OFFICIAL REPORT
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Public Audit Committee

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Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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PUBLIC AUDIT COMMITTEE
33rd Meeting 2024, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

*Jamie Greene (West Scotland) (Con)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Scott Heald (Public Health Scotland)
Caroline Lamb (Scottish Government)
Maggie Page (Scottish Government)

CLERK TO THE COMMITTEE

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 19 December 2024

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning. I welcome everyone to this, the 33rd and final meeting of the Public Audit Committee in 2024. Agenda item 1 is for members of the committee to decide whether or not to take agenda items 3 and 4 today in private. Is the committee content to take those items in private?

Members *indicated agreement.*

"Alcohol and drug services"

09:00

The Convener: Agenda item 2 is consideration of the joint report by the Auditor General for Scotland and the Accounts Commission, "Alcohol and drug services". We took evidence from the Auditor General and his team a couple of weeks ago, and this morning I am pleased to welcome representatives from the Scottish Government. We are joined by the accountable officer from the health and social care directorates, Caroline Lamb, who is the chief executive of NHS Scotland and the Scottish Government's director general of health and social care. Caroline is joined by Maggie Page, who is the head of the Government's drugs strategy unit. You are very welcome. We are also joined by Scott Heald, director of data and innovation and head of profession for statistics at Public Health Scotland. You are very welcome, too, Mr Heald.

We have some questions to put to you but, before we get to those, I invite the director general to make some opening remarks.

Caroline Lamb (Scottish Government): Thank you for the opportunity to appear before the committee today. On 31 October, Audit Scotland published its "Alcohol and drug services" report, providing a thorough review of progress made and outlining key areas for further development. The Scottish Government welcomes the report, which captures the complexity of the drug and alcohol landscape in a clear and balanced manner.

I sent a formal report for the cross-committee meeting on tackling drug deaths and drug harm on the Audit Scotland report earlier this month, outlining our planned actions under each recommendation. That has been shared with the Public Audit Committee in advance of this meeting.

In 2021, we launched the national mission to reduce drug deaths and improve lives. Rooted in evidence-based interventions and with significant additional investment, the mission represents a unified effort with our partners to address Scotland's long-standing challenges with drugs and alcohol.

During the first years of the national mission, we focused on laying the foundations. We are now committed to building on those foundations and intensifying delivery while responding to new threats and challenges, such as the emergence of novel and stronger synthetic drugs and the concerning rise of cocaine in implicated harms and deaths. The Audit Scotland report acknowledges the progress that has been achieved under the national mission, particularly in improving national

leadership, increasing residential rehabilitation capacities and doubling the total investment in alcohol and drug services since 2014-15. Notably, that includes sustaining a record £112 million for alcohol and drug partnerships this year, as well as innovative initiatives such as piloting a safer drug consumption facility in Glasgow, which will open early in the new year, and our recently published charter of rights.

It is clear, however, that there is more to be done. Delivering whole-system, preventative change is a priority, and wider Scottish Government activity is supporting that, for example through the recent publication of the mental health and substance use protocol and the prevention-focused population health framework, which will be published in early 2025.

The report emphasises that greater attention must be given to alcohol-related harms alongside drug issues. We are already taking steps in that area, including by working on a United Kingdom-wide basis to develop clinical guidelines for alcohol treatment and by sustaining impactful measures such as the minimum unit price for alcohol, which Public Health Scotland research has shown to be effective.

The report underscores the need for a more sustainable transition plan beyond the national mission's conclusion in 2026. We have begun to work with partners to ensure that long-term strategies are managed smoothly through to the next parliamentary session. The on-going independent evaluation of the national mission will also help to ensure that those strategies are underpinned by robust evidence.

Audit Scotland highlighted the need for better cost effectiveness. Conducting that on a large-scale health programme has challenges. However, the evaluation will include an external study of how national mission funds have been allocated and spent, and information on the benefits that the expenditure has or is likely to have delivered.

We are all aware that Scotland's drug and alcohol deaths remain too high, and we remain steadfast in our commitment to deliver change, guided by the evidence and the principle that every individual deserves the opportunity to live a healthier and more fulfilling life.

I welcome your questions and the opportunity to elaborate further during this session.

The Convener: Thank you very much for that opening statement, which covers a lot of the ground that we will get into a bit more detail about in the next hour and a half. I will begin by asking the question that I often pose on these occasions, which is whether you accept all of the recommendations that are contained in the Auditor General and Accounts Commission report.

Caroline Lamb: We accept the recommendations, and we will find them very helpful with regard to continuing to progress that work.

The Convener: Can I explore that a bit more? You referred to the letter that you sent us, which I think was dated 10 December, in which you very clearly, and quite often, use the phrase:

"The Scottish Government accepts this recommendation"—

indeed, you use it in regard to nearly all the recommendations. However, there are two for which you do not. The first is recommendation 1, which is to

"work with key stakeholders to agree actions"

to address the lack of

"focus and funding for tackling alcohol-related harm".

Do you accept that there has been a loss of focus on alcohol-related harm?

Caroline Lamb: First, the Scottish Government remains absolutely committed to addressing alcohol harm, and many of the actions that we have taken under the national mission have, by virtue of the fact that alcohol and drug partnerships are focused on both alcohol and drug-related harms, impacted on those affected by alcohol abuse as well as other substance abuse. I could give you many examples—residential rehab, workforce, stigma and so on—where the actions that we are taking are supportive of people with both alcohol and drug abuse issues.

However, it is clear that stakeholders feel that there might not have been the same level of focus on alcohol as there has been on drugs, through the national mission. We continue to engage closely with stakeholders, and as part of an action coming out of the publication of our population health framework in 2025, we will be looking to work further with stakeholders to develop the detailed actions that will continue to progress that work on alcohol alongside the work on drugs.

I am sure that I can give you more information if you want me to go into that now—for example about how the work that we are doing on developing the national specification absolutely responds to concerns about both alcohol and drugs.

The Convener: Members of the committee will pick that up. However, obviously, you are not a stakeholder but the accountable officer for the Scottish Government.

Caroline Lamb: Absolutely.

The Convener: So, I am really asking you whether you accept a recommendation that points to the lack of focus on and funding for tackling alcohol-related harm. Do you accept that?

Caroline Lamb: What I have said is that a lot of what we are doing—

The Convener: Do you accept that?

Caroline Lamb: Yes, I do accept that, which is why, as part of our response to the population health plan that will be published in 2025, we will be looking to set out specific actions.

The Convener: Okay, thank you. The other recommendation in this report for which there is not that clear phrase,

"The Scottish Government accepts this recommendation",

is in relation to a human rights-based approach to tackling alcohol and drug dependency and relying on the lived and living experience of people who are using services or maybe, in some cases, are not able to access them. Do you accept the recommendation that there needs to be more focus on a rights-based approach?

Caroline Lamb: Yes, absolutely. The rights-based approach and absolutely embedding the lived experience of people has been at the heart of all the work that we have taken forward through the national mission, and I would expect that to continue.

The Convener: In relation to that, you mention in the letter, which was sent on 10 December, that the national collaborative charter of rights was due to be published on 11 December. Was it published?

Caroline Lamb: Yes, that has been published.

The Convener: Maggie Page, do you want to comment on that?

Maggie Page (Scottish Government): The charter of rights was published on the 11th. Both the First Minister and the Cabinet Secretary for Health and Social Care were at the launch, along with a number of other people, including representatives from the United Nations. That was published, and we fully support it.

The Convener: Okay, thank you. We will have more questions around issues to do with the focus on alcohol-related harms and so on, but first I will turn to the opening sections of the report that we have before us this morning, which, once again, puts some focus on Scotland's performance when it comes to drug deaths. In paragraph 2 of the report, it is cited that

"Scotland had a drug-induced death rate of 27.7 per 100,000 population".

The next highest in Europe is 9.7 per 100,000, so that is almost three times the rate of drug deaths. What work is the Government doing to understand why there is such a public health crisis with drug deaths in Scotland?

Caroline Lamb: I will come to Maggie on that one, but I will first say that those statistics are shocking. It is very challenging to understand the differences between different countries in relation to socioeconomic factors and to how data is collected and how things are counted. Notwithstanding any of that, one of our key areas of focus has been to understand some of the underlying reasons behind all that in order to inform the actions that we are taking. I will ask Maggie to give you a bit more detail on that.

Maggie Page: I absolutely endorse that. We are well aware that those numbers are unacceptably high. The national mission was announced back in January 2021, when those numbers first went above 1,000 a year. We are absolutely clear that those numbers are unacceptable, and our response has been remarkable additional investment in addressing drug deaths.

You will not be surprised to hear that we are often asked why the numbers in Scotland are so high. The answer is that it is very complicated and complex. It is a source of a lot of debate in the academic community and the wider drug and alcohol community, but there are a number of different drivers. There is a report called the national drug-related deaths database, which Public Health Scotland produces. It tells you a lot about the background—not just the toxicology in relation to drug deaths, but the circumstances of deaths and the background of the people who have died. That report shows us that about three quarters of those people were using drugs for at least 10 years—some of them for more than two decades. This is a long-term, chronic problem that we are trying to address.

There is some research that points to an aging cohort of people. We are seeing the biggest rise in drug deaths among people aged from 35 to around 50. The average age of a drug death is now 45, and it goes up by about a year every year. There is a cohort moving through the system who have been using drugs for a very long time and who have been impacted by social policies and conditions over that period. Some academics point to that as a driver, but there is mixed opinion as to whether that can account for everything.

Poverty is another major driver. You will see from the report that drug deaths are 15 times more likely in the most deprived areas than in the least deprived areas.

Those combined issues have had a particularly negative effect in Scotland, particularly in the post-industrial areas along the central belt. However, none of those drivers fully explains everything—there are multiple factors.

The third factor that I will talk about is the mix of drugs. When we started to see a big increase in

drug deaths in Scotland, as you will see from some of the charts in the drug deaths report from the National Record of Scotland, that was alongside a huge increase in street benzodiazepines.

The emergence of illicitly produced benzodiazepines really impacted Scotland. That is partly down to the culture in Scotland—benzodiazepine use was more common than in the rest of the UK. Drug use is a cultural phenomenon, and you will see different patterns of drug use in different areas. There was a bit of a perfect storm, with street benzos becoming cheaper and much more prevalent and accessible, alongside other factors that were particularly impactful in Scotland.

09:15

The Convener: One of the things that is mentioned in the report—Caroline Lamb mentioned it in her opening statement—is the increased incidence of drug harms related to cocaine, rising from 6 to 41 per cent. That is documented in the report. Do we know whether that is a Scottish phenomenon, or is it happening across the UK and Europe?

Caroline Lamb: Again, I point to Maggie Page on that one.

Maggie Page: Cocaine use is rising across Europe. It is becoming cheaper and more prevalent across Europe. You can see that in the English and Welsh data, too.

The Convener: I do not know whether Mr Heald has a grasp on this, but is the figure of 41 per cent comparable to the levels that we see in deindustrialised and poverty-ridden parts of south Wales or northern England?

Maggie Page: Do you mean the prevalence of cocaine?

The Convener: For example.

Maggie Page: One thing to point out with drug deaths is that almost all of them involve poly drug use—around 95 per cent, although I might be wrong on the percentage. More than one drug is implicated. It is the build-up of lots and lots of different drugs that people use that causes particular harm. I cannot tell you for sure what the percentage is in relation to cocaine in the rest of the UK.

We have very detailed toxicology here in Scotland. Our surveillance systems are considered to be much more advanced than in other parts of the UK. Other areas are looking at modelling things that we have, such as our rapid action drug alerts and response—RADAR—surveillance system.

I do not think that different areas are fully comparable, percentage-wise. There are variations in pathology and toxicology throughout the rest of the UK, too. What we do know is the top line for drug deaths. The comparable measure, drug poisoning deaths, is accurate enough for us to say that it is comparable. However, once we get into the detail, it becomes a bit more challenging.

On trends, cocaine use is on the rise across the UK and Europe.

The Convener: Before I invite other members of the committee to come in, I will ask about drug poisoning, which you mentioned and which is the index that allows you to compare across the UK. However, that tells us that the incidence of deaths is twice as high in Scotland as it is in other parts of the UK. You say that it is complicated, but surely it is your job to understand what the factors are and why Scotland is such an outlier. As we said in the evidence session with the Auditor General, there is huge multiple deprivation in parts of the north of England and south Wales, and in Northern Ireland, yet the figures in Scotland are so shocking.

Maggie Page: Absolutely. As I have outlined, it is complex, and a number of separate factors contribute to the situation. There is no one thing that I can point to and say, “This is why Scotland is so much worse.” It is a source of a lot of debate and discussion. I cannot come to you and say, “It’s absolutely this one thing that’s made this an issue,” because it is far more complex than that.

Scott Heald (Public Health Scotland): I echo and support Maggie Page’s points about the complexity. This whole area is a big priority for Public Health Scotland. Public Health Scotland is referenced throughout the Auditor General’s report. A key thing to highlight is the availability of data in Scotland. We may talk more about data later.

The Convener: We will, Mr Heald—we will.

Scott Heald: Data here is strong relative to other countries. Our ability to use that data to drill down and understand what is happening is a powerful asset that we have in this country. However, the data that we have can mean that seeking comparisons with other countries is difficult, because they do not all have the same systems that we have in place in Scotland to understand what is happening.

The Convener: I think that we all accept that there is a public health crisis that requires urgent action.

I invite other members of the committee to come in. I start by asking Colin Beattie to put some questions to you.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I will carry on from where

the convener left off. I am looking at the "Alcohol Framework 2018" and the obstacles that have been encountered in delivering the commitments in the framework. I would appreciate it if my question was addressed across the three principal areas that are laid out in the framework, which are to reduce consumption; to support positive attitudes and choices; and to support families and communities. What have the obstacles been? Have there been achievements that we do not know about?

Caroline Lamb: The first major achievement that we would point to is the introduction of minimum unit pricing. The minimum price has been increased, as was recently been confirmed through the Scottish Parliament. I will ask Scott Heald to say something about the evidence of the impact that that policy has had. I think that it has been a success in Scotland.

We would also point to is the work that Public Health Scotland is undertaking on alcohol marketing. We recognise that there are different views about that, which is why we are being careful to gather the evidence.

On positive attitudes, Maggie Page might talk a little bit about the work that we have been doing to tackle the stigma that extends across drugs and alcohol in order to enable people to come forward and seek help when they have a problem. A lot of helpful work has been done to support families, including young people in families, that are affected by substance abuse, whether it be alcohol or drugs.

Maggie Page: The work that we have been doing with the workforce covers both the drug workforce and the alcohol workforce—front-line services are often delivered together or via alcohol and drug partnerships, which cover both. A major part of the work that is being done is on tackling stigma within the workforce. It is also a part of the work that we are doing in the wider public sector workforce that people who have drug and alcohol problems interact with regularly. Similarly, the national collaborative, which is for people with more general substance use problems, is about taking a human rights-based approach.

To go back to the alcohol framework, we are working with families and taking a whole-family approach within treatment services. That is about making sure that families are involved, that they can make a positive contribution to a loved one's recovery, and that they can support them in their recovery on their terms. To be clear about what we mean by "family", it is clearly not just the immediate biological family; it is whoever that person considers to be their family and their loved ones. They all have an important role to play.

Scott Heald: The evaluation of minimum unit pricing that Public Health Scotland undertook has been well trailed, and the conclusions of the report were that minimum unit pricing was having an impact in Scotland. The report contains details about the impact of the measure on mortality, hospital admissions and other factors that we can look to.

An important point that the report highlighted was that the 50p minimum unit price had stayed static for a number of years, and one of the key recommendations for consideration was that it should be reviewed. That supports the Parliament's recent decision to increase the price.

Colin Beattie: You talked about the ageing nature of those who are dependent on drugs and how many have been in their situation for 10 to 20 years. Is there evidence that consumption of alcohol among younger people is dropping? Are crude consumption levels an adequate indicator of the harm that is being done? Is the situation similar, with a fall-off in consumption among younger people, but those who have been dependent on alcohol for many years still coming through the system and getting older? Does alcohol consumption track drug taking?

Maggie Page: The profile of people with alcohol problems is different from that of those with drug problems. The average age for a drug death is around 45, whereas the average age for alcohol deaths is considerably older—I cannot remember off the top of my head, but I think that it is around the early 60s. That is quite a different profile in relation to the progression of the dependency and the appropriate treatment pathways.

On the subject of alcohol and drug use by younger people, academic work done across the developed world shows that there has been a drop across the board in substance use by younger people. What concerns a lot of people is that, although there may be an overall drop, there may be a division, with more people choosing to be abstinent and a smaller group of people who have really quite chronic problems. You might look at an overall drop without really understanding the degree to which that aligns with the number of people who will develop a problem.

We also saw that with alcohol use. Scott Heald may be able to keep me right here. During the pandemic, we saw a slight drop in overall consumption, but there was a real division between some people who were drinking an awful lot less and others who were drinking a lot more, which averaged out overall. When we look at top-level measures, we must be careful to really understand the difference between manageable substance use—not only the use of alcohol but drug use that is not necessarily a problem for the individual—and drug use that starts to become a

problem and can be ultimately life threatening. There is complexity and we cannot say how the patterns that we see in young people now will present in the future.

Scott Heald: That was a good summary of the challenge in the statistics. Another complexity with the alcohol data is that the underlying conditions that arise from alcohol use can sometimes take many years to present themselves, which is why it is really important that we continue monitoring the data to understand what is happening across the country.

Maggie spoke about the differences during the pandemic, with some people choosing to be abstinent while others were drinking more. That averages out, so we must be really careful in interpreting the numbers.

Colin Beattie: That takes us neatly to data collection, which is always a problem for the public sector. The Auditor General comments on the lack of good data. How can we target our resources against the problem if we do not have the data to inform us how to do that? How limited is the data? Is it capable of being used to properly inform local service planning? I am thinking of the rural areas that are described as being hard to get to. You have already highlighted changing patterns in drug use and the fact that there is not one particular drug of choice. How do you make effective use of the limited data that you have, and how accurate is that data in informing how you deliver services?

Caroline Lamb: I will turn to Scott Heald to give us the detail, but data is absolutely crucial to our evidence-based approach. I slightly challenge the idea that we have limited data and I am sure that Scott will want to challenge that in more detail, so I will hand over to him.

Scott Heald: There are several aspects to unpick. Scotland has good data. There are gaps, and I will come on to some of those and what we are doing to challenge them. It is really important to recognise that there is more than one data source that we can use to understand what is happening.

Colin Beattie: I am sorry to interrupt but, to be clear, do you disagree with the Auditor General's statement that there is a lack of good data?

Scott Heald: I disagree in part. The Auditor General's comment is particularly about the drug and alcohol information system—DAISy—which I will come on to if I may, but it is important to recognise that there is also other data. We have already cited the good mortality data that we have in Scotland. The hospital data is strong, and has been strong for many decades. That data can give us good insights into what has been happening.

09:30

The other important aspect is our ability to link data from different sectors to enable us to understand the pathways that particular individuals follow, which is important for understanding outcomes in terms of what happens to people with, in this case, alcohol and drug issues.

The Auditor General rightly highlighted that there are gaps in the data that is used by the DAISy system, which was introduced in April 2021. I will come on to why the gaps exist, what we are doing about that and how we address those gaps when we analyse and interpret the data, but first it is important to understand why we introduced DAISy.

Although there are gaps in the data, DAISy is a powerful tool and has the potential to be even more powerful. Before DAISy, we had lots of disparate data—often aggregated, high-level, summary data—about particular aspects of an individual's treatment journey through the system, which made it difficult to understand what the outcomes were for that individual. The ambition behind DAISy was to have a system that allows us to track individuals' progress, so that we can understand what is happening. One of the advantages of the fact that DAISy works at the level of the individual is that we can also link it to the other data that I have talked about—the hospital data and the death data—which allows us to gain a good understanding of what is happening.

The other important aspect is that, prior to DAISy, the data that we collected covered only drug misuse. Following the introduction of DAISy, we have a lot more data on people who present with alcohol problems than we had in the past. So, although there are gaps, it is crucially important to recognise the ambition behind DAISy and that the data that we collect can still be used effectively.

On the challenges that the Auditor General highlighted about DAISy in his report, I acknowledge and accept that there are gaps. My role as the director for data in Public Health Scotland and as the head of profession for statistics is to ensure that we have data that is as robust as possible and that people can have confidence and trust in what we produce. That is at the heart of my role, and it is really important that we deliver that.

DAISy collects data at different parts of an individual's journey through the system. For example, we collect data on referrals, waiting times, assessments and reviews, and discharge from the service. The figures that are quoted in the Auditor General's report about completeness refer to the completeness of the individual's whole record; the Auditor General is not saying that we

do not have data for 34 per cent of individuals. We have some data for the majority of people, but there are gaps, particularly when it comes to assessment and review. We are currently doing work to address that—Maggie Page is chairing a review to get to the heart of the issue and address it.

I will explain why the data gaps exist. We have said quite a few times that the issue is complicated and complex, but, at its heart are two major issues. One is around an individual's consent to the data being used in this way. We are talking about highly sensitive data, and individuals regard it as such. Individuals come into contact with professionals in the system, and those professionals need to gain the trust of the individuals they work with in order to improve their health, which is the ultimate aim. If individuals choose not to consent to the data being submitted to DAISy, as is their right, that can cause challenges with the data coming through into Public Health Scotland.

The biggest challenge with regard to the data that is missing due to lack of consent is to do with the assessment and review data. Generally speaking, the data for referrals and waiting times is good. We know how many people are coming into the system, so we understand the profile of the patients, which enables us to understand where there might be gaps in the referral data and what we can do to estimate the impact of that gap in relation to policy making.

The other issue, which I think that you have touched on, is information technology or data sharing challenges. It is important to understand that the DAISy system is a data-collection tool and we are aiming to standardise the data that comes through, which will allow us to understand what the data is telling us across the country.

Between them, the ADPs use a combination of IT systems to record data about the individuals who come through their services. At the latest count, there were 20-plus different systems in use. That is a challenge, so I am putting that on the table. These days, the technology exists to enable us to get data out of those systems without mass standardisation across the country. However, up to now, one of the major challenges has been getting the data from those systems. We do not want to see the ADPs using valuable time double-entering information into their main system and then also into DAISy, because that would be a waste of their resource.

Therefore, a fundamental part of our review has been to work with the ADPs to ensure that there is automatic transfer from their systems into DAISy. Our team in Public Health Scotland is working closely with Government and the ADPs to address that. My sense is that that work will take time because it is quite a complex process. All those IT systems are different, so we have to factor that in, but over the next 12 to 15 months I expect to see real progress on the gaps in the data that are mentioned in the report. I will pause there as I have said quite a lot.

Colin Beattie: Thank you for the background on the data. I will come back to what I asked about before. How good is that data for the purpose of informing local service planning? I am thinking in particular about the rural side, which is more difficult to reach .

Scott Heald: Public Health Scotland takes a national perspective with regard to all the data that it manages and collects—that is an important part of what we do—but we also produce and make available data at local levels. If you are familiar with our official statistics that are publicly available, you will know that they are often published at ADP or health board level. One of the ambitions of the DAISy system is to be able to feed back to local systems what the data is telling them. Therefore, in those areas where there is relatively good completeness, the data is available. In the areas where the data is less complete, I would agree that that is more of a challenge. However, it is also worth remembering that those areas have their own local data that they can use. Our ambition behind DAISy is that we will have a common, consistent approach across the country that allows us to enable comparisons of what is happening across Scotland and inform future policy and direction.

Colin Beattie: A lot of money is going into this, there is a huge focus on it and I think that everybody in Parliament has a high expectation that DAISy will produce results. My concern is about whether the data is incomplete or will not give enough of a steer at a local level with regard to patterns of drug use and therefore the provision of the service to meet actual local need, which must differ between urban and rural areas and between different parts of the country. Are we getting enough information to be sure that we are targeting the right places with the right resources?

Scott Heald: In short, yes, but there is still work to be done. As I have highlighted, there are a lot of really robust data sets that have existed for many years that give us the granularity to understand what is happening in particular areas, and there are data sets, such as DAISy, where further refinements and development are required.

However, we have highlighted other innovative uses of data in Scotland, such as RADAR—forgive me, I always forget what that stands for, but it is the alert system for what is happening in different parts of the country. That is an innovative use of data in Scotland that allows us to highlight specific concerns that are arising in particular areas.

I do not want the committee to think that the gaps in data through DAISy are somehow limiting the use of data across the wider system. We acknowledge that there are gaps and we are addressing those gaps, but the ambition behind DAISy is to make the system even better, and we have to hold firm to that.

Maggie Page: Scott Heald is absolutely right. We need to do a lot more work to bring things together to make data collection more efficient so that collecting, managing and processing data is less of a burden on front-line services.

We have gold-standard national statistics. As we have said, other parts of the UK and elsewhere look to our RADAR surveillance system as a good example of a rapid surveillance system. That is where we use management information rather than gold-standard national statistics. We have data coming in much more rapidly and can respond more quickly to it. That means that we offset quality against timeliness, because we can never have both at the same time.

The implementation of the medication assisted treatment standards is supported by Public Health Scotland's MAT standards implementation support—MIS—team, which gathers a lot of data from local areas in order to provide that support. Where Public Health Scotland's expertise comes in is in relation to the rigour that ensures that that data is robust enough to be useful and not misleading. We rely on Public Health Scotland's expertise in making those judgments in an informed way, which enables us to interpret that data.

There is a move now to being able to reduce the data burden by being more efficient and centralised with things such as DAISy. However, at the local level, there is a lot of data reporting through the MIS team and the drug-related deaths database, which gives us a lot of detail about virtually all of the drug-related deaths across the country. That tells us a lot about people's backgrounds and the challenges that they face, which is a valuable source of information for developing strategy at the national and local level.

Colin Beattie: You indicated that comparisons with other countries are difficult, certainly from a data point of view, but there must be lessons that we can learn from other countries. They must have had successes that we could, to be frank, steal. We should not be too proud; if someone has found a way to do something better, we should latch on to that and see if it will work here. How good are we at learning those lessons?

Caroline Lamb: I agree absolutely. In every area, we want to see what is happening and what is working well, whether in other parts of the UK, across Europe or internationally. We have engagement with other systems. Maggie Page can provide some of the detail on that.

Maggie Page: I absolutely agree with what Caroline Lamb said. I will give a couple of examples.

There are 10 MAT standards. MAT standard 1 is about same-day prescribing. When somebody presents, particularly with an opiate dependency condition, they have the right, if it is clinically appropriate, to be prescribed on the same day. That comes from international evidence, and other countries have seen real improvement in treatment rates as a result of such an approach. That is one of the standards that we are working towards implementing throughout the country and is just one example of how we are taking an evidence-based approach using international evidence.

Similarly, our surveillance approach is connected with the rest of the UK and internationally because, obviously, the drug trade routes are international. The international information on trends is hugely valuable. At the start of this year, we hosted a round table at which we had presentations from various countries, including the Republic of Ireland, Canada and the United States of America. They talked about how they address drug incidents, particularly when there is a major influx of a new or novel drug into the market. That incident management approach has very much informed and supported our approach in that area.

Colin Beattie: My final question relates to early intervention, which, in almost anything, is a good thing. What progress has been made on early intervention and preventative measures by way of education in schools? How is the Scottish Government working with Education Scotland to take that forward?

09:45

Caroline Lamb: Prevention and early intervention are at the heart of what we are trying to do. We have been working with projects for young people, including Planet Youth and the routes programme, which are aimed, in the first instance, at preventing people from getting into substance abuse situations. The routes programme also works with and supports children who are in families who are already affected by substance abuse.

I referenced earlier the work that we have been doing with the Convention of Scottish Local Authorities on the population health framework, which is due to be published early in 2025. That is absolutely about looking at all the determinants that impact on population health, including the use of drugs and alcohol. It is a whole-Government—in

fact, a whole-society—approach to ensuring that people have good employment, good housing, good education and good opportunities in a way that helps to ensure that they are able to keep themselves well and to have better life chances.

I have already referred to the population health framework and the work that we will be taking forward on that. Maggie Page can talk about the detail of our work with Education Scotland.

Maggie Page: The work on the population health framework is really important. A few years ago, a literature review called "'What works' in drug education and prevention?" was published, looking at all the evidence in the area. It is a huge report, but to summarise it in one sentence, it says, in essence, that, rather than taking the "Don't take drugs, kids" approach, you need to take a holistic approach and build resilience in young people so that they take positive decisions.

It is important to take that holistic approach and consider a young person's decision to use drugs, particularly when they start to use drugs and alcohol very harmfully, because there is a lot going on that gets a young person to that point. We need to understand and address the drivers of drug use, and not just see the drug use in isolation. That is really important, which is why we have been working across Government on the population health framework.

We are also working with Education Scotland. We will meet it again early in the new year to take forward the specific recommendation from the Audit Scotland report, but it is already taking forward work on the issue from our cross-Government plan, which was our response to the Drug Deaths Taskforce. We hope to work further on that in the new year on the back of those recommendations.

I would also like to talk about our whole-family work. I do not mean to offend Public Health Scotland, but the drug-related deaths database can look like a dry statistical publication. However, it is rich in detail and in understanding of the challenge that we face, and I urge people to read it. One of the most striking statistics in it is that, in one year, more than 500 children under the age of 16 lost a parent to drug-related death, and that was not a particularly exceptional year, so thousands of children are experiencing that.

The intergenerational and multigenerational aspect of this challenge is really important. The whole-family approach work and the work of the routes programme, which Caroline mentioned, are important, because they are specifically about supporting the children who are experiencing that. Work on parental drug and alcohol use is really important, and it is about targeting the children who are affected. The education and curriculum approach is important and absolutely has its place, but a lot of our energy and focus right now is on that whole-family approach and working with those families most in need.

The Convener: Thank you very much. James Dornan is joining us via videolink, and I invite him to put some questions to you.

James Dornan (Glasgow Cathcart) (SNP): I have some questions about barriers to accessing services. Will you explain the reasons for slow progress on key national plans, including the specific actions that are set out in the workforce and stigma action plans, such as the workforce mapping exercise and the implementation of a stigma accreditation scheme? What are your plans to address those?

Caroline Lamb: Again, I will start, and I will ask Maggie Page to provide further detail. You will be aware that we published the workforce action plan in December last year. Work is continuing to progress the actions under that plan, at least one of which was listed in the letter that I sent to the committee. A workforce framework will be published early in 2025.

We have also been working to ensure that there are routes into the workforce for people with lived experience, in particular by supporting an apprenticeship programme, and that there are guidelines for employers on how to support their workforce. We face challenges in relation to workforce planning and workforce data, which we are working on, too, but getting the right workforce in place and supporting that workforce are key to the sustainability of the work that we do through the national mission and beyond.

Equally, we have already touched on the work on stigma. That approach needs to run through every aspect of what we do.

Maggie Page: I agree with that. There is an outcomes framework for the national mission, and stigma is one of the cross-cutting themes in absolutely everything that we do. That includes work on a workforce framework and a national collaborative and things such as the implementation of the MAT standards.

To add to what Caroline said on the subject of the workforce, the workforce plan was developed with the workforce expert delivery group—the WEDG. That group is continuing. It is taking a co-production approach with experts in the field. An awful lot of work has been done over the past year, and the three new publications will come out early in the new year.

The capability framework will set out the knowledge and skills that are expected of the workforce, in an effort to upskill the workforce and to acknowledge the important and special skills

that people who are working in front-line drug and alcohol services have. The provision of pathways for people with lived or living experience to get into the workforce includes the provision of volunteering opportunities. In some cases, volunteering can be a valuable pathway. That is part of the guiding principles.

As Caroline mentioned, there is also the addiction worker training programme, which is run by the Scottish Drugs Forum. It provides a Scottish vocational qualification-level qualification that people who have lived or living experience can gain so that they can go on to be addiction workers. That is a really inspiring programme. If members ever get the chance to go along to the graduation ceremony, I would encourage them to do so.

James Dornan: Thank you very much for that offer.

Do you agree that progress has been slow, or are you happy with the progress that has been made? Alternatively, is it the case that progress has been slow, but there is now an acceleration in progress?

Caroline Lamb: As I said in my opening remarks, a lot of the work has been about laying the foundations and making sure that the process is informed by evidence and by people with lived experience, and that we do the right things in the right way. We are now moving into a period of accelerated delivery. That is where we are. The focus has been very much on getting this right.

James Dornan: On residential rehabilitation, what is your understanding of the demand for it, the capacity that exists and whether the service offers value for money?

Caroline Lamb: On capacity, we set out the aim of providing 1,000 residential rehab placements a year. I think that we are well on track to being able to evidence the fact that we can deliver those numbers. I will hand over to Maggie to talk about that. We have also demonstrated success in increasing the number of residential placements that are available to us.

Maggie Page: We have set ourselves the milestone of getting to 1,000 placements by 2025-26. Yesterday, a report was published that shows that we have already managed to surpass that, but we have an ambition to further increase the number of placements. The additional placement fund that was introduced this year will provide more funding so that even more people can be referred. In my view, that shows that there has been a real shift in the amount of progress that has been made on residential rehab, given where we were at the start of the national mission.

On demand, our commitment is to increase the number of beds by 50 per cent. I am just checking the data here.

Caroline Lamb: From memory, I think that it was to go up to 500 and something beds from 425.

Maggie Page: We are committing to go from 425 beds to 650 beds by 2026. As of September, there was a maximum capacity of 513 residential rehab beds in Scotland, so there is progress there, as well.

James Dornan asked about value for money. At the start of the residential rehab programme of work, we did a lot of baseline working, because, when we started on this area, there was very little knowledge. The majority of residential rehab is either third sector or privately run, and there are a couple of national health service providers. Our investment has largely gone into that third sector area. There are around 20 providers in Scotland now, and they are all quite different.

The challenge when talking about value for money is that people will compare residential rehab with a pharmaceutical intervention, such as methadone, for which there is a much more standardised approach to understanding cost and value for money because of the scale and standardisation of the approach that is taken for pharmaceutical interventions—you go through National Institute for Health and Care Excellence trials and those sorts of things. Residential rehab is a psychosocial approach and you cannot do the same kind of comparative work on it—that is just not possible with such an approach.

The baseline data that we have gathered showed the costs of residential rehab and the various costs for different providers. By and large, the average cost of a placement is around £20,000. It is useful to know that for when you are doing the maths and working out how much it costs to get people into residential rehab.

I would argue that we are seeing results from it, and the fact that we are getting more and more people into residential rehab and that people are asking for it is really important.

James Dornan: I will just come back to value for money. I agree that residential rehab is vitally important, but there must have been some work done on that issue. There must be some way to gauge whether it is a more cost-effective—as well as successful—way to treat people who need that kind of input, rather than medication or the other routes that one can go down. Some work must surely have been done on it beforehand.

Maggie Page: Yes—a lot of work has been done. We invested a lot in analysis in the baseline work on residential rehab because we were

starting from such a low base, with the sector being quite underdeveloped in Scotland at that stage. As I said, there has been a lot of work.

It is very challenging to look at value for money. From an analytical perspective, to look for the exact value for money of residential rehab and compare it with that of a medical intervention such as methadone is comparing apples and pears. There are methodological challenges.

Having said that, we have commissioned Public Health Scotland to undertake an evaluation specifically of the residential rehab programme, and that fits into its overarching evaluation of the national mission as a whole. That evaluation is looking at value for money. Not only did we look at the evidence base that was out there at the start, but, with our major intervention of a significant investment in both capacity and referrals to residential rehab as a result of the mission, we recognised that we have a duty to follow that through and add to the evidence base as we go.

A core minimum data set is being developed. The publication that I referred to that was published on Tuesday—everything is on a Tuesday with Public Health Scotland—was the first publication from that core minimum data set. At the moment, the data set does not tell us a huge amount—it tells us about the number of referrals—but it will build as we go. We will be able to collect data and, we hope, to track some people going through residential rehab to contribute to the evidence base.

This is always a real challenge in health. Some things are easier to measure, but that does not mean that they are more effective or more important than others. That is where we have to be quite brave, follow the evidence and add to the evidence base as we go.

10:00

James Dornan: I have one final question. Could you give me an assessment of the size and scale of recovery communities and of whether adequate measures are in place for safeguarding the welfare of volunteers and those with lived and living experience who play a key role in those communities?

Caroline Lamb: I will come to Maggie on that question, too. Clearly, recovery communities are really important and are another area that we have been seeking to support and promote throughout the mission. Maggie, do you want to answer on the specifics?

Maggie Page: I do not have to hand the data on the size and scale of recovery communities. I do know that we are supporting recovery communities through the Scottish Recovery Consortium, which is the national body for recovery communities. It has reported a growth in the sizes of individual recovery communities and in their numbers. I do not have the exact data, but I am sure that we can provide it for you in writing. The Scottish Recovery Consortium plays a really important role not only in being the voice for recovery communities but in supporting them on issues of safeguarding and leadership in that area.

James Dornan: It would be helpful if you could get that information to us when you can.

Caroline Lamb: We will do so.

The Convener: I will pick up on one thing that Maggie Page said, which is that the residential rehab sector is underdeveloped—you painted a picture as though this is year zero. Was there not a much greater level of capacity previously and then a contraction—so what we are seeing now is an expansion on the back of a former period of reduction of a lot of those places?

Maggie Page: I do not really recognise that. I will have to check. We did the baselining report to consider what was out there, because there was not a central investment in residential rehab, so there was no central record of the number out there. A lot of work was done at that stage to understand what the provision was. I was quite involved in that report, and some of it told us that, although a lot of residential rehab centres existed, they were almost exclusively private and, quite often, had an international clientele—although they were based in Scotland, they were not necessarily part of the Scottish landscape of provision.

I can get back to you in writing, but I do not recognise that capacity contracted over the shorter term. Anyway, it depends on what period we are talking about.

The Convener: I might be talking about a slightly longer time horizon. The matter has been raised with me in discussions that I have had over the past few years.

We need to move on, so I am very happy to invite Graham Simpson to put some questions to you.

Graham Simpson (Central Scotland) (Con): Thanks very much, convener, and good morning to you all. It has been a really interesting session so far.

I want to pick up on a few things that have come up already—I will stick to the matter of residential rehab. The Auditor General says on page 33 of his report that there are barriers for people accessing residential rehab. He says that

“many people are identified as unsuitable”

for it

"because they have mental health issues ... there are no local facilities and for whom moving family and children would be impractical .... they are not ready to cope with the high intensity of a residential programme"

or

"they are not able to meet the requirements of an abstinence-based approach."

Given that he is quite clear about that point, do you think that there are people who need residential rehab who are missing out on it?

Caroline Lamb: As an introduction, I will say that residential rehab will not be suitable for everybody: it is not the only answer. We need to ensure that services are available that respond to people who are ready for abstinence—to take one example—just as much as to those who might not yet be ready to take that step. I ask Maggie to provide detail.

Maggie Page: I agree with that. The points in the report that you have highlighted are largely correct. Our aim is for residential rehabilitation to be available to everyone for whom it is deemed to be clinically appropriate.

It is really important that residential rehab should be clinically appropriate for individuals, because it can be a high risk path for people if they are not ready for it. An abstinence-based approach can have a high risk of relapse, or a residential placement might just not work for them. If they drop out of it, it can be psychologically stressful, so there has to be close clinical involvement in the discussion about what is appropriate for the individual at that time.

That covers the point about whether a person meets the requirements, and it is important to highlight the clinical appropriateness requirement and that the individual needs to be psychologically ready and in the place where they want to be. Residential rehab is not the magic bullet that it is presented as in some of the discourse, and we should not be compelling or forcing people into residential treatment. That would never be the intention.

On Mr Simpson's other points, we accept that the Auditor General's report talks about people for whom

"there are no local facilities and for whom moving family and children would be impractical".

However, we have also introduced and funded two new mother and baby units in Scotland, one of which is supported by Aberlour, and there is also Harper house, which is a whole-family unit. Those are new interventions that try to widen accessibility of residential rehab to people who have lots of different needs.

Mental health issues are a much wider challenge. We are aware of that and are taking action to address it. We recently published a protocol for mental health and substance use, because people are telling us, and the evidence suggests, that they cannot get their drug treatment because they have a mental health condition, or they cannot get their mental health treatment because they have to sort out their drug condition. The protocol sets the gold standard for how the two services should work together at the local level. Healthcare Improvement Scotland is developing that on our behalf and it is being rolled out across the country. That is important—not just for residential rehab, but for drug treatment and mental health treatment more generally.

Graham Simpson: I accept that not everyone is suitable for residential rehab and that it is not a magic bullet. That is true. However, my basic question is this: are the barriers too high in some cases? Are there people who might be suitable but who are missing out because of the strict criteria?

Caroline Lamb: You say "strict criteria", but it is about clinical assessment of whether the treatment is clinically appropriate for somebody. What is important is that we ensure that, when residential rehabilitation is not clinically appropriate for someone, other routes are available to them.

Maggie Page: That is absolutely right. Again, Public Health Scotland is carrying out an evaluation of residential rehab programmes specifically, and it will go into such questions in a bit more detail. We are taking a learn-as-we-go approach.

Graham Simpson: I will ask about another area. Colin Beattie raised a point about younger people. Anecdotally, we read that younger people are perhaps not drinking as much as their parents did. I can testify to that. We have read various reports that there are now younger people who just do not drink at all. Have you got any data for Scotland? If that is the case, it would suggest that, at some point, the alcohol problems that we have will lessen.

Scott Heald: The situation is complicated. Anecdotally, what you outline is correct. The challenge that we highlighted before is that there will be people who choose abstinence, so they do not drink, and there will be people who drink excessively. That is the area that we need to understand. Those individuals might have a further impact on the system at a later date, so it is important that we get beneath the data. I do not have the figures to hand, but Maggie Page might have more details that she can share.

Maggie Page: I do not have the figures to hand, either.

Graham Simpson: Do they exist?

Maggie Page: I think that they do. We have certainly been tracking the situation. I am not sure how recent the statistics are for Scotland, but we definitely track it.

Graham Simpson: It strikes me that it would be interesting to find out why it has happened, because there seems to have been a shift. I am sure that it is complicated, but it would be good to understand what has led to that shift and whether we can learn anything from it.

Maggie Page: We could come back in writing with some more detail on that. It is the source of a lot of academic debate because, as I mentioned before, it is a Europe-wide phenomenon that there has been a cultural shift away from heavy drinking—from drinking generally—among young people. Like anything that is a source of academic debate, it becomes complicated and there is never one straightforward answer.

There are good points. If there is less drinking overall and that becomes a generational shift that we move through, that cannot be a bad thing. However, I also highlight the point that we need to make sure that we understand what is happening underneath that. If there is still a cohort of people who drink to excess, that could become even more isolating for that cohort, so we probably have to change our approach. I am not saying that it is a good or bad thing, but we need to be mindful of that.

Scott Heald: I echo that. We have a team in Public Health Scotland that is dedicated to looking at alcohol misuse, so I can certainly take the question back and work with Maggie Page to come back with a briefing.

Graham Simpson: Okay. That would be great.

Maggie, you said that street benzos are more prevalent in Scotland than they are elsewhere. Do we have any idea why that is or has been the case?

Maggie Page: Prior to the emergence of street benzodiazepines, what was common was misuse of prescribable benzodiazepines, such as temazepam: blues or jellies—you might have heard them referred to as various things over the years. Temazepam and diazepam, which are the two main prescribable ones, were commonly misused in Scotland. That was just a cultural thing—crack cocaine was more commonly used in the south-east of England, for example. One of the drivers—I am not saying that it is absolutely the only driver; as I mentioned, the situation is complex—is that use of Valium, temazepam, jellies, or whatever you want to call the drug, was more common and a greater part of drug-use culture up here in Scotland. That meant that, when the stronger and cheaper more prevalent street benzodiazepines emerged—we have seen drug seizures of those in the millions in recent years in Scotland—the Scottish population was more vulnerable to them than people in the rest of the UK.

Graham Simpson: The national mission is due to end in 2026. What is the national mission and what has it achieved?

Caroline Lamb: The national mission set out to address the public health emergency around drugs and, as we described, it has had a positive impact in relation to a lot of the work that has been done on alcohol.

In the early phases, it has been about setting the foundations. We are now moving into sustained delivery. From there, we will transition into the post-national-mission work. A lot of the work that has been done on the workforce, the national guidelines and development of the national specification for drug and alcohol services is absolutely about putting all that on a sustainable footing for delivery going forward. That will be supported by the evaluation that Public Health Scotland is doing.

We have reported regularly on the progress of the national mission: Maggie Page might want to add to what I have said.

10:15

Maggie Page: Yes—I can add to that.

Essentially, the national mission is a mission to reduce deaths and improve lives. It is really important that it is for both. We are responding to the drug deaths crisis and the unacceptable levels of deaths, while recognising that that response alone will not address the need to improve the lives of and support people who use drugs, and their families, in the communities that they live in.

I am emphasising that the national mission has a dual purpose, but it is difficult when we go on to what it has achieved. We are rightfully judged on the overall top-line figure of drug deaths, which peaked in 2021. In 2022, we saw a significant drop but, unfortunately, that drop was not sustained in 2023: we saw a 21 per cent drop, then a 12 per cent increase. The suspected drug deaths figures were published recently, and showed a 7 per cent decrease in the first three quarters of 2024 compared to the period in 2023.

I think I might have got my dates muddled up—I acknowledge that for the *Official Report*.

We are not seeing that increase continuing. It looks as though the figures are coming down by somewhere in the region of 7 per cent this year, but we will have to wait to see what the official statistics say.

My point is that the national mission is not just about deaths: it is also about improving lives. It is much more challenging to measure and evaluate what is achieved in that, but it is important that we do it. That is why we had Public Health Scotland do the full evaluation of the national mission and ask those evaluative questions. It is doing a lot of work around understanding that. It has done key informant interviews and a workforce survey that was published a few months ago. It is also doing a survey of lived and living experience, in order that we can understand the perspectives of the people who are directly involved in the national mission or are being supported by it.

Graham Simpson: My reading is that it is all very well to have the mission, but given the figures that we have already discussed, it has not been a roaring success, so far. That is just my view.

I want to move on to discuss the clear link between poverty and drug deaths. In 2021, National Records of Scotland made clear the link between the two. It produced a report that stated:

"In 2020, after adjusting for age, people in the most deprived areas were 18 times as likely to have a drug-related death as those in the least deprived areas … That ratio has almost doubled in 20 years. In the early 2000s, those in the most deprived areas were around 10 times as likely to have a drug-related death as those in the least deprived areas."

Things have got worse, really. Why do you think things have got worse?

Caroline Lamb: I will start off by saying that the link between poverty, drug and alcohol abuse, and therefore drug and alcohol-related deaths, is well understood. As I described earlier, the links between poverty and population health more generally are challenging. The way that we have approached the drugs mission and the response to the Scottish Drug Deaths Taskforce report is not just a cross-Government mission, but a cross-society mission.

Earlier, Maggie Page quoted statistics about the enduring nature of drug use and the impact that it has had. It is about drug use having its roots in poverty, but people continuing to use drugs for long periods of time also have an impact. Maggie, do you want to add to that?

Maggie Page: I think that you are right. This is a national problem, but it is particularly acute in the most impoverished areas, and we absolutely recognise that in our work. Also, although the ratio has doubled, it has happened at the same time as we have had an increase that has negatively affected the poorest areas most.

That is why we have been taking a cross-Government approach with the national mission. Our response to the Scottish Drug Deaths Taskforce report was a cross-Government delivery plan, with more than 80 actions that we are committed to and which we are tracking as we go. We are working really closely on that. We have a whole-systems unit in the drug policy division in Government, and it is working really closely with people across the Government, including in mental health, with the protocol that I mentioned earlier, with colleagues who work in homelessness, with justice services and with other areas to make the links and ensure that we are delivering on a whole-system basis.

I spend a lot of my time making presentations on and talking about the national mission to other parts of Government, and other areas of public policy generally, to emphasise the needs of people who use drugs. After all, the people who use drugs use lots of other services and need lots of other services and support, too. They should not be looked at as a drug problem; they are people with a multitude of challenges and needs that we need to address, so that is absolutely the approach that we are taking.

Graham Simpson: Okay. I did not want to leave the Auditor General out of this, so I will quote from his report, which says:

"In 2022/23, people in the most deprived areas of Scotland were seven times more likely to be admitted to hospital for an alcohol-related condition than those in the least deprived areas".

I think that we are all agreed on that, but it strikes me that the NHS and the alcohol and drug partnerships are having to pick up the pieces for a failure to improve the general wealth of the nation. If poverty is embedded in some communities and is not getting any better, it is you guys who will have to pick up the pieces. I was therefore concerned to read in the Auditor General's report about an 8 per cent decrease in real-terms funding for ADPs over two years. Why was that done, given that we have such deep-seated problems?

Caroline Lamb: I think that we need to focus on the record investment in dealing with alcohol and drugs and on the fact that that level of investment, as the Auditor General notes, has doubled. Despite what, as you will all recognise, are some extremely challenging financial circumstances, we have maintained investment in alcohol and drug partnerships at £112 million, and we have sought to progressively mainstream and baseline that money to give security of funding against an extremely challenging financial backdrop.

Graham Simpson: There are a couple of other areas that I want to ask about quickly. You have already mentioned minimum unit pricing. In your letter to the Auditor General, you repeatedly called the policy "world-leading", saying that it

"has saved hundreds of lives".

What is the evidence for that?

Caroline Lamb: The evidence was provided by our colleagues at Public Health Scotland, so I will ask Scott to speak to that one.

Scott Heald: Our evaluation of minimum unit pricing looked at a range of factors related to its impact across Scotland. Within that, we highlighted its impact on hospital admissions and on reducing deaths, and those are key success factors. As I have commented, our summary of that report was that minimum unit pricing had been a success, and we were supportive of the increase that came in earlier this year.

Graham Simpson: But how were you able to link the two? How was that possible?

Scott Heald: In terms of—

Graham Simpson: How can you link minimum unit pricing to admissions to hospital?

Scott Heald: One of the things that the report did—and we have a team of evaluators in Public Health Scotland who looked into this—was to make baseline comparisons with other countries. In the report, we showcased the impact on the changes and trends that occurred in Scotland compared with trends in England and other parts of the UK that have not introduced minimum unit pricing, as well as other literature reviews that were undertaken by the team. A lot of data is contained in our evaluation, which showcases our view that MUP has had an impact in Scotland.

Graham Simpson: How far do you think it should go? Should we just keep increasing the price of drink in Scotland, year on year?

Scott Heald: The important point that our report highlighted was that, although the initial price of 50p had stayed static, inflation had increased over that time. That means that, in real terms, from when it was first introduced to when it was changed to 65p, there was, in effect, a decrease. There is definitely a point about ensuring that we track the inflationary rates in the country; that is what led to the change to 65p.

Graham Simpson: If we have this divergence between Scotland and England, at some point, people will start to react to that. In fact, I read in *The Sunday Post* at the weekend that we are getting "booze runs", which used to refer to people who live on the south coast hopping across the Channel to stock up on cheaper drink, but which now appears to be happening in Scotland—certainly in the south of Scotland. People are driving across to Carlisle, filling their boots and driving back.

Scott Heald: We need to be careful of anecdote around those types of stories. Although I do not doubt that some individuals will be doing that, the Public Health Scotland report looked into that issue, and I do not think that it was as big as has perhaps been suggested.

An important part of any evaluation is that we continue to evaluate as time progresses. Following the increase to 65p, it will be important that we keep monitoring the key indicators such as hospital admissions, deaths and other harms related to alcohol.

Graham Simpson: I have one other question in another area—

The Convener: One other very brief question.

Graham Simpson: Yes, a very brief question, convener.

Caroline, in your letter, you list a number of stakeholders that you are liaising with, such as the Scottish Health Action on Alcohol Problems, Alcohol Focus Scotland and the Scottish Alcohol Counselling Consortium. It struck me that nobody on that list is actually involved in the drinks sector—the Scottish Beer and Pubs Association would be just one example. Do you also take advice from people who are involved in serving the public?

Caroline Lamb: We work closely within the Scottish Government with our colleagues through the director general economy. There has been a lot of work and discussion with them around the work that Public Health Scotland is doing on alcohol marketing, for example. We engage through DG economy with other stakeholders as well.

The Convener: Thank you for your forbearance, Graham.

I now invite the deputy convener, Jamie Greene, to put a final suite of questions to you.

Jamie Greene (West Scotland) (Con): I am not sure that the questions will be sweet, but they are a suite of questions.

Thank you very much for the evidence that you have given. I have been listening with great interest.

Where do I start? Ms Lamb, let me put this in context. This coming Sunday will mark 22 years since I lost my dad to drugs and alcohol. I was 22 years of age at the time, and he was 42. I am now two years older than he was when he succumbed to those diseases. You might thus appreciate my sense of sadness, frustration and perhaps even anger that we are having this conversation, two decades later. Far too many people in Scotland are still going through what I went through as a young boy.

We have talked about a lot of statistics today, and behind every one of those statistics is a person. Year on year, more and more people are

dying of drugs and alcohol in Scotland—two decades on from when I thought that things could not get any worse.

I guess that what I am asking is this: do you understand why so many people are so frustrated and so angry at the direction of travel with the statistics? Do you understand why so many people have lost confidence in the Scottish Government and in your ability to manage the problem?

10:30

Caroline Lamb: First of all, I am very sorry for the experience that you went through.

We have recognised that the level of deaths from drugs and alcohol is unacceptably high in Scotland. We work very closely with families, stakeholders and people with lived experience—I am sure that Maggie Page can expand on that—and so, yes, we absolutely understand the level of grief, frustration and, indeed, anger of the many people who have been personally impacted by losing loved ones and, indeed, by the stresses and strains of living in situations where people are affected by drugs and alcohol abuse. We absolutely understand that.

Maggie, do you want to say anything more?

Maggie Page: I echo what Caroline said. One of the cross-cutting themes of the national mission is putting lived experience at the heart of this work. We have seen that in the human rights-based approach of our work through the national collaborative, which has been very much co-produced with people with lived and living experience, and we also make sure that we are listening to the voice of lived and living experience across everything that we do. We work closely with organisations, particularly those such as Scottish Families Affected by Alcohol & Drugs, which does tremendous work in supporting families, including bereaved families, at what are, I absolutely accept, impossibly difficult times for them.

Jamie Greene: It is impossibly difficult, particularly if you are young. Many young people are living through the experience of being the carer for their parents who are struggling with alcohol and drug problems. That is indescribable, to put it mildly.

I had the unfortunate experience of having to repeat the situation a couple of years ago with another close member of the family, so I have gone through all the experiences that we have talked about today more recently—everything from the ADPs to the rehab options to the primary care options. I do not say this to score points, but I can tell you from first-hand experience that it was incredibly difficult and nigh-on impossible to get support for someone who was struggling with an alcohol addiction. That was just a couple of years ago, in modern-day Scotland, and years and years after my previous experience. Personally, I do not think that things are getting better, and I think that many people watching this session will share that view, unfortunately.

Here is what I do not understand. I appreciate all the money that has been pumped into this: you talked at great length about the doubling of the budget from £70 million to £160 million between 2013 and 2023-2024, the ring-fenced money for ADPs and the national mission cash that has gone into all of this. I have heard a lot about that, and it is all very welcome—it really is. However, despite that, year on year, the numbers still go up: there were 527 drug deaths in 2013 and 1,172 in 2023. It seems as if cash is not solving the problem. We can keep pumping money into it, but the statistics are still heading in the wrong direction. I cannot get my head around that. Please help me to understand why pumping more money into the problem has not solved it.

Caroline Lamb: First of all, as Maggie has explained very eloquently, the problem is extremely complex and also very long standing. I hope that you will have heard from the evidence that I and my colleagues have given today the commitment and the drive towards improving things. However, although people are working incredibly hard—not only in the Scottish Government and Public Health Scotland but across all our alcohol and drug partnerships—it is going to take some time to turn things around.

Yes, we are investing. As I said, we have invested in setting the foundations in order to have an increased pace of delivery but also to sustain delivery. This is an ingrained problem. Some of the actions that we are taking, such as the increase in residential rehab placements, are more effective in the short term. Other actions around stigma are going to take longer to become absolutely mainstream in society and in people's attitudes so that we create the conditions to really accelerate success in this area.

Jamie Greene: I have heard two phrases used a lot this morning: one is that the issue is complicated, and the other is that it is complex. I do not disagree with you. There are so many intertwining issues that make it complicated. These are long-standing generational problems in communities such as the ones that I grew up in—I understand and appreciate that—and many of the wider macroeconomic factors that have been affecting the issue over the years are outside your control.

However, hearing that the issue is complicated and complex does not fill me with confidence that

we are heading in the right direction. I came to this evidence session with an open mind, and I wanted to leave full of confidence that the problem is understood, that there is a strategy and that the direction of travel is right, and having seen that there is some honesty about any failures that have happened. I have heard responses that give me some confidence in that respect, but I have heard other responses that do not. This is your opportunity to say to people, yes, it might be complicated and complex, but it has always been complicated and complex. It was complicated and complex 20 years ago—that has not changed.

Caroline Lamb: We have a strategy, and we are taking work forward that is absolutely evidence-based, drawing not only on our own data and understanding but on what we know works from the experience of other countries and from international evidence. At the same time, we are tackling the changing nature of the issue—the change not just in the different age groups concerned but in the use and availability of drugs. We are also very conscious of the impact of synthetic opiates and what we need to do to ensure that we are not only using our early alert systems to alert us to those issues but ready to respond. I was at the round-table meeting that took place earlier this year that Maggie Page referred to. It was really helpful to hear about the work that has been done in this area in Dublin and Cork. We are seeking to learn all the time and to adapt our approaches as we go.

Maggie Page: I support that.

Jamie Greene: If I may ask a very specific question, are you as nervous as I am that we are on the precipice of a major problem with fentanyl in Scotland? We have seen what has been happening in other countries. If that arrives on our doorstep and the serious organised criminal gangs find a cheap and easy pathway to get that drug on to our streets, we will not be talking about 1,100 people dying—we will be talking about 10,000 or 11,000 people dying of drugs in Scotland.

Caroline Lamb: That is exactly why we convened the round-table meeting in early 2024. It was absolutely about recognising the risks that we are facing and seeking to learn from countries that are already in the throes of that experience. Yes, it is a huge risk. We are trying to do as much as we can to ensure that we are ready for that and that we are learning from the experience of other countries. Maggie, do you want to add to that?

Maggie Page: Yes, it is a very real risk, which is why we have stepped up RADAR and the incident management team for public health leads across the country. We now have guidance for any incident that involves a new or novel synthetic opiate coming into the country.

I will just add that the trend that we are seeing is not in the use of fentanyl but in the use of nitazenes, which are actually more potent than fentanyl. In Europe, the issue seems to have skipped over. We have been vigilant about fentanyl for many years now—these drugs are of huge concern.

RADAR publishes a quarterly report that goes out to the sector and details what we see. That is also an active process. If alerts that come up in between reports or any of RADAR's indicators look like they are of concern, the team will pick that up with local areas and feed that data out to the people who need to have it so that they can manage the response—and do so responsibly, given that it is very delicate information to manage and interpret.

The situation is a big concern. It adds to the other driver of increased drug harms, which is the increased dynamism of the drug market. More, newer and stronger synthetic drugs are coming out. Over the past decade, we have seen lots of new ones. I talked about the new street benzodiazepines. We had etizolam, which was replaced by bromazolam. New ones come out all the time, so it is a massive challenge. However, we are very aware of the issue and are working really hard to address it.

Jamie Greene: This brings me on to a point that was discussed earlier around minimum unit pricing. I am open-minded about doing whatever we can to tackle Scotland's drug and alcohol deaths problem. I hope that you appreciate my earnest approach to that. However, I was not entirely convinced by the academic research that makes the link. I want there to be a link—I want the policy to be a success, if that is the policy—but we also need to be clear that there is evidence that makes the link. The evidence that I have is from speaking to alcoholics and drug users. I can tell you that when the cost of alcohol went way above what they could afford, many of them simply moved on to street drugs. There are many people who will tell you the truth about that situation.

That is not a case of me trying to politicise the matter because I have a problem with the policy. It is just evidence from the anecdotal conversations that I have had with many of the support groups in the third sector that are helping people on the ground. I hope that you are open-minded to that work as well, because feedback from real users is what matters, not just spreadsheets and statistics plucked out of NHS boards.

Scott Heald: I totally agree. As you said, there are people behind all the statistics, so I am very attuned to that. In your anecdote, you highlighted the consequences of a particular policy, but it is important that we not move to discrediting that

policy, because evidence shows that it is having an impact. However, it is important that such feedback feeds into the work that we all do day in and day out.

On the point that was raised about RADAR, a key point is that Scotland has that early warning surveillance system in place. That should give the committee comfort and confidence that, when new drugs emerge, we have the mechanisms in place for alerting the country to that happening.

Jamie Greene: Yes and, obviously, Police Scotland has a massive role in that as well.

I cannot let the evidence session pass without raising the joint letter that the committee has received from Alcohol Focus Scotland and Scottish Health Action on Alcohol Problems. Those are two organisations for which many MSPs will have a huge amount of time and respect. Perhaps we will not all agree on every issue, but that is not the point.

The letter is short, but I am afraid that it is stark and critical. Alcohol Focus Scotland and SHAAP simply want us to ask you to respond to their letter. They welcome many of the measures that you are taking—there is no doubt about that—but their view is that

"this is an inadequate, piecemeal approach and the actions ... do not add up to a coordinated plan to respond to the ... 'public health emergency'".

They go on to say:

"We would be very interested to hear views from"

the witnesses

"as to how the actions listed in"

your letter, Ms Lamb—including

"a real terms cut to the Alcohol and Drugs Policy budget line—square with ... comments"

and recommendations

"made by the Auditor General."

Here is your opportunity to respond.

10:45

Caroline Lamb: I have covered some of the points throughout the evidence session, but the first thing that I should say is that, given that alcohol and drug partnerships provide services to people who are affected by both alcohol and drug abuse, a lot of the actions that we have taken have been aimed at supporting people regardless of the type of substance that they have challenges with.

In relation to the increase in residential rehab, about a third of the places are used by people who have alcohol abuse problems and about a third are used by people who have both drug and alcohol abuse problems. The work on reducing stigma is absolutely relevant, regardless of the nature of people's problems. There is also the work on the workforce action plan and the work, as Maggie Page described, that is aimed at ensuring that mental health services work more closely with alcohol and drug partnership services and provide support for families. A lot of the work that we are doing is absolutely relevant to the points that have been made.

We have been developing a national specification for drug and alcohol services, which we expect to publish next year. On a UK-wide basis, we have also been working on the development of clinical guidelines for the treatment of alcohol problems, which are aimed at ensuring that those treatment principles are equal to those relating to drugs.

Jamie Greene: Will you be able to achieve all that with a real-terms budget cut?

Caroline Lamb: I come back to my earlier response. We need to focus on the fact that the budget has been doubled. In the face of significant financial pressures, we have maintained the budget, and we will be allocating £112 million to alcohol and drug partnerships. We are seeking to ensure stability by providing assurance that money will be provided in the future, because we know that having security about funding is really important in allowing the partnerships to spend money well, so we have been working to increasingly baseline the funding. Finally—

Jamie Greene: You must sit around the table with the Cabinet Secretary for Health and Social Care or the Cabinet Secretary for Finance and Local Government—

Caroline Lamb: Both.

Jamie Greene: —and say, "We need more money. It's as simple as that." I hope that you can give me some reassurance that you are jumping up and down in asking for more money, because you know that that is what it will take to deliver improvements. We cannot settle for a real-terms cut.

Caroline Lamb: Absolutely. In my role as accountable officer, I must consider a range of pressures across the budget, but I also have to be realistic about the total level of funding that is available to the Scottish Government and the need to invest in other portfolios, too.

My final point is that the population health framework will be published next year. A lot of what we need to do involves addressing the underlying causes of poor health, including poor health that relates to alcohol and drug issues, and the socioeconomic factors that drive that. That is a

cross-Government and, as I described earlier, cross-society approach.

Jamie Greene: I am glad that that is the focus.

We are running out of time, but another part of the Auditor General's report that really struck me was exhibit 4, which is on barriers to accessing services. I think that I raised the issue with the Auditor General when he gave evidence. The table talks us through someone's journey from identifying that they have a problem to getting treatment and being supported after treatment, but it paints a very dim picture, given the many barriers that exist as people go through that process.

The same issues come up time after time, including being unaware of where to get help, people being unavailable to provide help, waiting lists, shortages of suitable staff and the strict eligibility criteria, which Mr Dornan mentioned. Once people get into the services, they need to find a service that works for them, because everyone is different and every situation is unique, and once people come out of those services, they need to sustain their sobriety or abstinence from substances. It feels as though the whole system is stacked against people, and I know from anecdotal evidence that it is incredibly difficult to navigate it.

Caroline Lamb: I accept that our services need to be more joined up and easier to navigate. Earlier, Maggie Page spoke about the national rights charter—is that what it is called? I cannot remember.

Maggie Page: It is the national collaborative charter of rights.

Caroline Lamb: That was published earlier this week. It will help people to understand their rights, and it points to the importance of having people with lived experience not just at the heart of the national work that we are taking forward but engaged with local alcohol and drug partnerships. Our latest reports show that all our alcohol and drug partnerships now include people with lived experience, who are the best people to provide lived experience of what it is like to try to access services. That will help local services to improve the way in which they work and to work collaboratively with other services to make things as easy as possible and ensure that any stigma is taken out of the process.

Jamie Greene: That will work only if the services are available. The reality is that people have a very limited time to speak to their general practitioner about such issues, and services need to be as close as possible to people in their own communities. I am afraid that the reality is that, over the past decade, many services have simply disappeared due to funding issues. That is a real source of shame and has resulted in many regional disparities, including in my West Scotland region.

The report paints a picture of a postcode lottery on outcomes. After Glasgow and Dundee, Inverclyde and North Ayrshire, in my region, are numbers 3 and 4 in relation to the per capita drug death rate, but East Renfrewshire and East Dunbartonshire are at the bottom of the league table. At the bottom of the table, seven or 11 people die per 100,000 of the population, but, at the top of the table, the figure is 33 or 37 per 100,000, so there is a huge difference. Life expectancy in those areas is massively different, too, but they are a stone's throw away from each other. That does not make sense. What is going wrong?

Caroline Lamb: We recognise that there is variation. As Maggie Page described and as we know from the drug deaths statistics, a lot of that is driven by underlying rates of poverty in those areas. Across the Government and across society, we need to work to address that core cause.

Jamie Greene: Thank you. I appreciate your time.

The Convener: On that last point, I am bound to observe that the issue is not just about poverty; it is about inequality. As a Parliament, we should perhaps spend a bit of time looking at that issue in a bit more depth.

I draw this morning's evidence session to a close. I thank each witness for the answers that they have given to our wide-ranging questions. On behalf of the committee, I thank Scott Heald from Public Health Scotland for his evidence; Maggie Page from the drugs strategy unit for answering the questions that we put to her; and Caroline Lamb, the chief executive of NHS Scotland, director general of health and social care and accountable officer, for appearing before us and helping to answer the questions that we posed.

10:53

Meeting continued in private until 11:12.

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