OFFICIAL REPORT
AITHISG OIFIGEIL

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

Wednesday 1 May 2024

Session 6

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CONVENERS

*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)
Katy Clark (West Scotland) (Lab)
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)
Ruth Maguire (Cunninghame South) (SNP)
John Mason (Glasgow Shettleston) (SNP)
*Roz McCall (Mid Scotland and Fife) (Con)
Ivan McKee (Glasgow Provan) (SNP)
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)
Sue Webber (Lothian) (Con)
Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Alison Crocket (Scottish Government)
Michael Crook (Scottish Government)
Dr Emma Fletcher
Kirsten Horsburgh (Scottish Drugs Forum)
Christina McKelvie (Minister for Drugs and Alcohol Policy)
Justina Murray (Scottish Families Affected by Alcohol and Drugs)
Dr Saket Priyadarshi (NHS Greater Glasgow and Clyde)

CLERKS TO THE COMMITTEES

Alex Bruce
Stephen Imrie
Claire Menzies

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)

Wednesday 1 May 2024

[The Convener opened the meeting at 10:00]

Decision on Taking Business in Private

The Convener (Audrey Nicoll): Good morning, and welcome to the first joint meeting in 2024 of the Criminal Justice Committee, the Health, Social Care and Sport Committee and the Social Justice and Social Security Committee, to consider the progress made in implementing the recommendations of the Scottish Drug Deaths Taskforce. We have apologies from Gillian Mackay MSP and Sue Webber MSP.

Our first item of business is to decide whether to take item 3, which is to review today's evidence, in private. Are we agreed?

Members *indicated agreement.*

Drug Deaths and Drug Harm

10:01

The Convener: Our main item of business is to take evidence on the progress being made to tackle drug harm and reduce drug deaths. I am pleased to welcome our first panel of witnesses: Kirsten Horsburgh, chief executive officer of the Scottish Drugs Forum; Justina Murray, chief executive officer of Scottish Families Affected by Alcohol and Drugs; and Dr Emma Fletcher, director of NHS Tayside public health and chair of Dundee alcohol and drug partnership. I refer members to papers 1 and 2 and thank witnesses for providing helpful written submissions.

As ever, we move straight to questions. I will get things under way. I would like to ask individual questions, and I come to Kirsten Horsburgh first with what is probably a bit of a big question. Reporting in the media today is highlighting the latest figures, which suggest that the number of drug-related deaths has, again, increased, but that there has been a significant decrease in the number of hospital admissions. What is that telling us and how do we need to respond?

Kirsten Horsburgh (Scottish Drugs Forum): Thank you very much for the invite to come back today. When we had the suspected and confirmed drug deaths figure for the year before last, there was some anticipation and hope that that was the start of a reduction in drug-related deaths. However, we saw a potential rise with the suspected figures for the full year last year—we will have the confirmed figures through the National Records of Scotland in the summer. It is quite clear, therefore, that we are still not getting things right.

In relation to hospital admissions specifically, a lot of good work has taken place around out-of-hospital activity. There has been much more community response and a lot of additional work has happened with the Scottish Ambulance Service and Police Scotland around overdose response. I do not know the exact answer to the question, but I surmise that a community approach across the country has taken place, with a lot more engagement in the community.

The flip side is the concern that people do not seek help when they are experiencing issues. We know that major concerns remain about stigma and discrimination around access to health services for people who experience drug problems. Those are probably the two sides of the coin.

The Convener: I am not aware that the specific issue of hospital admissions has been raised, highlighted or, indeed, discussed in our previous

committee meetings. Do you have any views on what is behind that decrease, which is reported to be around 24 per cent?

Kirsten Horsburgh: It is basically what I have explained: I do not have a clear answer for it, to be honest. More community work has taken place, but there is still a real resistance from people who experience drug problems to access the health service, and both those things will have an impact.

I do not think that, just because there has been a reduction in hospital admissions, that is to be seen as a positive. When people have experienced an overdose, if they have been taken to hospital by the Ambulance Service, they will quite often end up not being admitted because they will leave prior to admission—people do not like to stay in the hospital environment.

The Convener: Thank you. I am sure that other members will want to probe that a little more.

I come to Justina Murray. In your comprehensive written submission, you state that, although

"It is welcome that family members have the opportunity to engage and influence"

the development of approaches to tackling drug harm, they are not reporting the level of change on the ground that you would expect to see at this stage, and that there remains an

"implementation gap"

between policy and delivery. From your perspective, how do we start to close, or address, that gap?

Justina Murray (Scottish Families Affected by Alcohol and Drugs): We talk about the implementation gap quite a lot—in fact, I talked about it when I was at committee last year. In Scotland, we have quite a progressive approach to drug policy, and we are writing down a lot of the right things in legislation and in policy and strategy but, as I said in my written evidence, it is just not feeling real for families on the ground.

There is a lot of activity, but it sometimes just feels a little bit like busyness. In my written evidence, I reflected on just how much paper has been produced from talking about all the things that we are doing, and different plans and strategies and so on. A lot of that is still very much behind the scenes. Some of the flagship projects such as the safer drug consumption facility and drug-checking projects, which we are supportive of, are not yet functioning in reality. All that work is going on in the background, but families are not seeing anything on the ground. We come to Parliament and talk about the Government, but we need to do a lot more of getting alongside people on the ground and exploring what is getting in the way of implementation for them.

There is still a postcode lottery. Even where we have had good national initiatives such as the medication assisted treatment standards, it very much depends on where people are in the country as to how well those are being implemented. From my own team this week, I heard good and bad examples of that.

We do not truly understand why things are not being delivered on the ground as much as they should be. It is not all about resources, to be honest, because a lot of extra resource has been released into the system. Some of it goes back to culture and attitudes; Kirsten Horsburgh talked about stigma, for example.

You asked about hospital admissions, convener, but we should not see that as separate from everything else that is going on. We need to redesign the whole system together.

The Convener: Thank you—there is a lot in there. That brings me neatly to my next question, for Dr Fletcher, which is on a whole-system approach.

Your submission, on behalf of the Dundee ADP, sets out the work that is being undertaken to drive the whole-system approach, but you state that

"there is scope to further improve the"

approach

"and identify the highest priorities for upstream interventions to prevent drug deaths and wider drug harms."

I am very interested in what you are looking at in that regard, and I would like to hear a wee bit more about that.

Dr Emma Fletcher: A whole-system approach is imperative. It has been clearly reflected across national and local discussions that it is not down to one agency, organisation or approach to solve the issue—it requires all of us, working together with a shared focus and priorities. The alcohol and drug partnership is an excellent forum to enable all key partners to be in a room and work towards the same priorities and aspirations. I think that we do that very well in Dundee, and increasingly so in recent years.

There are further opportunities to develop the approach, building on the work of the MAT standards, which have been very helpful in driving action, particularly around opioid and substance use.

As an ADP chair, I am considering, and my colleagues are considering, upstream interventions. I am thinking about housing, employment and poverty. We invest in the local community planning partnerships, and we devolve

matters to enable areas across Dundee to take a grass-roots approach and work with communities to support people who are affected by substance use. However, in a time of increasing financial challenge, it would be helpful to think and have greater evidence about where we can best direct the limited resources that we have for greatest impact.

I come from a medical background. We have a huge amount of research and evidence on, for example, cancer treatment and cancer care and what makes the biggest impact. However, there is a paucity of understanding with regard to where the greatest impacts can be in those upstream interventions for people—and their friends and families—who are affected by substance use.

The Convener: You mentioned issues such as housing and employment. I noticed that you outlined in your submission that the

"vast majority of people who are affected by drug death experience multiple severe disadvantages".

Perhaps more work is required to address that as a single approach.

Dr Fletcher: That would be incredibly helpful. My colleagues beside me will also be able to give examples of how elements of the system that we work in are not quite as responsive and supportive as we need them to be for people who are finding themselves in real difficulties.

The Convener: Thank you, everyone. I will bring in other members now.

Pauline McNeill (Glasgow) (Lab): Good morning. I am interested in the statistics on male deaths, as that issue seems to be one of the big problems. Has any work been done to try to understand why that is? Can you help me to understand why there is a prevalence of drug deaths among men?

Dr Fletcher: We are seeing a changing pattern with regard to drug deaths and the impact on men and women. For many years, we had predominantly seen drug deaths impacting men on a ratio of about three to one. That has changed substantially over the past five years. For example, in Dundee, in 2018, there were 47 deaths impacting men and 19 deaths impacting women. In 2022, there were 18 deaths impacting men. Sadly, the figure for women is constant—the number of deaths is 19 to 20. The reduction that we are seeing locally has been due to a reduction in drug deaths impacting men, but we are seeing little change for women.

We really want to understand that much more. We are taking a gendered approach and doing further analysis. We are also working with colleagues who are protecting people. Over the past five years, the dynamic that we are seeing is really changing. It is important that we take that whole-family person-centred approach to understand and provide the individual support that each person needs.

Pauline McNeill: Does anybody else want to answer that question?

Kirsten Horsburgh: On a national level, it is absolutely still the case that males are more likely to die from drugs use. More males use drugs, so the population is larger. There are specific risk factors for both groups, but males are more likely to experience homelessness, to be rough sleeping and to be using drugs on their own.

I agree with Emma Fletcher that there is a gap in specific service provision for women and services that cater for the specific needs of women.

10:15

Pauline McNeill: I was interested in the fact that,

"In 2022, males were twice as likely to have a drug misuse death".

That was only two years ago. Dr Fletcher, I have to say that I did not fully understand what you were saying about the changing pattern over the past five years, given that in 2022 men were

"twice as likely to have a drug misuse death".

Dr Fletcher: I am sorry, but can you repeat that?

Pauline McNeill: In my papers, it says:

"In 2022, males were twice as likely to have a drug misuse death as females. Most of the decrease in the past year was in males."

I thought that you said that there was a changing pattern with regard to men and women.

Dr Fletcher: Yes.

Pauline McNeill: But it was only two years ago that men

"were twice as likely to have a drug misuse death".

Justina Murray: I am happy to jump in here. I think that Dr Fletcher was talking about Dundee statistics rather than national statistics—

Pauline McNeill: Oh, I see.

Justina Murray: Nationally speaking, 20 years ago, men were four or five times more likely to die than women, whereas they are now twice as likely to die. Women's deaths are reducing more slowly than men's deaths; over the past year, men's deaths fell by 26 per cent and women's deaths by 10 per cent.

As Kirsten Horsburgh said, we need very different approaches for women. The Simon

Community has said that the Glasgow safe drug consumption facility—which it supports, along with us—is much more likely to be used by men rather than women, so we need to think about alternative provision for women such as high-tolerance housing and other kinds of support. I think that that is where the confusion has arisen: we were talking about trends in Dundee rather than national trends.

Pauline McNeill: That was helpful. I also note Kirsten Horsburgh's comments about men being more likely to be homeless and all the factors that might lead them to be vulnerable to a drug death.

Russell Findlay (West Scotland) (Con): First, I have a quick question for Dr Fletcher. A drug consumption facility is coming to Glasgow, and Edinburgh appears to be next. Does Tayside have any plans in that respect?

Dr Fletcher: It is something that we are very interested in and are following closely. It will be useful to see the evaluation from Glasgow, as that will guide our approach to and potential adoption of such facilities in future.

It is important to note that the picture in Dundee is more of polysubstance use, and that will have an impact on what the optimal approach might be. We are very focused on a multi-agency, outreach and person-centred family approach that is responsive to a polysubstance picture, but we are interested in what will happen in Glasgow and then in Edinburgh.

Russell Findlay: If the facility in Glasgow gets up and running in the summer, as we have been told might be the case, how long will it need to be in operation before you can make an assessment?

Dr Fletcher: Again, it will be really helpful to see the evaluation, as that will guide how we might implement our approach to best effect. That is what we are looking for.

Russell Findlay: Roughly, what kind of timescale would provide useful data? Would it be a year, or six months?

Dr Fletcher: It depends entirely on how the approach is implemented, the feedback that is received, the expansion of MAT standards nationally and all the priorities that we are seeking to address.

Russell Findlay: In the submission from Justina Murray's organisation, the facilities are described as "safe". Do you accept that there is no such thing as a "safe" drug consumption facility, given the substances that are being taken? Surely the correct word to use is "safer".

That question is for anyone.

Kirsten Horsburgh: I will reflect on some of the comments that Emma Fletcher just made. The Glasgow service is called a safer drug consumption facility. Such facilities have all sorts of different names, but they are all about safer drug use, because there are people who can provide support if any emergency or incident occurs.

I am concerned about areas stalling in introducing such facilities while they await an evaluation being carried out in Glasgow. We are not trailblazers in introducing such facilities; they have been available globally since the 1980s. If we took the approach of introducing such facilities across the country wherever they are needed, where people are involved in street-based injecting, we would have a variety of models operating at the same time. Some could be peer led and some could be NHS led, while some could be static and some could be mobile. That would enable us to evaluate—

Russell Findlay: I presume that they can be tailored to specific local circumstances, as Dr Fletcher described.

Kirsten Horsburgh: Absolutely.

Justina Murray: I am happy to come in on that, too. One of the challenges for Scotland is to do with the fact that all our communities are so different. The Government invests in big flagship projects, which tend to be in cities—they are often in Glasgow, where there is a very high level of need.

Someone suggested to me, "If they solve the Glasgow drug deaths problem, they solve Scotland's drug deaths problem." Statistically speaking, there is some accuracy to that, but I do not know how that makes a family member in an area such as Dumfries and Galloway or the Highlands feel. Where is the equivalent response for them? The Glasgow model will not necessarily be the right response for them, because that was first proposed to deal with the health risks of street injecting; it was not designed to deal specifically with drug-related deaths. Therefore, that model will not work in a lot of other areas. People in those areas should get an equivalent investment to develop local responses, but that investment does not always follow through.

Dr Fletcher: The other thing to note about the provision of a safer consumption room is that it is one element of an approach. We need to be so alert to and cognisant of how we spend the very limited resources that are available to us in such a way that they have the greatest impact. That is why I express an element of caution about that. We absolutely need to advance work in other areas to support the person and the family who are impacted, to look at prevention and to reduce stigma. The importance of all those other elements is reflected in some of the evidence on safer

consumption rooms. In addition to providing such a facility, we need to provide people with holistic care.

Russell Findlay: I want to move on to the issue of synthetic opioids, 15 of which have just been assigned the status of class A substances.

Synthetic opioids have featured in a significant, and growing, number of deaths in Scotland, as they have done worldwide. From the point of view of your expertise and different perspectives, how prevalent are synthetic opioids becoming? Could you explain the specific concerns about them to people who might not understand the difference between traditional opioids and the synthetic stuff that we hear about?

Kirsten Horsburgh: That brings us back to the problem that, overall, people do not know what they are taking, because we do not have widespread drug checking facilities to enable people to test what is in their substances.

Given that we already have a significant issue with our drug deaths crisis, the introduction of synthetic opioids such as nitazenes is a major concern because of their potency and because people simply do not know about them. All of a sudden, their normal supply could contain much more powerful opiates.

Synthetic opioids are not hugely prevalent at the moment. The truth is that we do not know. If they were very prevalent, we would know, because people would be overdosing in even higher numbers than they currently are.

We have started some small pilot projects, which involve supplying people with nitazene test strips so that they can test their substances to see what is in them. Yesterday, we had our first positive test from one of the test strips in one of the areas. We are using that as a tool to get a little bit of information.

Russell Findlay: If an individual uses one of those test strips and it comes up positive, would that make them not take the substance or would it simply allow them to know what they were dealing with? What is the thinking behind that?

Kirsten Horsburgh: It is an interesting tool to use to encourage engagement with people. It is partly about enabling people to potentially identify whether a substance is positive for nitazenes, but it also helps us to open up a conversation with people about their concerns about new substances and reducing the risk of their drug use.

When we have been training people in the living experience groups to which we have been supplying the test strips, we have had a variety of responses. The staff who have been delivering the tests have asked people what they would do if they got a positive result. Some people said that they would not use the drug; some said that they would still use it but that they would use less; and others said that they would carry on in the same way. It is about having those conversations with people.

We are also asking people to send the samples on to WEDINOS—the Welsh emerging drugs and identification of novel substances project—for confirmatory testing, because we know that there is some concern about the accuracy of the test strips.

Russell Findlay: You said earlier that you have not seen a significant rise in that regard—thankfully; touch wood—but is it the case that you are almost anticipating the likelihood of that?

Kirsten Horsburgh: Absolutely. If there is a large introduction of nitazenes into the drug supply, there will absolutely be an increase in the number of drug-related deaths, and we are not equipped to deal with that. We are not equipped to deal with the current emergency situation that we face, so that is an additional element on top of the crisis that we already have.

Russell Findlay: I do not know whether the other witnesses would like to come in.

The Convener: I want to move things on—we can come back to that issue if we have time.

I will bring in Paul Sweeney.

Paul Sweeney (Glasgow) (Lab): Ms Horsburgh, you just mentioned that Scotland is, by far, not a leading proponent of the introduction of safer overdose prevention facilities. Do you have a view on the pace of, and the process for, the development of the official pilot safer drug consumption facility in Glasgow?

Kirsten Horsburgh: Yes. I am a member of the implementation board and the workforce sub-group for the Glasgow facility, and I was involved in some interviews for the key staff the other day, so that is an exciting bit of progress. The initiative is being implemented as quickly as possible. The build work for the facility has started, and the expected timescale is still that it will be open towards the end of the summer. I do not think that those involved could move any faster than they are currently. Nonetheless, it has been almost eight years since the proposal was first made, so, in that respect, progress has absolutely been far too slow.

Our concern now is whether progress will be even slower in introducing such facilities across the rest of the country.

Paul Sweeney: Does the model that has been adopted in Glasgow for the overdose prevention centre, or safer drug consumption facility, match what you would like to have seen in an ideal world,

based on international benchmarks? Could it benefit from further development?

Kirsten Horsburgh: Absolutely. There are some restrictions in relation to what the Lord Advocate has allowed in order for the facility to be introduced. For example, the facility must be integrated with and attached to other healthcare services, and there are restrictions on what the service is able to do. The major red flag is that the facility will not have an inhalation component, but we know that there are a lot of people smoking crack cocaine or heroin who would benefit from that being part of the facility. I hope that that will be introduced, too.

I do not think that there are any issues with the model. That approach has worked well in other countries, but it is not the only approach, hence why I said that it would be good to have other types of facilities that might suit, and be able to be accessed by, different people with different needs. It would also help to have more facilities running at the same time in order to take the real tension and the media and political focus away from one particular service. It would be good to introduce others at pace.

Paul Sweeney: When I read about the Copenhagen facilities, I noticed that there was a cluster in the district with rehabilitation facilities and drug checking facilities available on site. There was also a lot of pastoral support with social work and housing, and there was even a drug users union in the community. Overall, it seemed to be a very good self-reinforcing ecosystem that had massively reduced drug-related criminality but had also achieved great public health outcomes. Is there a significant opportunity to develop a model along those lines in the wider community?

Kirsten Horsburgh: Absolutely. As others have said, the consumption facility itself is not the only answer—it is all the wraparound things that make the service a success. That includes all the things that you mentioned, plus I would like us to move to a model of high-tolerance housing, which has been mentioned. The Netherlands, which has had such facilities for many years, has actually started to close some of them down because the country has moved to a much higher tolerance and acceptance that people can use within residential facilities. The wraparound services that you described would absolutely be welcome in Scotland.

Paul Sweeney: Dr Fletcher, I noticed that you were nodding there. Are you looking closely at emulating what is currently happening and, I hope, benefiting from the learning curve that Glasgow is leading on?

Dr Fletcher: Absolutely. As Kirsten Horsburgh has described, holistic wraparound support is incredibly invaluable.

10:30

Justina Murray: That is perhaps a good example of the fact that, although we applaud ourselves in Scotland for our public health approach to drugs, in reality, we have interpreted that as a health and then a health service approach. So much of the investment in tackling drug harms in Scotland goes into NHS services that it is not really a public health investment, which is about families, communities, whole populations and, as you said, wraparound initiatives relating to poverty, homelessness, relationships and all the other issues. It seems that, again, there will be quite a clinical model. Clinical models work—as Kirsten Horsburgh said, they are evident elsewhere—but we are not really living up to the public health banner that we champion so much in Scotland.

Paul Sweeney: Have you seen any examples from around the world that we should look more closely at emulating?

Justina Murray: I will give what is, actually, a really bad example, because it is a health service example. The other day, I was at an event where someone from Australia was talking about a model in which a dedicated hospital ward had been developed for people who were admitted under the influence of drugs or alcohol. On that ward, which had six beds, there were clinicians, but there were also social workers, peer workers and people who dealt with issues relating to poverty, debt, housing and homelessness. Those kind of wraparound services, with a multidisciplinary team, were provided in a health service setting.

I had never heard of anything like that in Scotland. Apparently, that model is now being looked at, but I am not sure where. That is a really bad example when I just said that not everything should be within the NHS, but it shows that it can be done. However, I am not aware that it is being done in Scotland just now.

The Convener: Okay, thank you. Before I bring in Clare Haughey, I think that Pauline McNeill wanted to ask a follow-up question.

Pauline McNeill: I agree that it is an exciting and important step to take to see what contribution safer consumption rooms can make. As a Glasgow member, I am obviously familiar with where the pilot is going to take place. Has there been any feedback from the local community? It strikes me that it really has to have the support of the local community, because if they do not feel safe where that is located, that could be a setback. Can you tell the committee anything about what

engagement there has been with the local community? One thing that I am aware of and has been fed back to me by the local councillor is that there is some concern, and they think that the location is not great for public transport.

Kirsten Horsburgh: You have a witness on the second panel who will be able to speak in more detail about that, but certainly they have been doing a lot of community engagement. You are right that there is a lot of tension there, as well. However, everywhere in the world that has introduced these types of facilities has had that experience with the local community initially. I do not think that it will ever be possible when introducing such a facility to win over hearts and minds until it is up and running and people can see with their own eyes the difference that it makes.

It is so important for the team in Glasgow to engage with the community, the neighbourhood and the businesses, which they are doing, to keep them up to date with the progress of the facility and, once it is operational, enabling them to have a look in the facility to see what it is like. Sydney was a good example of that. They used to have open mornings—obviously, when people were not in there injecting—so that the community could have a look to see what it actually was, and to dispel a lot of the myths around it.

The team will need to have a really responsive approach. The facility will not immediately reduce all the discarded injecting equipment in the area, but if, for instance, the community has a contact person within the service who can be really proactive in their approach and can respond to any concerns as the facility develops, that will help with the local relationships. The team is doing everything that it can, but it is inevitable that there will be concerns until the facility is up and running.

Pauline McNeill: Thank you very much.

Clare Haughey (Rutherglen) (SNP): I refer members to my entry in the register of members' interests. I hold a bank nurse contract with NHS Greater Glasgow and Clyde, and I recently worked in an alcohol and drug recovery service on a bank shift.

Russell Findlay has already covered much of what I was going to ask on synthetic opioids, which we have known about for some time. Public Health Scotland published a rapid action drug alerts and response—RADAR—alert in January 2023, which was updated in December, and Dundee alcohol and drug partnership noted in its submission an increased risk associated with emergent synthetic opioids. So, what more do we need to do to tackle the issue and get ahead of that danger that is coming towards us?

Dr Fletcher: I will come in on that, as you are citing Dundee ADP evidence.

I highlight the fact that we work in a dynamic landscape. The substances that people take change, and they have changed quite markedly over the past five to 10 years. In the past five years, we have seen the emergence of new psychoactive substances, the threat of fentanyl, increased use of cocaine, benzodiazepine and gabapentanoids, and now, nitazenes. We are absolutely right to be alert to that. Kirsten Horsburgh mentioned drug checking, and that will help in future.

Through our public health function, we monitor local trends closely, using the suspected drug death notifications that we receive from Police Scotland—although I note that there is a significant time lag with the post-mortem and toxicology results at the moment, which creates a concerning challenge for us. We also monitor the near-fatal overdoses, and we meet daily to discuss any such notifications. Although we might not be able to know immediately what the underlying driver of such an event is, we can monitor for any clustering or increasing incidence and convene what is called a problem assessment group or an incident management team, under the public health structure. That is a multiagency forum that enables risk assessment, risk management and risk communication, and we can use that to build up a much clearer, combined understanding of what is happening and of any concerns that we need to be aware of, be it through local intelligence or what people are reporting. It is difficult to get confirmation of the substance that is being used through anecdotal reports, but such reports trigger increased communications and alerts to health and social care providers and education services and enable us to take a much more intensive harm reduction approach as required.

Our general approach is about being vigilant. It is about collaborative working with all agencies and organisations: we have a forum where people feel enabled to raise concerns, to collectively understand what is happening and to provide outreach and support in the communities that are impacted. That is the approach that I would advocate, and that is certainly the one that we are taking locally in regard to preparations for any emerging trends, one of which involves nitazenes.

Clare Haughey: That is all well and good in terms of the agencies, but in terms of families and those who are using the substances, what sort of education and outreach is there to equip them with that information about what is emerging and what the dangers are of those particular substances?

Dr Fletcher: That is done through the range of services that support people, such as the

specialist drug and alcohol recovery services, third sector organisations' services, the specialist harm reduction services that we have, education in schools or policing in the community. We use the forum in which we work to share the understanding of what is happening and to support colleagues to upskill in knowledge about emerging trends and be able to engage with people to have those conversations and to provide support.

Broadly, the harm reduction approaches are common to all drug takers, but we want to make sure that they are alert and aware of potential emerging trends.

Clare Haughey: I will come back to Kirsten Horsburgh in a second, because she might be able to wrap up her answer with her response to my next question.

Dr Fletcher mentioned harm reduction and the use of naloxone. We have seen a decrease in the use of emergency naloxone, and I am keen to hear from our witnesses how they interpret that. Is it a sign that it is not needed as much, or does it indicate that people are not using it because they do not see that they need it or are unable to access it?

Kirsten, can you wrap up both of those questions when you answer?

Kirsten Horsburgh: No problem. I just want to add something about what we should be providing for people who use drugs, and I mentioned the nitazene test strips. We can produce as many alerts as we want about new drugs, but being able to provide somebody with something physical, whether it is something to test their drugs or a naloxone supply, says with actions much better than words that we care about them, and we care about whether they live or die. It really helps to impart that message about risk.

The provision of physical things is important. For instance, we do not have inhalation devices for people who are smoking crack cocaine, so a lot of our services are not equipped to provide people with the equipment that they need to provide alerts; however, it is the actions that are more meaningful.

Naloxone is a good example here—naloxone works on synthetic opioids, so we are encouraging people to carry more than one kit with them. Increasing the supply of naloxone is important. I imagine that the figures that you quoted there are from the Ambulance Service. Reduction in administrations through the Ambulance Service maybe hints towards more use by laypeople, although that data is not collected as comprehensively. We have police administering naloxone, and we have members of the public—community members, people who use drugs and their families—all administering naloxone, and those figures are not collected as routinely as they are for the Ambulance Service. Therefore, I imagine that those numbers could potentially be added.

Justina Murray: I am happy to give some evidence about our click-and-deliver naloxone service. Since it was established in May 2020, we have issued almost 16,000 naloxone kits across Scotland. They are used by a wide variety of people, including people at risk who overdose, families, professionals and members of the public. The latest statistics show that we issued pretty much the same number of kits—just over 5,000—in the previous financial year and the year before. In the previous financial year, 36 per cent of those kits went to members of the public.

It is a fantastic development that people are happy to carry naloxone, and that they realise that they have the potential to save a life, just as with any other first aid intervention.

I will also comment on the synthetic opioids issue. There is always a risk that it becomes a new shiny thing that distracts from what we should already be doing. I am reinforcing what Kirsten Horsburgh is saying here: we should not be doing too much that is different from what we should already be doing around harm reduction. I am slightly anxious that there will be an over-emphasis on the impact of synthetic opioids when this year's drug-related deaths statistics come out. Almost 10,000 people have died through drugs in Scotland over the past decade, before synthetic opioids were really around.

We should be doing all of those harm reduction measures anyway. We know that synthetics are right through the supply, and families often do not know what their loved ones are taking anyway. If people themselves do not know what they are taking, families will definitely not know. We are pushing out the information that we can, but we need to double down on the harm-reduction measures instead of moving at the slightly glacial pace of change that we are experiencing just now.

Clare Haughey: Thank you.

The Convener: Before I bring in our next member, I will pick up on the points that you were making, Dr Fletcher, about feedback on toxicology, given the issues that we are facing at the moment around the timescales for post-mortems. You articulated that in some detail, but I am interested to know what timescale we are looking at. Is it weeks, or longer?

Dr Fletcher: My understanding is that it is months, but I would need to check with my colleagues what the current state is. It is certainly impeding our intelligence and understanding of the underlying causes from a substance perspective,

and it is also impacting the families affected, which is really sad and devastating to see.

The Convener: I am not an expert in toxicology, but are there options available that can provide some early feedback while we are waiting for the fuller toxicology work to be done? Is there something that can be provided by way of an early indication?

10:45

Dr Fletcher: My understanding is that the only early indication is through what people have reported that the person has understood that they have taken, but that often does not replicate what is in the substances. Again, my colleagues on either side of me might know more about this, but toxicology is a national contract, so there is very little that we can do. My understanding is that the contract is through the Crown Office and Procurator Fiscal Service, so there is nothing that we can do to impact that or get an earlier understanding.

The Convener: Do you want to come in on that, Kirsten or Justina?

Justina Murray: It is an example of how much the system is focused on people who have died in overdose situations. What about everybody else? We know that we could be doing a lot more around improving people's quality of life and reducing harm when they are still alive. That also applies to the number of meetings and the amount of effort and funding that goes into responding to overdose and death—"Let us wait until someone has died, then we will find out what they were taking."

I understand that there is a small project in Glasgow that tests after someone has had a non-fatal overdose, but that is academic, and those results are not shared with the individual or their family—it is just to find out what is happening in the drugs market.

We already know that people are using very toxic combinations of drugs—we do not need toxicology reports to tell us that. It feels like that bit of the system is focused on the situation after the fact as opposed to focusing on everything around prevention and early intervention, which we talk about doing through that public health approach all the time.

The Convener: That is really interesting. I am aware that work is under way to address the wider challenge of access to pathology services in Scotland, and we will be looking at that closely.

Paul O'Kane (West Scotland) (Lab): Good morning to the panel. The committee has been interested in the progress of the MAT standards and has sought to scrutinise and track them. It is fair to say that the most recent benchmarking data that we have from Public Health Scotland found implementation to be patchy, and there has been slippage in the timescales for full delivery in community and justice settings, with 66 per cent of standards 1 to 5 being fully implemented and 88 per cent of standards 6 to 10 being partially implemented.

We are keen to get a sense of where the barriers are. We have read in written submissions about the challenges around what has been described as "a postcode lottery" and around some infrastructure not being in place. Does Dr Fletcher want to reflect on progress and on her views on the barriers to full implementation?

Dr Fletcher: The MAT standards have been very helpful in driving change. In Dundee, we have made considerable progress, and we have recently submitted our evidence for the latest benchmarking. We have received encouraging informal feedback, which has been welcome.

There are limitations to the MAT standards. They are very opioid focused, and, as I have described, we work in an environment that involves polysubstance use. On work going forward, my understanding is that there is consideration of broadening the MAT standards, which would be welcome, but we would be keen to be involved in the discussions about how we can nationally influence and drive them forward for the greatest benefit and impact.

The resource that has been attached to the MAT standards has been welcome and helpful. If you look at how we spend our public sector pound, particularly in health, you will see that supporting people with drug and alcohol issues is relatively underresourced compared with spending on other health conditions. We have a degree of apprehension going forward. Should the resource that has been allocated to support the implementation of MAT not be continued, that would pose considerable risks in a number of areas. However, broadly, the MAT standards have been helpful in driving forward change locally.

Paul O'Kane: Now that we have made progress on the infrastructure in place, are you concerned that on-going resourcing might become the more substantive issue?

Dr Fletcher: Absolutely. We have a number of fixed-term posts and we have been able to take forward work as a result of MAT funding. If we were not to have confirmation of that for the future, that would be a significant risk to the continuity of delivery of that work.

Kirsten Horsburgh: I agree that there has been significant change in the way that services are provided because of the MAT standards. However, service provision is far from perfect, and

services are also missing the boat when it comes to people's changing drug use.

Emma Fletcher mentioned the focus on opioids. We hear from a lot of people that they are not attending services because, although they use opiates, they also use crack cocaine, cocaine, benzos, gabapentinoids and everything else, and they know that those needs will not be met. They do not see the point of attending treatment services to have one small part of their drug use looked at with the whole picture not being addressed.

We definitely need to look at what our prescribing services offer people. Benzodiazepine prescribing is very limited, and no pharmaceutical equivalent is being provided for cocaine use, which is becoming extremely problematic and has contributed to many more deaths in the past years. All of that needs to be addressed.

Recent research shows that the population of people who are experiencing problem drug use is static, but that research also heavily indicates that, although the number of people who experience problem drug use has not risen, the risk factors for that population absolutely have. We are just not meeting the needs in the way that we should be.

Recent research has also highlighted that treatment is absolutely a protective factor. We always have to repeat the message that treatment is protective, but not without the wraparound interventions that are required.

Paul O'Kane: Do you recognise that there is a significant challenge in those additional services that are tangential to the work of delivering the MAT standards, such as social work, advice on rights and all the support that sits around that? I take from your answer that we need to take a holistic look at service delivery.

Kirsten Horsburgh: Yes, absolutely—and there needs to be much better education for people about their options before they even approach a treatment service. That is where we get into issues with same-day prescribing. A same-day service does not mean a person approaching a service one day and, on the same day, getting an appointment for a week's time. It means a person approaching the service knowing what they want and being provided with it on the day that they appear.

A lot of people attend the services, and we hear from the services that they explain the choices to them, which takes time. We need to get better at taking a whole-systems approach and ensuring that people know what is available to them and what they can access so that same-day prescribing works a bit better. However, there are still major issues with implementation.

The other thing that we heard recently was that some areas are saying that they feel that they have met the needs of everybody in their area who is experiencing opiate use, but we hear something very different from the people who use drugs in those localities for the reasons that I mentioned earlier about their not feeling that the services will meet their needs.

Paul O'Kane: Does there need to be a better way to capture and measure that lived experience and what those people are telling you?

Kirsten Horsburgh: There have been some really good examples of that. Experiential data is collected as part of the MAT standards work. We have been involved in some of that through the Scottish Drugs Forum. We have done an observational study with participants over a six-month period, and we have also supported some of the ADPs with their experiential work.

You have to hear about the reality from people if you are to improve your service. It is difficult to hear about the things that are not going well but, unless we get to the truth of what is happening for people, nothing will ever change.

Justina Murray: It has been great to hear about people using the MAT standards. Individuals and family members have gone into services brandishing them and claiming their rights. That has been very positive.

I think that that has also given permission to staff to work in a different way. When I asked my team for examples earlier this week, one person shared an example involving MAT standard 3 and assertive outreach. A woman had gone missing and things were looking very grim but, through partnership working involving the family, family support and the treatment service, there was real, assertive outreach, and the woman was located. They were able to keep her safe and link her back into treatment. That kind of permission to work in a certain way has been very positive.

The less positive side is what you do if the standards are not upheld. We do not really want people to have to go through formal complaints processes, legal challenges and so on, so that side of things definitely needs to be improved. Otherwise, I support what the others have said about work in progress.

Paul O'Kane: Do you feel that the engagement of the third sector as a valued partner is working well in terms of the services having parity of esteem and those important professional conversations happening?

Justina Murray: The third sector is definitely not in that place of parity of esteem, although the situation is patchy by postcode. However, there has definitely been more opportunity to work

alongside treatment services. The examples that I have have depended on families connecting with family support services to connect with the MAT standards. I am not so sighted on how much families have been able to link in without the facilitation of family support services.

Paul O'Kane: Okay. If I can briefly—

The Convener: Can I come back to you if there is time at the end?

Paul O'Kane: Yes, of course. Thank you, convener.

The Convener: A few members still have to come in. I will bring in Roz McCall and then Sandesh Gulhane.

Roz McCall (Mid Scotland and Fife) (Con): Good morning. The session has been very interesting so far. Thank you for that.

Earlier on, there were comments about stigma and the issues that it is causing, especially when it comes to people moving forward and seeking the support that is already there. Development of a national stigma action plan was one recommendation, and a rapid implementation of that plan was requested. The two important words for me there are "rapid" and "action".

I am interested, especially in light of the earlier submissions, in how that is going. I am interested in your views on the progress on the action plan so far. How effective has the action been? Is it working? What more has to be done? Would you say that what is being done is rapid?

I will put Kirsten Horsburgh on the spot first, if that is okay.

Kirsten Horsburgh: First, I think that the work of the national collaborative has been excellent in getting together a change team to produce a charter of rights. That has included people with lived and living experience, family members and others, and the process has been very inclusive.

I must admit that I am slightly confused about how the stigma action plan fits with that piece of work. I do not think that what has been done has been rapid or that there has been much implementation around a stigma action plan yet. I am still unclear—even though this has been presented to me, so maybe it is just me—about the links between the stigma action plan, the collaborative and all the other groups that we have started to see being developed. For example, there is a group on women and substance use that is also looking at stigma. That feels disconnected, and the concern with the disconnect is that there will not be any clout to that.

That is as much as I have to add on that.

Roz McCall: That is brilliant. Thank you. I like a short, succinct answer, especially when I ask four questions in a oner.

Dr Fletcher: Stigma is incredibly challenging. My reflection is about what drives it and why it arises. It results from a lack of compassion, a lack of understanding, ignorance and underconfidence. In an alcohol and drugs partnership, people are very alert to the impact of stigma, and they can help by being leaders across the area and the locality on how stigma should be tackled. We ran a local language matters campaign to raise awareness of stigma and, as I have described, stigma has been a focus of our work through the local community planning partnerships.

It is also about how we provide staff and people who work with and support families and people who are impacted by substance use with the confidence to be able to engage in those discussions and to signpost to advice. A focus of our work going forward is how to expand that much more widely outside the alcohol and drugs partnership.

11:00

Roz McCall: Does the information from the Scottish Government—whose action plan it is—meet what you are doing? Does it dovetail properly, or is it just not hitting the mark?

Dr Fletcher: We are cognisant of it, and we build it into our delivery framework.

Roz McCall: Last, but by no means least, I invite Justina Murray to answer.

Justina Murray: It would be a bit of a stretch to say that action has been rapid and that there has been too much of it, but what is positive is that there is talk in the new stigma action plan about some kind of accredited scheme for services.

At the time of the Drug Deaths Taskforce, a stigma charter was proposed. Families asked how that would work. For example, if a service was discriminatory and disparaging but had the stigma charter posted up, what could they do? We were told that it was not really about that—it was literally about the optics, I think—so families withdrew from that process. It is more positive now that there will be a more robust accreditation scheme that services can work towards.

One of the broader issues around stigma is the way that we keep othering the issue of drug harm. We act as though we are talking about somebody else. I am conscious that there are people in this room—and definitely in this building—who have experienced drug harms either through their own use or that of someone else. The issue involves our families, our friends, our colleagues and our

communities, but we think about drugs as being everywhere else.

The main way in which we can tackle stigma is by being more open and having more of a national conversation about what is happening with drugs in our families and communities. It is so hard to do that just now because, I reflect again, we are not really in that public health space. It is definitely a criminal justice space; it is all about individual behaviour and deviancy. That is the way in which drugs are seen in Scotland, and that does not help to tackle stigma.

Roz McCall: The question that I asked was about what more we can do to shine a light on that and start to discuss it more.

Justina Murray: We should be a little cautious about some of the public campaigns. I was not a fan of the previous one, which I called "the weeping lady campaign". There was quite a negative view of somebody who was using drugs or in recovery. There are so many more positive views and positive images that we could show of people using drugs safely or being in recovery. We should be more generous with that kind of imagery rather than using the sad and weeping kind. The last public advert on stigma had a very negative vibe.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising NHS general practitioner.

Dr Fletcher, at the start of the meeting, I think that you said that funding was not an issue.

Justina Murray: That was me.

Sandesh Gulhane: Sorry, Justina. I will put the question to you. Two thirds of ADPs report insufficient funds to implement the MAT standards and half report insufficient funds for residential rehab. Glasgow's health and social care partnership has made significant cuts in rehab and in services for children who live with drug users. That is stark and very worrying.

Justina Murray: My sense is that resources have always been the go-to explanation for why things are not implemented. Through the national drugs mission, £250 million of additional resource has been released into the system. As I have said, most of that money has gone to NHS boards for NHS-led services.

As a CEO of a charity, I will never say, "Oh, there's loads and loads of money in the third sector. We feel sorry for the statutory sector." We in the third sector are very much living on the edge, financially, and we are supposed to be working together in the system. A lot of NHS services are having issues with recruiting and retaining staff. Sometimes, the NHS route may be the most expensive way of doing things. We need to redesign and rebuild the whole system. I am not confident that we do not have enough resource in the system; I just do not think that it is all in the right place.

Sandesh Gulhane: More money going into the third sector would be a good way of doing that.

Justina Murray: It is obvious that I would say so.

Sandesh Gulhane: That is something that I would firmly support.

I turn to you, Dr Fletcher. With that stark outlook, how will we improve rehabilitation services?

Dr Fletcher: I have my doctor hat on in answering this question. Within our health service, we are weighted towards funding treatment of health conditions that have more of an impact on people living in least deprivation. That is according to the research that we have conducted to date, which involved strong, evidence-based, randomised control trials. The difficulty, through a public health approach, lies in being able to evidence the impact of housing and education to the same degree. We are in a position whereby, as a collective, a population and a society, we need to think carefully about how we spend our money.

For premature mortality in Tayside, the number of people living in greatest deprivation who die before the age of 75 is twice that of those living in least deprivation. The drivers of that are drugs, alcohol and mental health challenges. However, if we were to examine the spend on healthcare services across all health conditions, we would see that it is starkly weighted towards health conditions that are experienced to a greater extent in areas of least deprivation. There is a huge question for us, as a society and as a medical profession, as to where we may best direct our resource, how that is evidenced and how that evidence drives how we spend our money.

Sandesh Gulhane: You are of course right, with the new GP contract rewarding those in better-off areas, with more money going there.

I want to focus on rehab. I visited Rainbow house in Glasgow, which is a residential rehab programme that offers peer support through volunteers. I spoke to three of the peer-support volunteers. It was a fantastic experience. The volunteers were very clear on what they wanted me to raise and discuss: it was to ensure that people who ask for help get it in the way that they ask for it and in a timely manner. They said that peer support is the best way of getting through to people.

I have another example from when I visited an innovative, award-winning Glasgow rehab facility.

The person who works there as the only real employee is a former user who now does community outreach. He has seen a huge drop in the number of people using drugs. His funding has been cut, however. Those at Rainbow house are worried about their funding, too. How can we get people to stop consuming drugs if we are not funding rehab?

Dr Fletcher: That reflects all the discussions that we have had during this session so far about the importance of that holistic, wraparound support. Recovery is a priority focus for us at the Dundee alcohol and drug partnership, and it is something that we are continuing to progress. That comes back to what we have described in relation to housing, employment and the family approach. We are collectively taking all that action to make a difference for the people in our communities who are impacted.

Sandesh Gulhane: Should we not be funding rehab more?

Justina Murray: If I may jump in here, I do not think that Scotland's drugs policy is to stop people using drugs. We need to differentiate between drug use and drug harm. In Scotland, lots of people use drugs and lots of people use alcohol. It is in relation to harm that we really need to get involved. Scotland's drugs policy is about reducing harm and drug deaths.

Rehab is a fantastic option for people for whom it works. About £100 million of the national drugs mission has been put towards rehab, so there should not be a shortage of money. Whether the funding is getting down to the rehab facilities is a different question, I suppose.

Rehab should not be the only option, however. Sometimes we have an unconscious bias towards thinking that abstinent recovery is what everybody needs to get to, and that that is the pinnacle. For some people, however, that is not their choice and it is not what they want, and that is damaging implementation, because that is seen as the gold standard. For a lot of people, it is not a reality.

Sandesh Gulhane: So, rehab is damaging—

Justina Murray: If you want to become abstinent, and the rehab model works for you, it will work. A lot of the big voices in Scottish drugs policy are those of people who have had very successful outcomes from being in rehab. However, I do not think that our whole policy should be moved towards abstinent recovery. That is just not the reality for people, and we need to focus more on reducing harm and being person centred. For some, their recovery might be more to do with their quality of life, their being safe in their drug use and their not being so at risk of overdose.

Sandesh Gulhane: This will be my last question, convener. We all talk about drug deaths, but illicit drug consumption has significant health harms; even if you were to take a drug just once, you could have experience of a significant health harm. So far, all of our questions to the panel have focused on everything else apart from rehab, which is why I am focusing on that now. What people have told me about it is clear. Dr Fletcher, do you think that we should be spending more money on rehab, given the amount of cuts that are coming from the Glasgow HSCP and given that half of ADPs have reported insufficient funds for residential rehab?

Dr Fletcher: I refer you to my previous answer about our resourcing the health system and the public sector to support people who are living in greatest deprivation. That area presents huge challenges, otherwise we would not be here today. All the elements are important, and rehab is part of it.

Collette Stevenson (East Kilbride) (SNP): Good morning, and apologies for being late.

I want to ask about the drug-checking pilot projects that have been rolled out in each of your areas; indeed, I understand that the areas involved are Glasgow, Dundee and Aberdeen. Dr Fletcher, can you provide an update on the introduction of the pilots? Have you found or encountered any particular issues or problems?

Dr Fletcher: The Dundee drug-checking pilot has been taken forward by one of our third sector partners in the partnership—Hillcrest—and is supported by the alcohol and drugs partnership. It is fair to say that the work has been quite extensive and, indeed, resource intensive with regard to preparing the applications, doing the preparatory work and giving consideration to the logistics, which are quite complex. I am thinking, for example, of the mechanics of transporting a substance for testing.

The team has had a lot to work through, and they have also been working closely with the other pilot sites to share learning and the best solutions for advancing this work. I can tell you that the application went in at the end of last month.

Collette Stevenson: When will you get the outcome of the application for the licence?

Dr Fletcher: I do not know. I am afraid that that is outwith my control.

Collette Stevenson: Thank you. Perhaps I can bring Justina Murray and Kirsten Horsburgh in on this question.

Justina Murray: I do not have a lot to add. I know that families are supportive of drug checking, and that the Scottish drug-checking project found that people who would use such a facility or

service definitely supported third sector delivery as the model that they wanted, because it was seen as very accessible, non-stigmatising and so on. I am looking forward to seeing how the pilots develop.

Kirsten Horsburgh: I would say that, as with the drug consumption facilities, having only three static sites for drug checking will not be enough for the whole of Scotland. In other countries that have developed this approach in a really good and significant way, mobile testing devices have been used that can be taken into, say, services to provide drop-ins for people, people's homes and so on. Indeed, people have been provided with their own testing kits. It is great to see this work progressing, but it is just too slow and it is not enough.

Collette Stevenson: How have you found the practicalities of it, such as enticing people to use the service?

11:15

Dr Fletcher: In our pilot, we are embedding the provision within a service that already provides harm reduction advice. That was a purposeful choice, so that we can offer drug checking as part of a wider harm reduction approach.

Kirsten Horsburgh: We have been providing WEDINOS bags to people who attend our living experience engagement groups. WEDINOS is the Welsh drug-checking service, which accepts samples from anywhere in the UK. We encourage participants in that forum to send off their own samples, and they are engaging with that really well. There is a desire among people to know what is actually in their substances. We want to give people a bit more autonomy around their drug use, and that has been proven to work so far.

Collette Stevenson: I go back to Justina Murray. Are the kits available to most third sector organisations?

Justina Murray: The drug-testing kits?

Collette Stevenson: Yes.

Justina Murray: No. The only developments in the projects that I have heard about are the three that you mentioned. You talked about nitazene strips; I know that the family support service in South Lanarkshire is now stocking those. Currently, we are issuing naloxone kits, and we have not yet had a conversation about what to do next, but I am mindful of what you said about using it as an engagement tool in order to have a conversation with people along the lines of, "We care about your wellbeing, and here's something that could help."

Collette Stevenson: That is helpful—thank you.

The Convener: Paul Sweeney wants to come in with a supplementary, and then I will bring Paul O'Kane back in.

Paul Sweeney: I have a quick question on WEDINOS. It is a great service, but it is effectively a correspondence service. Is there an opportunity with the overdose prevention pilot in Glasgow to set up a co-located facility that could rapidly screen the types of drugs that are circulating in Glasgow, for example, and that would be able to provide an early alert on unsafe substances?

Kirsten Horsburgh: My understanding is that a drug-checking service will be incorporated as part of the facility going forward, if the licence for that is approved. That would obviously be an ideal location for it. With WEDINOS, as you said, people have to wait a few days, or whatever it is, to get the results. There is not the immediacy that we would get from a proper roll-out of drug checking, when people would get their results in 20 minutes with some advice attached to that. That would be the ideal scenario.

Paul O'Kane: My final question in the context of the MAT standards is about the timescale that the minister has offered, which is April 2025 for full implementation. Given the challenges and opportunities that you outlined, are we essentially on track to have meaningful delivery by that date? I know that it is hard to say, but it would be good to get a view, because we have the minister before the committee in the next session.

Justina Murray: We would not really know. On implementation, we know what ADPs are reporting and what has been reported back. I heard a story from my staff this week about somebody trying to get a prescription from the chemist for an opiate substitute therapy. They had an overdose and went into hospital. They came out on the Monday, and they were told to go to the chemist on the Wednesday to pick up what they needed, but it was not available. They went to the chemist again on the Thursday and then on the Friday, but it was still not available, and there was no explanation or urgency about it. On the Saturday, they decided to use street heroin again, because they could not access what they needed. They survived that experience, but it took place in the context of the MAT standards being implemented.

To go back to the system, we need all bits of the system to treat the issue with the urgency that it deserves. I genuinely feel that if someone had been in a pharmacy looking for a heart or diabetes medication, there would have been much more urgency about getting that and recognising that it is actually life saving. However, not everybody is on board with the MAT standards yet. I agree with Kirsten Horsburgh that it is good to see progress, but it is too slow and there is not enough of it. The year 2025 was mentioned, but when families tell

us that progress is happening, I will believe that it is.

Dr Fletcher: From our perspective, we have seen significant progress, and we hope that that is reflected in the 2024 benchmarking report that is due out in summer. We will not definitely know whether that is the case. However, regardless of that, MAT is only one part of the system. As we have described, we are very aware that, although we have made significant progress, there is still a huge amount of work and improvements that we are really keen and committed to drive forward locally.

The Convener: Kirsten Horsburgh can have the final word.

Kirsten Horsburgh: I have one quick sentence on that: I agree with everything that has been said, but we need to broaden our horizons in terms of the substances that we are addressing through the MAT standards.

On the previous question, about parity with the third sector, we really should have prescribing services available within the third sector services that we have, so that people have a choice of location as to where they get their prescribing. I think that we would see a dramatic improvement in the implementation of the MAT standards if we took that approach.

The Convener: That brings us neatly up to time. I thank you all for joining us this morning; it has been a really helpful update. We will have a short suspension to allow for a changeover of witnesses.

11:20

Meeting suspended.

11:25

On resuming—

The Convener: I welcome our second panel of witnesses: Christina McKelvie, who is the Minister for Drugs and Alcohol Policy—congratulations on your new role—Michael Crook, who is head of the harm reduction team, and Alison Crockett, who is unit head of the whole systems unit in the drugs policy division, both at the Scottish Government; and Dr Saket Priyadarshi, who is associate medical director of the Glasgow alcohol and drug recovery services. A warm welcome to you all.

I ask the minister to make some brief opening remarks.

The Minister for Drugs and Alcohol Policy (Christina McKelvie): Thanks very much, convener, and good morning, colleagues. Thank you for having me along to your committee and giving me the opportunity to update you on work that is under way through our national mission to reduce the number of drug related deaths and harms.

I have been in post now for nearly three months, so I am not quite new, convener. I thank my predecessors for laying a solid foundation on which I am able to build, and thank all the people working in the sector across Scotland. I have had the privilege and pleasure of meeting many of them over the past few weeks.

Since taking on the portfolio, I have made clear my commitment on continuing our national mission, following the evidence of what works to reduce the number of drug deaths while ensuring that we are providing a full range of treatment options, so that individuals are able to obtain support wherever they are with their substance use and recovery journey.

I have been clear in my desire to approach the matter in a cross-party and cross-United Kingdom manner. Problem substance use has no respect for borders, and, with some of the challenges that we face, along with the new threats related to synthetic opioids, it is vital that we work together to tackle all of those.

In the short time that I have been in post, I have met a range of stakeholders and people who are directly affected by substance use—those using substances, their families and friends and people who generally just love them. I have heard and learned a lot about the issues that most impact all of their lives.

Recently, I had a visit to the Bothy in Craigmillar—one of the first visits that I made in Edinburgh—to hear from peer mentors about the work that they are doing in that community to support people, which is incredibly inspirational. When communities, particularly recovery communities and others, come together with local and national organisations and the statutory sector, you can see real change and hope for people in their lives. What really touched me that day was the hope. Peer mentors who live, work and support people in those communities have lived experience. One of the people who is using that service said to me that, when they take the big step to walk through the door, it is really helpful that somebody on the other side is saying, “I understand. I know where you are. I’ve been there.” That is incredibly powerful.

The other part of that is about how we engage with and support the workforce. I was really pleased to be in the Glasgow city chambers the other week at the graduation ceremony for the people who were undertaking the addiction worker training, which will now be renamed as a national traineeship. The hope, joy, dedication and

commitment, and the opportunity for those people to go into the workforce and support the work that we need to do, was very clear on that day. I was sad to leave—I had to come back to the Parliament to vote—but it was a joy to be in the room with so many people who had taken their experience and turned it into a qualification and will now use that to be in the workforce. Just to see how proud their families were was absolutely amazing.

It is clear that the national mission has changed how we think about these issues and how we respond to them, which is not least due to the work of the many partners who are driving this forward, including those whom you have just heard from earlier today. I managed to catch some of the brilliant evidence that the previous witnesses gave you on the work that they are doing and the challenges that they give me, as a Government minister, to do more and better. The change is also due to the work of Dr Priyadarshi, who is beside me today and who is a real champion for this work. You will be very privileged and honoured to hear his evidence today, too.

11:30

Nevertheless, after welcoming the reduction last year, we have seen a rise in suspected drug-related death figures, and I do not take any of that unseriously; I take it very seriously. That is coupled with the very real threat that we are now seeing of new substances and behaviours. It is vital that my focus remains on delivering what the evidence says works and making sure that it has the effect that, I think, we all want.

I will finish there, convener, because I know that you have a lot of questions. I and, no doubt, Dr Priyadarshi will be happy to answer your questions. Thank you very much for having me along.

The Convener: Thank you, minister—that is helpful.

We had an interesting session with panel 1 earlier this morning. We will begin, as we began with our earlier witnesses, with today's reporting on the increase in the number of recorded suspected drug deaths and the noticeable decrease in the number of hospital admissions. We looked at the causes behind those two changes. I ask for your reflections on the figures and where we go from here.

Christina McKelvie: The quarterly figures are incredibly important for us as they allow us to see emerging trends and issues. We will not have the full picture until we get the National Records of Scotland data in the summer. I need to give a caveat around the RADAR figures and the police figures—we will not know until the summer what has been in the system and what is contributing to the rise that we are seeing.

One thing that we are recognising right across the UK—I met minister Chris Philp just the other week—is the issue of what else is coming into the supply chain now. People are involved in poly drug use. The Home Office told us that, in maybe six to nine months, heroin will run out. It is now being supplemented by synthetic opioids and benzodiazepines, and people are shifting to injecting cocaine. It is a very complex environment, particularly with some of the data on poly drug use and contributing factors.

Public Health Scotland is looking at all that. When we have drug-checking facilities in place, we hope to get to a position in which we have live data that will allow us to respond more quickly so that, when an incident arises, we can get in there and pivot services to support people in the appropriate way to reduce harm and the number of drugs deaths.

Every single one of those people who dies is someone who is loved. It might be your neighbour, your friend or one of your family members. We should never forget that every single one of those deaths is someone who is grieved and loved. That is certainly the attitude that I take. My condolences go to anybody who has lost anybody whom they have loved.

This is a really serious and complex issue. We need to understand what is happening so that we can engage the services and reduce harm and, therefore, the number of deaths.

The Convener: Dr Priyadarshi, do you have any comments on the latest statistics that have been in the media today?

Dr Saket Priyadarshi (NHS Greater Glasgow and Clyde): I do not really have a huge amount to add to what the minister said in her introduction and her response to that question. However, from a Glasgow perspective, we know that, unfortunately, after a very significant confirmed reduction in 2022, we are likely to see an increase in drug-related death figures for the city in 2023, based on the suspected drug-related death police data. As the minister said, understanding that will take some time, because of the dynamic nature of the drugs market and the drug trends in Scotland at the moment. However, I will mention some of the obvious headlines that we are seeing.

The profile of people who are dying from drug-related causes remains similar to that in previous years. Most of the drugs involved in polysubstance use remain the same but, from forensic toxicology, we have unfortunately seen a change in the benzodiazepines that are coming through. You heard in the previous evidence session about the delays in forensic toxicology, which mean that

intelligence comes to us months down the line, unfortunately. We have seen a change in the benzodiazepine profile from etizolam to bromazolam, which we think might be a contributor as part of polysubstance use.

The trends in drug-related deaths and hospital admissions tend to mirror each other up and down the way. If there has been a separation in that trend—I would need to examine the data a bit more closely—that is something different and would take a degree of analysis to understand.

The Convener: I will come back to the minister quickly before I open up questions to members. In the previous evidence session, there were questions about stigma, which introduced discussion about the charter of rights for people who are affected by substance use. I was interested to read about the charter work, which was highlighted in one of the written submissions. I would like to hear a wee bit more about the work that is going on to develop the charter. What are the objectives for that work?

Christina McKelvie: I will just make a final point on the previous question. One piece of work that we are doing is to roll out naloxone kits. I think that about seven out of 10 people who are identified by services as being most at risk are now carrying naloxone kits. That is a clear intervention and a way in which we can reduce harm and the number of deaths. That is just an additional point to the points that I made earlier.

The amount of stigma that has been directed to anyone who has a substance dependency and to their families and communities is not unknown to any of us. That stigma is a real barrier for people seeking support. The national mission was tasked with looking at how we can change the situation on stigma and discrimination. It is not difficult to understand where that comes from, given that a reservation in the Equality Act 2010 means that a certain group of people do not have the same rights as anybody else. We would like to change that.

The stigma in systems and communities and among people has been signposted to us as a huge barrier for anybody accessing services. That gets nuanced when we are talking about people from specific communities or people who have caring responsibilities. For instance, it is very difficult for mums to take that step over the threshold and ask for help, because of the stigma and the fear that they would lose their children, too.

Professor Alan Miller was tasked with coming up with a charter of rights, which is now in draft form and is being consulted on by the excellent organisations that have sat round the table to develop it. On Friday morning, I was at the Health and Social Care Alliance Scotland headquarters in Glasgow with the change group, which is a group of people who are delivering front-line services with organisations such as the ones that you heard from this morning as well as people with lived and living experience. They are sitting at the table working on what a charter of rights should look like.

As I say, the charter is in draft form and is out for consultation, and we hope to bring it forward. That is a bit of the foundation for the bigger human rights framework bill that we want to introduce. If we change the attitude to stigma and shift the issue clearly into a public health rights arena, that changes the complexion of all of it. It will mean that people with a substance dependency will have the same rights and deserve the same parity of health esteem as anybody else. It is an incredibly important piece of work to change that cultural attitude.

The Convener: Russell, am I right that you would like to ask a supplementary question on stigma?

Russell Findlay: Yes, that would be helpful, thank you.

A Scottish Drug Deaths Taskforce report from 2020 described abstinence as

"a notion based in stigma".

Is there a risk that rejecting an abstinence or recovery-based approach because it could be seen as stigmatising will actually make things worse for those who want to be drug free?

Christina McKelvie: That is an excellent question. We, as the Scottish Government, think that we need a range of services that suit individuals' needs, whether the need is for abstinence, medicated managed services, stabilisation services, detox in the community, detox in a unit or other recovery interventions. We need all those services in order to offer a truly person-centred approach to a recovery pathway that works for each person.

Russell Findlay: There seems to be a perception that there is a significant fault line between those who believe in a harm reduction model and those who believe in abstinence and recovery. I know that it is not necessarily either/or, as you just said, but there appears to be a very strong perception among some people that the Government should do much more to support recovery. Do you have any views on the spending, how the money is spent and whether more money should be put into recovery?

Christina McKelvie: You will not be surprised to hear that the Government is pulled in all different directions because different people have different ideas on the best way to do things. I am

taking my lead from the people whom I have met very recently—people who either are in recovery or have just finished recovery. Yesterday, at Abbeycare Scotland, I met all those groups of people plus people who have completed their recovery and are now volunteering in the service. They all say that they had tried this or that approach and that it had not worked for them and then this approach did. Then, I hear from people in other recovery pathways that are not based on abstinence—it might just be stabilisation, for example—and they say, "I needed to be stable first to get everything else in my life sorted out to allow me to think about the pathway to abstinence."

If we truly want to take a person-centred approach, we need to take account of all those views, and we need to provide all the services for the people who are telling me what works for them.

Russell Findlay: May I move on to something else, convener?

The Convener: I think that Roz McCall has another supplementary question first.

Roz McCall: Yes, I have another question on stigma. I know that this was prior to your being in post, minister, but, during the evidence that the committee took at the previous joint evidence session, the then minister said:

"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."—[*Official Report*, *Criminal Justice Committee, Health, Social Care and Sport Committee, and Social Justice and Social Security Committee (Joint Meeting)*, 2 November 2023; c6.]

Of course, recommendation 10 of the task force was to produce a stigma action plan and to rapidly put that into force. The earlier panel of witnesses gave evidence that there is a bit of a disconnect and unclear communication, that the process is certainly not rapid and that stigma is still a strong factor in preventing people from moving forward to get the support that is available and that they need.

Therefore, can you update us on where the action plan on stigma is moving and how quickly it will be in place? Will you put some meat on the bones rather than saying that it is out for consultation? Can we have a little bit more information, please?

Christina McKelvie: Yes. I can write to the committee with a much more detailed report on where we are with the stigma plan and the work that is being done. I do not disagree with some of your points. We all want that work to have been done yesterday, and, if we had tackled stigma a long time ago, we would not be where we are now with regard to some of the ways that we approach people who have a dependency. That is the case generally in the UK and globally.

Another point is that the people with lived and living experience whom I met on Saturday morning—I met a group of people in Edinburgh who are working on that particular piece of work—and the change group that I met on Friday want the action plan to be right. It is very hard to take a human rights-based approach to participation and co-production if we say, "We need to get this done by four weeks on Friday." That just has not worked for that group of people. They need some time to work through all this.

That does not answer your questions so far, but we met only this weekend, so let me provide in writing a much clearer update and timeline with regard to where we are. I can say that the people whom I spoke to on Saturday want us to get this right. They want massive change—it is massive cultural change that we are talking about—at every level of public service and in all the services that they come into contact with.

11:45

That is not an answer to the question of how fast and how far we have progressed, but there is a draft charter now, which I think is marked progress, and I can ensure that we share that with you if you want to see the draft work. Professor Alan Miller, who is leading the work and is well known for being a driver for change, would no doubt be happy to speak to you, too.

Roz McCall: I appreciate the answer, minister. I know that I put you on the spot a little bit there, and I am sure that you will have an update for me when I return to the issue at our next meeting.

Pauline McNeill: Good morning, minister. Could you expand on what you said about the human rights framework and say what you meant when you talked about parity of health esteem? I have some knowledge of alcohol addiction, and I would say that the issue goes beyond simply stigma, with the NHS, for example, not being keen to admit people who are desperate to get some help but who are still drinking—unless, of course, they have experienced something serious, such as a cardiac arrest. Is that what you meant by parity of health esteem, or did you mean something else?

Christina McKelvie: That is what I meant, along with the fact that the way in which the reservations in the Equality Act 2010 are worded means that anybody who has an alcohol or drugs dependency that has not come about as a result of a medical intervention does not have the same rights as everybody else—they are carved out as being reserved—and public authorities, health boards and other systems have approached the

issue from that perspective. That is the foundation of the discrimination, and it should change.

That approach has created systematic discrimination that has resulted in people feeling that they cannot get the actions or access the services that they need. One of the reasons for driving up the MAT standards was to tackle some of that, as well as the issue of people feeling that they have been passed from pillar to post because they have been told that they have to sort out their drug dependency before their alcohol issues can be addressed, or sort out their mental health issues before their alcohol dependency can be addressed. We want to make sure that a joined-up approach is taken to people's treatment.

There is a foundational structural inequality in everything that we do in Scotland and the UK, based on that reservation, and that has an impact on how the services are delivered. That needs to change.

Pauline McNeill: That is helpful. From one point of view, we can understand why clinicians in an A and E department would not admit someone who has an alcohol or drugs problem, even though they are desperate to get off alcohol or drugs, because they think that another service should be dealing with that issue. However, the problem is that people cannot just ring up a service and ask for a rehab bed. There seems to be a long gap between someone calling for help and their actually getting help.

Christina McKelvie: Yes, and MAT standard 1 is about same-day intervention, which is a huge change.

I see that Dr Priyadarshi is nodding, but I do not know whether that is because he agrees with me or because he has some experience to share.

Dr Priyadarshi: I am happy to make a comment, if that would be welcome.

Pauline McNeill: Please do—that would be great.

Dr Priyadarshi: First, I will make a declaration: I am working with Professor Miller as a duty bearer in a number of workshops that the national collaborative is conducting to examine the charter of rights and to think about an effective implementation plan. I am happy to contribute to that work because I think that it is crucial for the people I see as a clinician and as a medical manager.

The experiences of people in the system are not universal, but there is no doubt that stigma and discrimination—not only from members of the public around them in society but, unfortunately, from a range of services that they are looking to access and seek support from—are often an everyday experience. Therefore, I strongly welcome the charter of rights, and we are keen for it to be implemented effectively. We often have great plans and proposals, but it is really important that we implement those and monitor their effectiveness.

Two elements are important for us. The first point to note is that, from a drug services perspective, the MAT standards have quite a lot of overlap with the national collaborative work, so they have pulled us along in the right direction, although, of course, people need a whole range of services, including in health—such as primary care and acute services—and we need to bring them on board.

Secondly, it is a matter of taking a health-based, trauma-informed, psychologically informed and inequality-sensitive approach. I know that I have put a lot of buzzwords into one sentence there, but they have meanings behind them. It is really important to take those sorts of approaches into a wider range of statutory and third sector services and responses, and I hope that the charter of rights will play its part in that.

Pauline McNeill: I will follow up with a separate question. I raised an issue with the previous panel about some of the concerns that the public in Glasgow have about safer consumption rooms. I am sure you agree that it is really important that the community feels that the service is being run well. Could you comment on that? Do the proposals allow for those users who may want to make the transition to rehabilitation?

Dr Priyadarshi: There was always a plan for an engagement process around the drug consumption facility, once we had a legal framework to base it on. The Lord Advocate's letter to the Glasgow HSCP makes it clear that she expected a robust engagement process, and we began that immediately after receiving the letter. I went to a public meeting at the end of September 2023 and, since then, we have done a large number of engagement sessions with the local community, local businesses, third sector partners, people and families with lived experience and, crucially, people with living experience who are likely to be potential service users of the facility.

The range of feedback that we have received is very broad. At one end are people who are very keen for the plan to be implemented and to be successful. There are also folk who understand the model and the rationale but who have some concerns—I will come back to the concerns in a bit more detail. There are people who are ambivalent and, at the other end, there are people who are ideologically opposed.

From the community's perspective, the concerns that we consistently hear are those that

are heard across the world whenever such services are proposed and initially implemented. They include questions such as whether the service will bring more people into the area—we are talking here about the Calton area of Glasgow; whether there will be more visible drug use and more visible drug problems; whether there will be issues with open drug dealing, potentially between drug dealers; how the police will respond to all of that; and how people's concerns and experiences will be taken into account as the service is implemented.

We have regular open sessions at which members of the public can come and speak to us about such concerns, we have created a web page with a set of responses, we have a questionnaire for frequently asked questions and we have a video. We are also working with police colleagues on how we will work with them once the service is implemented, so as to recognise and manage the concerns of businesses and communities.

In due course, once the service is ready for implementation, we plan to have a community forum. That model has been developed in other parts of the world, where the service does not just engage before it is implemented but continues to do so at the point of implementation and for a long time afterwards. We hope that, in addition to a service representative, Police Scotland and other representatives will be on that forum, who will be able to respond to community concerns and have an open communication stream with them, as well as regular set meetings to understand the impact, whether that is negative or positive.

Our case for the drug consumption facility is based on the benefits for the community and society at large. It is located at a site around which we know that there are a number of public injecting sites. Public injection is very common, unfortunately. Virtually everybody from the community who has engaged with us has their own personal experience of being impacted by public injecting in their area—in their closes, in their back gardens, in their front gardens, in the parks immediately outside, in car parks and in other spaces.

From listening to that feedback, we get the sense that we are locating the facility in the right place, because that is exactly where the population involved is. However, we hope that we will be able to demonstrate for people that, once we do this, there will be a very significant reduction in the day-to-day impact that they currently experience. That tends to have been the experience with other services across the world.

Your second question was about recovery. The model of care is based on being able to offer people opportunities, through peers who work in the service, to get into a range of recovery communities, rehabs, treatments and other services that they want and need.

Pauline McNeill: Thank you.

Clare Haughey: Good morning—I got that in just under the wire.

Minister, as you may know, I asked the previous panel about synthetic opioids, which you mentioned in your opening statement—you spoke about the threats that they pose and the increased risk. There was a gentle challenge back from members of the first panel, who said—I am paraphrasing rather than quoting—that there might be too much focus on synthetic opioids, and that people's lives are being impacted by, and, indeed, people are dying as a result of, the kind of drug use that existed prior to synthetic opioids coming into the picture.

What are the Government and your officials doing to address that threat? What additional measures are you putting in place in relation to synthetic opioids?

Christina McKelvie: It is worth hearing about some of the international evidence around synthetics, the challenge that they pose, the fact that they are now being mixed with other substances that people do not know about, which means that people do not know that they have contaminated substances, and the fact that they are 50 to 500 times more powerful. My gentle argument back is that we have to be prepared for that coming down the line. We need to be very aware of what has been seen in the rest of the world.

In my first week in this role, I took part in a round table on synthetics with colleagues from Canada, New York and Ireland, and I heard about the actions that they have been able to take to tackle synthetics in the supply chain, and about how dangerous such situations can be. That is one of the reasons why the drug-checking facilities and the national hub will become very important. We will be able to see that coming in, which will enable us to pivot towards an alert system—indeed, I think that Public Health Scotland has already used such a system to alert people that something is not safe, and that they should therefore check it out or be safe when they administer it.

I also hear that there is synthetic opioid contamination of benzodiazepines and that people who are shifting to those substances do not realise its presence or its impact. There is also a shift whereby people are moving to injecting cocaine, which brings with it a range of health issues. In addition, we do not have a naloxone for stimulants: there is currently no treatment for

stimulants, so there is a huge amount of work to do there, too.

12:00

I am taking quite a broad approach, but it might be that we are seeing that because synthetics are in the news and at the top of everyone's agenda right now, and because they pose such a threat. I am alert to that, but it is not my experience here. Work is on-going in all the other areas. We are hearing from stakeholders about how behaviour is changing, how issues are being dealt with and how we can intervene, either through those stakeholders or with other services.

Synthetic opioids are a big threat, which we must not downplay, but I give a commitment that we are looking not only at that threat but at all the other information. The toxicology results and all the rich data that we get from NRS in the summer will give us some indication of what has been happening in the past year. The RADAR results are telling us that benzodiazepines and cocaine are playing a bigger part than they used to.

I will ask Alison Crocket to come in, because she takes part in lots of international work and has long experience. She may be able to give you an overview of the global picture and how we are using that to inform the work that we are doing here.

Alison Crocket (Scottish Government): We have been part of the debate about synthetics in the Commission on Narcotic Drugs, and we have tried to take what we can from the information about what other countries are experiencing and what they are doing that works.

If synthetics were to come here in the way that they have done in North America or in some other parts of Europe, we would see far greater distress and even more problems than we have now, which is alarming, given that our experience is already really difficult.

To address your point, the best evidence that we have at the moment is that we need to do what we are doing now to the fullest extent, to scale that up to ensure that services are as available as possible and to address people's needs at the point when they say that they need help. There is no panacea. No one has yet found a way of addressing a synthetics epidemic in their country. That is what we need.

What we can do is be as available as possible and scale up the things that we know will work, such as drug checking and providing access to services. We might look at the issue of prescriptions or talk about stigma and how to reduce the barriers, to the extent that we can, for anyone to access a service. Those are the key things that we must ensure that we do. There is no need to do something new or different. We should do what we know works, based on the best information that we have gleaned from other countries, and ensure that that is available for people who ask for it.

Christina McKelvie: I said that we do not have a naloxone for cocaine overdose or harm, which means that supervised detox is the only option and the only form of recovery. Cocaine Anonymous and other organisations are very helpful in supporting people who are in that situation, which is why increasing the number of residential rehab beds and the delivery of front-line services is important.

Synthetics may be the new thing in town, but we are still attempting to deal with some of the more traditional substances, such as cocaine, in a way that will reduce harm and deaths, as well as giving people a recovery pathway.

Clare Haughey: Before I continue, I refer members to my entry in the register of members' interests: I am a nurse and have a bank nurse contract with NHS Greater Glasgow and Clyde, and I recently worked in Greater Glasgow and Clyde's alcohol and drug recovery service.

You touched briefly on toxicology, and earlier, in a previous answer, someone mentioned delays in toxicology. What work is being done to ensure that we get toxicology results back in a more efficient manner, not only for academic interest but for families?

Christina McKelvie: Families want answers, and sometimes, sadly, toxicology becomes very important in giving them an understanding—that is the answer that they get. It also gives everybody else involved in the care and treatment of people an understanding of what that toxicology tells us.

The three-monthly RADAR reports bring in a few things, including toxicology results, primarily to see what is in the system. All that information is incredibly important, but it is all after the fact. One thing about learning about what the causes are is that we can look at how to create the treatment pathways that prevent people from coming to harm and losing their life, so we are working very hard with toxicology colleagues.

The drug-checking facilities—

Clare Haughey: I am sorry, minister, but can we stick to toxicology? My question is quite specific: what is being done to speed up toxicology results?

Christina McKelvie: Obviously, from my perspective, with the RADAR results being quarterly, that is the way in which we are looking at that and trying to scale all of that up.

General toxicology is a hugely challenging issue as well. I do not know whether any of my officials has an update on that, but information on the general issue would come from the health minister. I would be happy to elicit that information and to get back to you on that.

Clare Haughey: Could you or one of your officials write to the committee with that update?

Christina McKelvie: Absolutely.

Clare Haughey: It is an important issue that is raised with me as a constituency MSP, and it is also very important in terms of giving people answers. I will leave it there.

Russell Findlay: I have a question for Dr Priyadarshi about the Glasgow drug consumption facility. When is it opening?

Dr Priyadarshi: The official wording that we have used is late summer this year. To give you a bit more detail on that, the dependency is around the building work that is required, which started at the start of March. We are expecting a handover date sometime in August or by the end of August and we hope to have the staff recruited and to be able to deliver a service immediately.

Russell Findlay: If the handover is late August, late summer sounds a bit ambitious. It is more like the autumn, is it not?

Dr Priyadarshi: Unfortunately, we are possibly heading into early autumn. Early September is a date that we hope that we can meet.

Russell Findlay: Susanne Millar's submission said that the facility would

"hopefully be implemented in late summer",

but it sounds as though that will not be the case. There are also issues around recruitment. Is it correct that you have struggled to get staff?

Dr Priyadarshi: We have already recruited some senior members of staff for the facility. I am here today, but there is a recruitment event happening to attract the front-line staff who will deliver services. It is fair to say that alcohol and drug services have had challenges in recruiting and retaining front-line staff, but for this service we seem to have had a lot of interest and there is hope that we will be able to recruit the full complement of the multidisciplinary team.

Russell Findlay: Right, but there was not as good a response to the initial advertising as you would have liked, I think. Is that correct?

Dr Priyadarshi: No, there was a really positive response for the operational manager and the nurse team leader posts. We have had a fantastic response—more than we get for most posts in the service.

Russell Findlay: A previous witness this morning, and previous evidence received by these committees, talked about the need for the facility also to have smoking facilities for inhalation and so on, which, we understand from the previous evidence session, ran up against the smoking ban. Have you sought to overcome that particular hurdle or will the facility not include those?

Dr Priyadarshi: The service that will be implemented will start with eight injecting booths, but without an inhalation room, unfortunately.

The original proposal in 2016 was to include an inhalation room as well, but we found three challenges with that. One relates to certain elements of the smoking legislation. The technical ventilation aspects of an inhalation room are also challenging and would require significant capital investment. The third challenge is that we are locating the facility in the Hunter Street health and social care centre in the Calton area and, at the moment, the footprint of that building gives us limitations on the range of interventions that we can put in.

We therefore decided to begin with the injecting booths as our first ask of the Lord Advocate, and that will be evaluated and monitored. If we feel that we need to add to that, I hope that we will be able to make further representations in future.

Russell Findlay: That is interesting—thank you.

I have a question for the minister. Many of Scotland's prisons have significant drugs problems, and many prisoners do not get treatment of any type. Some prisoners go into prison without a drug problem and come out with one. The UK Government has recently created drug-free wings in 45 prisons in England and Wales, and is set to do more than double that. Those feature substance misuse courses and regular drug testing. In addition, there are plans for 18 drug recovery wings, where prisoners will receive six months of intensive abstinence-based treatment. I know that we touched on abstinence issues earlier.

Does the Scottish Government have any plans to offer anything similar to prisoners in Scotland?

Christina McKelvie: I welcome the work that is being done in England and Wales. Last Thursday night, I had the pleasure of being in Barlinnie—yes, they did let me back out. When I said to a colleague that I was going to Barlinnie, they said, "That must be grim," but actually, it was not. Barlinnie has been running a recovery cafe and creative change programme for almost eight years now, and I heard from people who have taken part in that process. I heard not just that they have been dry and clean for many weeks and months, but about all the other changes that have allowed them to focus on their general health and

wellbeing. Many of them go to the gym and are giving real attention to their general health and wellbeing and to their mental health and wellbeing.

I was really struck by the camaraderie of the groups of men, who were encouraging each other to take part, which is a real cultural change in that type of setting, although I am not saying that we have tackled all the issues. You may have seen some of the publicity over the past couple of days about Glenochil and the work that is being done there on recovery. The same is happening in Low Moss. Recovery work is going on in all those areas.

Russell Findlay: What about the idea of drug-free wings? Is that on the table? Has it been discussed with the SPS?

Christina McKelvie: The SPS is currently working with us on what it thinks would work. When I was in Barlinnie on Thursday night, I was struck by the way that the prison officers work with the people involved. There is a real respect for each other's roles and their journeys. We are working closely with the SPS on how it sees some of this being rolled out. In Glenochil, there is now a drug-free wing and work is being done to look at how that operates and how we can roll it out across all prisons.

Russell Findlay: So there is a drug-free wing up and running in Glenochil?

Christina McKelvie: Yes, in Glenochil.

Russell Findlay: Prison officers are increasingly becoming exposed to inhalation of dangerous substances and are becoming unwell as a consequence. Drug-free wings seem like an obvious thing to do if you have a cohort of people who desperately want to be in an environment where there is no risk of coming across narcotics that are going to harm them.

Christina McKelvie: Yes—everybody needs to be safe in their workplace. One thing about synthetics is that some of them are much more dangerous to people who work in the sector. We have to consider that when working through the support for the workforce. We need to ensure that people are safe at work and safe wherever they are.

The Convener: I will cut you off, as usual, Mr Findlay, but I will come back to you if there is time. I will bring in Paul Sweeney and then Collette Stevenson.

Paul Sweeney: I thank the panel members for their contributions so far. At the previous joint committee meeting in November 2023, we heard from Susanne Millar from the Glasgow city health and social care partnership that evaluation should be ready to start as soon as the pilot launches, which we just heard will hopefully be in early September. Is that still expected to be the case, and what criteria will the facility be measured against?

12:15

Dr Priyadarshi: The evaluation work is very much part of the implementation plan. It is led and co-ordinated by Dr Emilia Crighton, who is the director of public health, but it is being co-ordinated and delivered by a range of independent academics. We are fortunate to have four academic departments across the UK that are keen to be part of this work, and they are supported by Public Health Scotland. We hope that we can do the baseline work now. That involves examining current data to tell us what the baseline is, which we can compare to the post-implementation data.

The evaluation will focus on a whole range of different outcomes for a whole range of different stakeholders. Crucially, we want to examine health and social care outcomes for people who use services—that includes fatal overdoses, hospital admissions, blood-borne virus transmissions and injecting-related wounds—but it goes all the way through to the community's experience of discarded litter and people's feeling of safety in the area.

It is a comprehensive plan that is built on an international evidence base but has a localised feel. It is about the local issues for the group of people who will use the service and for the local community in the Calton area. There is also a significant element about the cost-effectiveness of the service.

Paul Sweeney: That is helpful. Will there be on-going real-time evaluation and will there be flexibility to make operational adjustments as issues arise? One thing that was raised at the previous joint committee meeting was opening hours—the Copenhagen model is a 24-hour service, for example. Could such things potentially be adjusted?

Dr Priyadarshi: Yes, absolutely. There is research and there is the day-to-day monitoring of the service. The full evaluation will take some time, but we will monitor the service with regular reports to understand its impact and to look at areas in which it might develop. For example, two areas that we are already thinking about are how we understand whether the opening times have been effective, as you mentioned, and whether they need a degree of adjustment. The second area, which was touched on in the earlier part of the discussion, is how the service can meet the needs of women within the confines and restrictions that it has.

Paul Sweeney: That is helpful—thank you.

I turn to the minister. What assessment has the Scottish Government made of the scalability of the model? We spoke about the capital constraints around inhalation, for example, in the operational model that has been deployed. Has consideration been given to how easy it would be to scale the model?

Christina McKelvie: That is the work that Dr Priyadarshi has just spoken about. There will be continuous monitoring and evaluation of what works and what does not work and how we can modify that so that it works. We will keep monitoring how the consumption room operates and what it delivers.

One thing that I can say about the building is that the architects came up with a plan, but the Simon Community's women's group then worked with the architects to bring about a new design that that group felt was much more user friendly. Even at that stage, we had people with lived and living experience influencing the structure of the building and how things should flow. That has been incredibly helpful, because it allows us to design out some of the barriers that are sometimes designed into building facilities.

You asked about scalability. The Lord Advocate has given us very clear guidance on this consumption room. We will certainly consider whether we can scale that up and have consumption rooms in other places.

When I visited Aberdeen a few weeks ago, I met people from Alcohol & Drugs Action, the first organisation to put in a licence application for a drug-checking facility, and they said to me, "We're watching what's happening in Glasgow to see if there's something that will work for us." Given the sensitivity involved in siting such a service, the impact on the community and the reactions that people might have, we need to take a measured approach and allow local areas to decide what will work for them locally.

It is about taking a much more flexible view but, as far as Glasgow is concerned, it still comes within the confines of the Lord Advocate's guidance and how much we can actually do in that respect. We will then see how we can use that experience in other ways across the country. Lots of cities have eyes on what is happening in Glasgow, and they will be really interested in the real-time evaluation to see how it could work for their areas. I think that we need to give them that space to allow these things to develop.

Paul Sweeney: Do other colleagues wish to comment?

Michael Crook (Scottish Government): All that I would add is that we are aware that other cities are doing work on this, too. We know that Edinburgh has taken a strong interest in what is happening in Glasgow and, in fact, it has done its own scoping exercise. The need for different models, which the minister referred to, has been recognised in Edinburgh; siting the facility in one area, as in Glasgow, would not work in Edinburgh as it faces a different challenge. We therefore need to look at alternatives and at whether they would work, but that brings us back to the issue of scalability and the evaluation of the Glasgow facility and how it has worked.

Paul Sweeney: I also wonder about peer review with other facilities around the world. Having recently visited Copenhagen, I know that Rasmus Christiansen, who runs the H17 facility, offered to come to Glasgow to brief members of the community about his facility's experience of the difficulties that arose from its introduction, how it was able to resolve that situation with the police, and so on. Have those conversations been going on?

Dr Priyadarshi: We have regular meetings with international colleagues who have had experience of delivering these services for over a decade now. Rasmus Christiansen has been really helpful. He has not been here and we have not been to Copenhagen, but we have had a number of meetings, including with his police colleagues, and we have linked them up with our police colleagues so that they can have separate conversations that do not involve the facility itself. We have also been talking to Sydney, to Vancouver and to those who are involved in the Norwegian drug consumption rooms.

We are not just going with our own ideas; we are listening closely and learning from international experience of not just the operational elements but the community liaison elements, which you are absolutely right to point out. Indeed, that is why I mentioned plans for a regular community forum with identified members of the service who will respond to community queries and concerns as the service is implemented. That approach is very much based on a lot of work that Rasmus Christiansen has done, but also on work that has been done elsewhere in the world.

Christina McKelvie: Police Scotland, too, has learned from other parts of the world in developing its guidance on how it will protect local communities while ensuring that we do not put more barriers in the way of people coming and seeking support.

Alison Crocket: The Scottish Government has been in touch not only with North America, which we have mentioned, but with Switzerland and Berlin. A lot of this work is already being done in the rest of Europe, as well as in Copenhagen, and we have learned a lot from those examples, but we are also looking at a raft of different models. In our most recent conversation with colleagues in

Canada, we talked about high-tolerance housing and different ways in which we can achieve similar objectives such as keeping people safe, ensuring that they get support, giving them access to services and so on.

However, the model will not always be the same. As the minister said, in different parts of the country—say, the more rural areas, or those with different needs—the model that is used might not look exactly the same. A different set of support services might be needed to achieve the objective, and it is important that we support communities to reflect their circumstances in whatever model is pursued.

The Convener: I have to move things on, because we only have about 15 minutes left and three members still want to come in. Succinct questions and answers would be helpful. I call Collette Stevenson, to be followed by Paul O'Kane.

Collette Stevenson: Good afternoon to the minister and the rest of the panel.

Minister, you touched on the drug-checking pilot projects earlier in the meeting and, indeed, in your opening statement. However, the previous panel told us in their evidence how resource intensive those pilots have been. Can you provide an update on the expected timescales and processes for setting up a drug-checking facility in each of the areas that have been targeted? What impact do you see those facilities having?

Christina McKelvie: I am really hopeful about the drug-checking facilities, which I think will give us real-time data on what is happening in local areas. We will also have the national hub, which will be sited between the University of Dundee and Ninewells hospital. It will allow further analysis to be done so that we have a real and deep understanding of the issue. It is one aspect of how we understand what is in the system.

I was in Aberdeen on the day when the people up there submitted their licence application to the Home Office. At the moment, there are two drug-checking facilities—a postal one called WEDINOS, which is based in Wales, and another in Bristol—and they have experience of the process and how tricky and complex it can be. We are certainly leaning a lot on our friends in other parts of the UK, and our officials have excellent working relationships with Home Office officials. I should also say that the criteria were designed not just to tackle that complexity but to ensure that whatever we do is within the law and allows us to maintain the restrictions of the Misuse of Drugs Act 1971. That challenge aside, the determination to do this has resulted in many organisations working together.

Siting the facility with an existing service that already provides other support will mean that people will not just get checked but will also be exposed to all the other support that is available to them. That is the Aberdeen model, which I think the convener will be very interested in. It is certainly worth taking some time to visit and speak to the people in that facility. As I said, they were the first to get their application in. It took a long time for them to meet all the criteria, but their application is now in. The Dundee application has gone in, too, and Glasgow's application is imminent—it is being worked on right now with Home Office officials and the people who deliver for Glasgow. The facility will give us results within minutes on whether a substance is more dangerous.

As I said, though, the facility is only one pathway by which a person can be exposed to all the services that are available. There are other intervention points that we can use to offer people support. It is important that people can make an informed choice and get the right advice. In that way, consumption rooms become part of the whole system, because someone who comes in might be told, "That doesnae look that safe—that's the advice we're giving you." The point is that they will be somewhere safe where, if they take the substance and have a reaction, they will be looked after. That is incredibly important because, again, this is all about harm reduction and reducing drug deaths.

It is all multilayered. There is the practical stuff—that is, what people need to know to make the decisions that they need to make, and to give them the confidence to make such decisions—and there is the data and analysis aspect, which will allow us to understand whether the profile of what we are seeing in the system is changing. If we suddenly see an increase of something very dangerous in the system, Public Health Scotland and other organisations can, as they have done once before, put out an alert to everybody on the front line so that people can be supported, know that there is something in the system that is potentially 500 times more powerful than their usual thing and be told how dangerous it is. There are different reasons why these facilities are good things.

Collette Stevenson: Thanks very much for that answer, which was really helpful. We have heard that mobile units work well, too, and not just within facilities. Have you looked into that? If not, would you be open to doing so?

12:30

Christina McKelvie: We have looked into that; my predecessor in the role looked into it. Some festivals have managed to do it. The Home Office

is pretty rigid, but we are working with it. Mobile units at big events could be a life-saver for some people, so my mind is not at all closed on that, but there are challenges in the Misuse of Drugs Act 1971, which makes it really difficult for that to happen. We have some experience of organisations asking to do it, but the situation is pretty rigid.

Michael Crook: One of the big things that came through the University of Stirling's research on drug checking was the desire for mobile units. As the minister alluded to, when we have been in discussion with the Home Office about what kinds of licence application would or would not be considered, it has been clear that any facility would have to have a fixed site and be attached to an existing drug or alcohol treatment service. At the moment, therefore, a mobile facility would be outside the Home Office's criteria for granting a new licence for a drug-checking facility. However, we will continue to speak to it and work with it on that.

Collette Stevenson: I have a quick question about the applications that have been put through to the Home Office. When do you envisage that you will get notification that those have been approved?

Christina McKelvie: I asked the Minister for Crime, Policing and Fire about that a few weeks ago, and he said that he would look into it. We expect that a site visit will be arranged and that there will be other back-and-forth about the facility. We would like it to happen now, but I suspect that it will take a wee while, especially for the site visits. However, we hope that, once one application has been passed, the others should be academic, in a sense, albeit with the same rigorous quality control over whether all criteria for operating a site have been met.

Paul O'Kane: Minister, you might have heard the evidence on MAT standards. I am keen to know your position on the implementation of the MAT standards to the timescales that have been set out. They should be implemented by 2025 and embedded by 2026. We heard quite a bit of evidence this morning about what is happening on the ground when it comes to the challenges that exist, particularly as regards needing a more holistic approach, perhaps, and going beyond opioids and looking at wider issues. Will you comment on that?

Christina McKelvie: Given that we set the MAT standards, we want everybody who accesses the service to get that service at the highest quality, and we want people to be informed about the choices that they have. The MAT standards are included in that. I mentioned mental health and dependency, and there is a specific MAT standard to tackle that issue. We are working closely. The advice that I was given by both previous ministers in the role was to keep driving up the MAT standards and make sure that the budget is protected. Those were two very good pieces of advice to me as I came into the role.

We published in 2021, and work is going on across the board to drive up the standards, not just in health but in all services. It is really a way of pushing forward the idea that the issue is one of health and it should be treated as such, and that people should have a high quality of service. It is a bit of a change for people who deliver the services—particularly in health boards—as regards how we increase all the standards in the way that we want to and give people the choices that they need in order to make the right decisions for their health.

We are also applying the MAT standards to justice settings. In relation to the points that Russell Findlay made earlier about what is happening in prisons, I add that we have prison to rehab, which is covered by the MAT standards as well. We hope to make sure that everyone is covered.

Great progress has been made. There is a great diagram that allows me to see immediately where we are. It shows red, amber and green statuses. Much of the work is coloured green or amber, so real progress is being made, particularly on MAT standards 1 to 5. Progress is also being made on standards 6 to 10. There are some challenges, particularly in rural areas and areas where there is a high incidence of issues that we need to face. However, I see things moving on quite markedly now, and I see, hear and understand that when I meet people. They understand it, too.

When I was in Blackburn on Monday, I was asked whether the health improvement, efficiency, access and treatment—or HEAT—targets do not work well with MAT standards under a trauma-informed approach. I will take that point away and look at it. It might be that we have frameworks or standards that do not quite work well together. I will consider that to see how we can use the MAT standards to push things forward in a more modern way.

Paul O'Kane: You expect to see progress, first, on the benchmarking that will come out in the summer and, secondly, on the challenges that were presented to us this morning, such as the fact that same-day prescribing is not working as effectively as it should. I also note the clear comment that was made about the standards being embedded where people and their families, in their lived experience, feel that there has been demonstrable progress in areas such as same-day prescribing. Will you consider specific action there, as a result of what comes out of the benchmarking, in order to develop that further?

Christina McKelvie: We are keeping track of what is happening in each area across Scotland. Where we are seeing challenges, organisations are coming forward with monthly reporting so that we can give advice, support and guidance on a monthly basis to push forward progress in tackling all those challenges. There are a number of areas where reporting has shifted from monthly to quarterly or from quarterly back to monthly, depending on where they are on the progress chart. In many areas, organisations have taken advantage of the opportunity to work with us on a monthly basis when reporting their progress on the standards, and I will continue with that work.

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

Minister, I am so glad to hear that you support recovery and, eventually, rehab for those who want it and are asking for it. Do you agree with Justina Murray from the previous panel, who said that rehab is actually damaging the implementation of reducing drug harm?

Christina McKelvie: Sorry—I did not hear the last bit of your question.

Sandesh Gulhane: Do you agree with Justina Murray from the previous panel, who said that rehab is actually damaging the implementation of reducing drug harm?

Christina McKelvie: I am aware that Justina is sitting right behind me. [*Interruption*.] Sorry—apparently she has gone. I will catch up with her soon.

Justina Murray has been an absolutely superb advocate in this area. I will have to look at what she was saying, because I did not catch that bit of the committee's meeting this morning.

I go back to a point that I made to Mr Findlay. We have to ensure that we have a number of pathways available for people so that they have a choice about the pathway that works for them. As I said, we get pulled in different directions. Some people think that a certain pathway is the best one, and other people think that another pathway is the best. Our responsibility is to create that choice for people so that they can understand the pathway that works for them. Two people who I met yesterday at Abbeycare, who are currently on an abstinence programme in a rehab facility, said, "We tried this and we tried that." They had both tried the same two things, which had not worked for them, but the programme has worked. That is important in understanding where the challenges are coming from.

Our stakeholders are doing amazing work, and we need to take on board their ideas about what works best. From my point of view, the responsibility is to create the choice that allows people to have the pathway and the person-centred approach that will work for them.

Sandesh Gulhane: Absolutely. Choice is important for those who seek help and it is important that they get the help that they ask for.

Like you, I have visited and spoken to people at Rainbow house in Glasgow, which offers peer support in a residential rehab setting. It is an innovative rehab programme, and it was one of the first to be set up. It involves peer support, but it goes out into the community. The peer-support volunteers at Rainbow house cannot speak highly enough of what they can do to help others. However, both of the establishments that we have mentioned are extremely concerned about their funding. Do we have enough money going into rehab?

Christina McKelvie: The argument will be that there is never enough money going in. From my perspective, I can say that, since I came into the role, there has been a 67 per cent increase in Scottish Government funding to ADPs and other support agencies. That tells you that there is a commitment to drive more money into the system to ensure that we get the outcomes that we all want. Last year, there was record funding of £112 million for ADPs. The allocations for budgets are being set now, and the First Minister has said publicly that this budget is protected.

We have seen increased funding coming into this budget, and we have seen the impact of that. We are about to see more than 100 additional residential rehab placements coming into play very soon. We have also seen an investment in the workforce, resulting in the addiction worker traineeship, whose graduation ceremony I attended the other week, and the work that the Scottish Drugs Forum is doing around that, along with the work that the Scottish Recovery Consortium is doing in prisons and communities. I want to see those organisations funded well. In a really difficult funding situation, I will fight that corner in Government, but I repeat that we have seen a rise in funding and we have seen that commitment.

Sandesh Gulhane: Can you and your department audit exactly where the funding that you are putting in place is being spent? I raise the issue because Glasgow's HSCP is going to have significant cuts in rehab and services for children living with drug users.

Christina McKelvie: I have been clear that the money from the Scottish Government for ADPs that goes into the system via local authorities is going to ADPs. I do not think that I could be clearer about that. We have challenges in the budget—everyone has challenges in the budget—and some of those are not of our making.

However, I know that we have had a 67 per cent increase in the budget for ADPs.

Sandesh Gulhane: My question was, are you able to audit to see exactly where that money is being spent and how the ADPs have increased their spend to the tune of what you are giving them?

Christina McKelvie: We have already done that. I can make sure that the committee gets that report, which was published at the end of last year. It contains the results of our audits of where funding went to, particularly around services such as residential rehab and other services, and it addresses a concern about underspends and the way that we were able to allow underspends to go back into the system for the money to be spent on other priorities. We can get that report to you.

Sandesh Gulhane: Thank you. My final question is for Dr Priyadarshi. Given that Glasgow has a very diverse community, do you have policies in place to help people from minority ethnic backgrounds who have issues with substance misuse? You might not have time to give me a full answer, but perhaps you could respond in writing.

Dr Priyadarshi: You are right to suggest that there are pockets of our communities in Glasgow where we have a high prevalence of people from minority ethnic groups, and we have had specialist services for them. In south Glasgow, for example, there was a black and minority ethnic ADRS service for a while, but it has been more mainstreamed recently.

Our case loads are predominantly—more than 90-odd per cent—white Scottish. We have been looking in the wider mental health system at how we meet the needs of people from minority ethnic groups in different populations. That is an area that our ADP has been trying to progress. I cannot give you a current action plan around that, but we recognise that as a developmental need in the ADP.

I want to return quickly to the issue of residential rehab beds. Glasgow has always commissioned residential rehab beds. The 16-bed unit that you visited, Mr Gulhane, is commissioned by alcohol and drug services. In addition, with the new money, we have added seven new beds, which we purchased from Phoenix Futures. The residential rehab service that is offered to deal with our case load is increasing and has been for the past few years.

The Convener: We have gone just a little over our time. I thank our witnesses for an informative session.

That completes the public part of our meeting, and we will now move into private session.

12:44

Meeting continued in private until 13:09.

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