiple doses; anyone giving naloxone will have to phone the emergency services at the same time, who must judge whether the person needs another dose of naloxone. The international evidence clearly shows that naloxone will still work, but that you need to have it in quantity in order to be able to react.

Drug checking should be rolled out at as low a threshold as possible. We need to work through what the pilots will look like, what they will tell us and how we will evaluate that, while operating within the Misuse of Drugs Act 1971. The ministers responsible for drug policy from all four nations will meet in a week and a half, and synthetics will be foremost in our conversation, because it is recognised across the whole of the UK that that is an increasingly important issue.

There are other things that we know could help. The safer consumption facilities will have professionals and supportive people on standby to respond to any crisis. Just this week, we have had the roll-out of safe supplies of naloxone to community pharmacies. We all recognise that those pharmacies are at the heart of our communities and are well placed to deliver that life-saving treatment, so it is a real boon to have that available everywhere.

Alex Cole-Hamilton: That is fantastic. I have one final question, if I may, convener.

The Convener: I am sorry, but we must move on. I will come back to you at the end if we have time, but we now move to questions from Katy Clark.

Katy Clark (West Scotland) (Lab): Minister, you have made it clear that you have been in discussions with the Crown Office. The Lord Advocate has said that it would not be in the public interest to prosecute users of drug consumption rooms for simple possession offences and that she would be prepared to draft a prosecution policy along those lines. Have you engaged with the Lord Advocate on that point? What legal protections will be in place for staff at drug consumption facilities?

Elena Whitham: We know that Police Scotland has created an operational procedure that will dictate how any such facility is policed, and it is for Police Scotland to communicate that.

You are absolutely 100 per cent right, Ms Clark, to ask about how the staff of such a facility would be protected. It is for Susanne Millar to reassure us about the advice that Glasgow has taken on that. As the minister, I believe that the individuals who will be supporting some of our most vulnerable citizens should themselves be protected. I will hand over to Susanne to answer that.

Susanne Millar: It is a significant concern for us, and has been for some time, to understand the legal parameters that we must operate within. We are refreshing our advice, but it is our understanding at this point that we must have standard operating procedures in place, have a clear staff training and support plan and have clinical and care governance systems to assure us that our staff are following those procedures. Our staff will be protected if they operate within those expectations, which must be clearly set out in the formal standard operating procedures that are part of staff induction and on-going training.

That is the advice that we had when the proposal was under consideration by the Lord Advocate. We will reassure ourselves that that advice remains current and will refresh it if necessary before we open any such service.

Katy Clark: That matter is on-going and you have it under active consideration.

Susanne Millar: Yes.

Katy Clark: My next question is for the minister. It is estimated that funding for Scotland's alcohol and drug partnerships has been cut by around £19 million, but that funding is essential, given the role that those partnerships play in trying to address the public health emergency of drug deaths.

I am not going to ask the minister to give an undertaking on what will be in the budget, but I will ask her to give a commitment to make the case—in the strongest terms—as to why those cuts need to be reversed and further funding needs to be devoted to those partnerships. Is that something that she feels able to commit to?

13:45

Elena Whitham: I will always make robust representations when it comes to the portfolio and the individuals that my portfolio policy seeks to support across the country. However, at this point, I need to refute that there is any notion of reduction in budgets.

Katy Clark: In the forthcoming budget or historically?

Elena Whitham: In the past budget as well. If we think about what happened last year, the money that was made available to ADPs never changed. As is fiscally prudent to ask any organisation to do when we are publicly funding it, we asked ADPs to make sure that any unspent reserves that they were carrying were used in the first instance and that they sought to draw down after that. Provision was made for any non-recurring spend that ADPs had perhaps earmarked against projects that they needed that funding for, but the full envelope of the money was there.

The total drugs and alcohol budget has steadily increased over the past few years: in 2021-22, it was £140.7 million; in 2022-23, it was £141.9 million; and, in 2023-24, it is projected to be £155.5 million. As I said, I will always seek to make representations in relation to my portfolio in the strongest of terms.

I also seek to reassure the joint committee that, as of next year, around two thirds of ADP funding will be baselined. That means that that funding is there and committed and that it will be recurring. I hope that that will allow ADPs to feel more comfortable in their long-term spending commitments and planning. I give you my guarantee that I will make robust representations in relation to the budget.

The Convener: We turn to questions from Paul O'Kane. I am sorry—I mean Paul Sweeney.

Paul Sweeney (Glasgow) (Lab): It is easy to mix us up—I think it is the glasses. [*Laughter.*]

I went along to the Calton community council consultation event on 28 September. It is fair to say that it was fairly confrontational. What lessons have been learned from that exercise?

Susanne Millar: We are used to robust community consultation on the services that the Glasgow city health and social care partnership delivers, and we are committed to that on-going honest conversation with our local communities and beyond. Since the event, we have been talking to the community council about how we keep that discussion going. We have also had a discussion with three of the local housing associations. We have met the local business developer and had previously met the local elected members from Glasgow City Council. We have a local engagement plan that takes us all the way through to the turn of the year and slightly beyond the immediate future.

With regard to what lessons have been learned, those conversations are difficult, but I expect them to be difficult, because they are honest. I spoke with the community council chair after the meeting, and it is my observation that, once we had set out our stall, people went away and thought about what we had said to them. Again, part of the engagement experience is that we will repeat that and go back to them, because people need a lot of time to absorb the information. We are steeped in the issue. Their anxieties are entirely understandable and reasonable. We will need to spend quite a bit of time in that dialogue with them, and we are absolutely committed to it. Robust consultation is something that we expect not only in that area but across our work.

Paul Sweeney: In your communication plan with the local community, do you anticipate using examples from other countries or lived experience from other countries and jurisdictions that have experienced the roll-out of those facilities?

Susanne Millar: Yes. I should have mentioned that another critical element of the consultation engagement is that we work with people who have lived and living experience. That is going well. As you know, in Glasgow city, we also have a number of family groups who are affected by addictions and, again, we have really strong working relationships with them. We have had offers from them to be part of the consultation engagement, so that the story that is told is a Glasgow story,

and it is one that resonates. We have had contact with our counterparts in Bergen in Canada, who have really powerful stories from lived and living experience, but our first port of call is our own people—if that is the right way to put it.

Paul Sweeney: That is helpful. One of the major concerns that was raised in the community council meeting was the role of the police. There was a lot of anger that the police had not been present—which is a fair point, because, beyond platitudes, they have not really been present at all in public discussion on the topic. Is there an appetite from Police Scotland to be more engaged, particularly with the concerns about how drug dealing will manifest itself within the local community as a result of the facility?

Susanne Millar: That was a specific action that we picked up from the community council meeting, so we have raised it with Police Scotland. The new divisional commander is absolutely committed to the engagement plan that we have shared with him, and he has committed that Police Scotland colleagues will be involved in that. I am sorry—I should have mentioned that as one of the lessons learned. You are absolutely right.

Paul Sweeney: That is helpful.

I visited the H17 facility in Copenhagen on 12 October. A key point that was raised in discussion with the people there was the strength of the co-location of services, but they also had some concerns about the direct co-location of the enhanced drug treatment service with the overdose prevention centre. Is that a potential issue for concern?

Susanne Millar: One of the recommendations of the "Taking away the chaos" report back in 2015 or 2016, which was the genesis of our work on the enhanced drug treatment service and the start of our work on a safer drug consumption facility, was that the services be co-located. We are cognisant of the fact that co-location assists the clinical leadership in particular to make sure that we have a good support system for the staff who are involved in providing those services.

However, we are also cognisant of the fact that, for example, the services will need discrete access, because they are very different. Self-referral means that access to the safer drug consumption facility will be at a low threshold. I am sorry—I am using my hands in an attempt to indicate that they will have different entrances. We are cognisant of the fact that the people using the services must understand that they are separate, but, from our perspective, when it comes to that clinical oversight, there are real overlaps, and one of the recommendations was that they be co-located.

Paul Sweeney: I also have a question about the ability to adjust in real time during the pilot. One of the lessons from Copenhagen was about 24-hour coverage. There are two centres within about 200m of each other. They operate for 23 hours a day and they close for an hour for cleaning. Are you concerned that there might be an issue with the opening hours, and is there an opportunity in the pilot to extend those quickly if it is deemed obvious that that is a need?

Susanne Millar: That relates back to the question on evaluation. We are looking to be agile but are cognisant of the facts that we are working with. We need to take really seriously the Lord Advocate's view and the framework in which we are operating. We need to make sure that we do not adapt anything that cuts across those.

The evaluation will report on an on-going basis and we will be able to make operational changes, as we did with the enhanced drug treatment service. However, we need to be crystal clear that we continue to adhere to the expectations that the Lord Advocate has given us.

Elena Whitham: That clearly demonstrates to me that if, in the UK as a whole, there was a move towards an array of different types of safer consumption facilities, or if we were given the ability, with devolved powers, to make such a move, that would allow us to be more flexible and agile in responding at the same time, and to have more third sector partners involved in providing and delivering those services. Although we know that the facility will save lives when we get the pilot up and running, that situation demonstrates some of the constraints that we are operating under.

The Convener: I call—this time—Paul O'Kane.

Paul O'Kane (West Scotland) (Lab): I apologise to you, convener, and to colleagues for having to come late to the meeting. I am interested in the MAT standards, which have been touched on in other questions. I think that it is fair to say that Public Health Scotland's recent benchmarking report found progress to be patchy, and challenges were identified in that it is a bit of a postcode lottery when it comes to what is happening in different parts of the country. Will the minister speak to progress on the MAT standards and to why she thinks that that outcome is patchy at the moment?

Elena Whitham: The 10 MAT standards came from the Scottish Drug Deaths Taskforce itself, and were created after a concerted effort and work with people with lived and living experience and other partners. If we think back to when the standards were first discussed, we were talking about an entire system and culture change to create services that would deliver at pace on the ground. That was made difficult from the beginning

by the fact that ADPs and health and social care partnerships are all set up in different ways, so we started from a really difficult and complex position.

I will keep pushing for local areas to deliver on the MAT standards, because we need them to do that and we know that that will save lives, but the fact that two thirds of areas delivered standards 1 to 5 last year was a big step change. I am really conscious of the fact that standards 6 to 10 will be where we really start thinking about advocacy work, trauma-informed work, psychological and mental health support and how we start to embed the MAT standards within primary care, which will all be really tricky.

I will have to have robust conversations with local areas. Some areas have moved to monthly reporting, which is really important, but other areas where we have seen progress have gone back to quarterly reporting. Some specific situations will be tricky. There are some areas where drug deaths have not started to decline or where there are perennial issues, which means that I must have sit-down conversations with them. That will be very supportive, as opposed to me telling people what I think they should do, because that is not how we should work. We must ensure that we take areas with us. Despite progress not being as fast as I, or any of us, wanted it to be, we must recognise that people across the country have pulled out all the stops.

Also, because of the way that healthcare operates, we will find it tricky in our justice settings. Just last night, I met other ministers who are responsible for what healthcare should look like in a prison setting. We know that 76 per cent of those admitted to prison test positive for illicit substances and have significant substance use problems, so the MAT standards must work in justice settings.

I will continue pushing so that all 10 MAT standards are fully implemented by the end of 2025 and, by the time that we get to the end of this session of Parliament, the standards will be sustained and they will operate as business as usual.

Paul O'Kane: I recognise a lot of what you have said about the progress made on standards 1 to 5 and the challenges with standards 6 to 10. Is there a feeling that standards 1 to 5 were slightly more straightforward because they are about changing culture, attitudes and approaches, but that 6 to 10 will be more challenging because they involve implementation and delivery? I noticed that you mentioned timescales. Are you committed to 2025 as the point by which all 10 standards should be implemented?

Elena Whitham: All 10 should absolutely be implemented and operational by 2025 and they must be sustained by the end of this session of Parliament. We must find a way forward so that, beyond this session of Parliament and this Government, the MAT standards are treated as business as usual and will be what people can expect.

I have spoken with officials about the decision to split the standards into two groups after the first year, which predated my time as minister. The decision might have been about what was easier to measure: the first five standards were measures that officials within Government, and locally, thought could more easily be benchmarked.

We must not underestimate the work that the MAT standards implementation support team, which is based within public health, is doing at the moment. Members of the team have created entire data capture systems that did not exist beforehand. There is a massive amount of work to do in capturing experiential data, which is more difficult to quantify. That is why, if you look at the MAT standards, you will see that some are only provisionally marked as green because the experiential data, which will be led by people with lived experience, is being captured. Services say what they are doing, but the data will show how people are experiencing that service. It was quite tricky to set up the collection of that data, so we must recognise the sheer amount of work that has been undertaken.

The Convener: We have a hard stop at five past two, so I will go to Sue Webber for a very brief supplementary question, to which we need a very brief response please, minister.

Sue Webber: My question might be better directed towards Susanne Millar. I was curious about the community engagement that you mentioned and the fact that you are having to go back to community councils. What will the community consultation process change? Will you not go ahead with the work irrespective of communities' views, so is the engagement process not a bit disingenuous?

Susanne Millar: No—absolutely not. In our opinion, engagement with the local community and a range of stakeholders is critical to the success of the safer drug consumption facility. There had been engagement up to the point of the proposal but then we were not able to engage with anyone specific because we did not have a specific location or the Lord Advocate's agreement. Our engagement plan is detailed.

As I said in answer to Mr Sweeney's question, we are well aware of the level of anxiety and the questions that we require to answer. We will work through those, as we are used to doing. We will take the local community with us, because we know that we will have to do so if it our work is to

be successful. We were very clear with the local community council that we would be back in touch with it and that there will be on-going engagement; the consultation was not a one-off exercise. The people whom the safer drug consumption facility will support are the citizens of Glasgow. They are the sons, daughters, brothers and aunts of the people who live in our city. That is what we will work with the local community council on.

Elena Whitham: Might I add to that?

The Convener: I do not know whether we will have time, because Russell Findlay also wants to ask a brief supplementary. As I said, we have a hard stop at five minutes past two.

Elena Whitham: It was just to say that the Lord Advocate will not proceed with her prosecution statement unless she has satisfied herself about the process.

Russell Findlay: I have a question in response to the issue that was raised by Paul Sweeney—criticism of Police Scotland in relation to drugs consumption rooms. I was quite surprised by that, because my understanding was that Police Scotland has engaged with the Government and has been supportive of the proposal. I would be keen to hear your view on that.

Elena Whitham: I will just briefly say in response to that that I would ask members of the joint committee to reach out to Police Scotland, put questions to it, and perhaps take its evidence, because I think that that will help you to form the bigger picture. Police Scotland has been supportive in understanding the need for such a facility. Assistant Chief Constable Ritchie was behind the proposal from the beginning. Police Scotland has come on a journey as regards playing a role on the issue. It was probably an oversight that none of its representatives was available at the community council meetings. I do not think that either of us can speak for Police Scotland, except to say that, since 2016, it has certainly supported our endeavours.

The Convener: I thank the minister, her officials and Ms Millar for their attendance. We now move into private session.

14:02

Meeting continued in private until 14:15.

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