OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Health, Social Care and Sport Committee

Tuesday 25 March 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 25 March 2025

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

10th Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Pamela Dudek (Dundee Alcohol and Drug Partnership)
Jackie Dunbar (Aberdeen Donside) (SNP) (Committee Substitute)
Eddie Follan (Convention of Scottish Local Authorities)
Kelda Gaffney (Glasgow City Alcohol and Drug Partnership)
Dr Sue Galea-Singer (NHS Fife)
Flora Ogilvie (NHS Lothian)
Gillian Robertson (Aberdeenshire Health and Social Care Partnership)
Liam Wells (East Ayrshire Alcohol and Drug Partnership)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 25 March 2025

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 10th meeting in 2025 of the Health, Social Care and Sport Committee. I have received no apologies for today's meeting.

The first item on our agenda is a decision on whether to take agenda item 6 in private today, whether to consider our work programme in private on 1 April and whether to consider a draft report on the Assisted Dying for Terminally Ill Adults (Scotland) Bill in private at future meetings. Do members agree to take those items in private?

Members *indicated agreement.*

Right to Addiction Recovery (Scotland) Bill: Stage 1

09:00

The Convener: The next item is continued evidence taking on the Right to Addiction Recovery (Scotland) Bill. The committee will hear from two panels of witnesses. We will first take evidence from local authorities, national health service boards and health and social care partnerships. The focus of our second panel will be on alcohol and drug partnerships.

I welcome Eddie Follan, chief officer for health and social care, the Convention of Scottish Local Authorities; Dr Sue Galea-Singer, clinical lead for addiction services, NHS Fife; Flora Ogilvie, consultant in public health, NHS Lothian; and Gillian Robertson, service manager, Aberdeenshire health and social care partnership.

We will move straight to questions. What difference would the bill make to people who have addictions or who make harmful use of drugs or alcohol.

Dr Sue Galea-Singer (NHS Fife): I declare that I am also the chair of the faculty of addictions at the Royal College of Psychiatrists in Scotland.

I do not think that the bill will make a huge amount of difference, because what it stipulates is already being done. It stipulates that treatment begins within three weeks, but we already stick to targets, in collaboration with the patient, to arrive at a care package that is suitable for them and that allows them to make choices. That is already being done, and adding a legal aspect to that might have unintended consequences rather than benefits.

The Convener: Would anyone else care to comment?

Eddie Follan (Convention of Scottish Local Authorities): Do we need to press the button to operate the microphone?

The Convener: You do not need to press the button, Mr Follan. Our broadcasting team will do that for you.

Eddie Follan: I should know that.

We support the intention behind the bill to increase people's access to treatment. However, we are concerned that the focus on having a single health professional determining treatment overlooks the role of whole-system working, including the work of multidisciplinary teams. I have looked at the evidence given so far, and a number of witnesses have said that that might be quite restrictive.

We are concerned that the definition of "treatment" is medicalised and abstinence-focused and that it overlooks the importance of harm reduction. I know that there is debate about harm reduction and recovery, but we do not see those two things as being mutually exclusive; we see the whole package. Last Friday, our health and social care board heard a presentation on whole-family approaches and the need to bring in the whole family and a wide range of professionals. The bill seems to us to be fairly narrowly focused.

Flora Ogilvie (NHS Lothian): To add to what has already been said, it is really important that everyone's rights are enshrined in existing human rights. There is a potential risk that a bill that singles out a particular group of service users would stigmatise them by not recognising that their right to treatment is already enshrined elsewhere. The recent publication "National Collaborative Charter of Rights For People Affected by Substance Use" sets out that people should be empowered to access their existing rights rather than needing a whole new and additional piece of legislation.

The Convener: Gillian Robertson, do you have anything to add?

Gillian Robertson (Aberdeenshire Health and Social Care Partnership): I echo what has been said. We might lose a lot of the multidisciplinary approach that we know works very well for people in recovery. The journey might be a lot bigger than what is described in the bill.

The Convener: I will pick up on something that you said, Dr Galea-Singer. You mentioned that people who are accessing services and being treated are already involved in their care planning. The bill affords the right to participate in the decision-making process, which you seem to be saying is already part of clinical practice.

Dr Galea-Singer: Absolutely. You cannot make something work unless you have a collaborative or participative approach. You are not imposing care on someone; you need to have mutual agreement on it. You provide your expert advice about something, but there is an element of choice in that the patient and their family—that is, not just the patient—have to agree to it.

The Convener: The bill also mentions getting a second determination if the person accessing services does not agree with what has been offered to them. Will you confirm whether people accessing drug and alcohol services already have a right to seek a second opinion from someone else about their treatment options?

Dr Galea-Singer: Yes, that right is always in existence, not just with drug and alcohol problems but for any treatment, such as for cancer.

However, it is often the case that, when a patient seeks a second opinion, that boils down to the explanation not being clear as to why the treatment that is being offered is not the treatment that the patient thought they wanted. That is the key. If you take a collaborative approach, explain things and work with the patient and their family, you are likely to all be on the same page straight away.

The Convener: Thank you. I remind members that I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

Brian Whittle (South Scotland) (Con): Dr Galea-Singer, I am interested in what you said about the things that are being called for in the bill already happening in your jurisdiction. If that is the case, that is fantastic. However, the overwhelming evidence is that it is not happening across the country, as there is a rising number of deaths related to drug and alcohol addiction. In my view, the bill sets out a right to be treated within three weeks, which is incredibly important for somebody who has the bravery to come forward and ask for treatment. Much as you are saying that that is happening in your jurisdiction, would you accept that that is not the case across Scotland?

Dr Galea-Singer: Actually, I do not. I also think that "within three weeks" is too long for beginning treatment. In fact, treatment is generally started within 24 hours in most areas in Scotland. We have had in place the medication-assisted treatment standards—those are standards, not law—and they have helped clinical services to adapt so that they are able to see people within 24 hours of treatment being requested. That is happening now. All services—not just NHS but all ADP-provided services, including those provided by the third sector—have had to report to the Scottish Government on the provision of treatment within 24 hours.

The key thing is that treatment should not be seen as a prescription. Treatment is whatever the patient needs. There needs to be provision of wraparound care. For example, if a patient needs housing more than anything else, getting them housing is the most important aspect. We see a lot of high-need and complex-needs patients, who often present opportunistically because they are in such a dire state. They are short of money and cannot eat. Basically, their only option is to come in for treatment. Working with that opportunistic approach, we get them in to see what their need is for further treatment.

Brian Whittle: Okay.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): For the purposes of this session, I declare an interest as a former East Ayrshire Council councillor and COSLA spokesperson.

I want to explore the right to receive a treatment determination. The bill seeks to give people who are diagnosed as having a drug or alcohol addiction by a relevant professional the right to receive a treatment determination and be provided with treatment. However, a number of submissions that we have received highlight concerns about the requirement in the bill for individuals to be given a diagnosis in order to receive a treatment determination and any subsequent treatment. What impact could the requirement to receive a diagnosis for addiction have on people's ability to access services—particularly people who do not wish to seek a diagnosis? I will start with Eddie Follan and then bring in other witnesses.

Eddie Follan: You are probably starting with the wrong person, but that is okay. I can certainly respond to that.

I defer to the addiction specialist next to me, Dr Galea-Singer, but not everybody will want a diagnosis of addiction at that point. There is also a danger that people will feel stigmatised.

I will hand over to my colleagues, because they are working on this in the field.

Dr Galea-Singer: When I see someone, I often do not write a diagnosis; I write an impression. That would be my impression of what the person was suffering from and what the main needs were for that individual. It is a totally unrealistic expectation to think that you know a person when you have seen them for just half an hour or a maximum of an hour. It is not at all fair for that individual if you are making a judgment on what their issues are right from the word go. They do not know you; they come in and they have to open up to you about what their issues are. A lot of them have such histories of trauma that it is impossible for you to have made a definite diagnosis.

The need to have a diagnosis so that you can say that there is a treatment determination would have unintended consequences. A diagnosis is something that develops as you get to know the person you are treating. You find out much more, and it is often not just about one diagnosis; there might be a number of diagnoses with a number of needs.

Often, I do not necessarily like to label something. There is a value in a diagnosis—for example, if somebody is suffering from prostate cancer, there is specific treatment for that. However, there is always a stigma linked to a diagnosis when it comes to addiction or mental health. You need to be mindful of what the person has been through in their life to be in that situation.

We know from the statistics that there is much more prevalence of addiction problems in areas of poverty. Levenmouth—which has the fifth most deprived area in Scotland—has the highest figures for deaths and harm from drugs and alcohol in Fife. We need to think about the bigger picture rather than just the diagnosis—the diagnosis is only a tool and should not be a determination.

Gillian Robertson: If people had to get a diagnosis in order to access services, that would be almost like another barrier. As has been explained, people often find themselves in a complex situation and they present with a totality of issues that need to be dealt with. Putting another label on them is often not helpful. It does not help people to come into services; it probably makes them shy away from them.

Flora Ogilvie: I echo that point and the importance of taking a trauma-informed approach, reducing barriers and making it as easy as possible for people to access services.

There was a reference to drug-related deaths earlier. It is also important to recognise that a reducing proportion of drug-related deaths are from substances for which there is an evidence-based treatment. Wrapping up diagnosis with treatment potentially risks limiting access to other forms of support for people who might not have a formal diagnosis or who might not have a diagnosis that is treatable through, for example, opioid substitution.

Elena Whitham: That answer is brilliant, because my next question is about whether there is a risk of impacting the availability of services for people who would wish to access treatment that does not require a formal diagnosis in different settings away from the medical setting. Is that risk a worry to you? I see nodding heads.

Dr Galea-Singer: As I said, a diagnosis is only a tool and it should not be a barrier to accessing treatment. There is a wide range of options for treatment, and the bill provides for a wide range of options, but the treatment has to be tailored to the individual and they should not need to have a medical diagnosis in order to access whatever is needed.

09:15

It could be that, initially, the treatment is not residential rehabilitation or detoxification but making sure that the person is safe in their home—for example, they might not have heating in the middle of winter. Human needs come first, then you get on to the other aspects of treatment.

Elena Whitham: Is the no-wrong-door approach fundamental to engaging with a person and the totality of their needs as they present?

Dr Galea-Singer: Yes. In fact, we need to focus on access to treatment provision, irrespective of the treatment. If you make access equitable and as easy as possible, you have done the right thing, because people can come in—every door is the right door, wherever they turn up, and services try to be flexible. That is where we need to change. We are a bit too siloed in our approaches. Working together, we need to be flexible and come out to the person rather than have them come to us.

Elena Whitham: I want to explore the impact of the label "addicted", which is a contested term—some people like it but others do not. I am wondering about the interaction with the Equality Act 2010, because addiction is not a protected characteristic under that act when it comes to things such as employment law. Does anybody have a comment on that?

Gillian Robertson: That can be—and is—problematic. There is stigma. That is something else that people have to deal with, and it prevents them from coming to services.

It is assumed that we have not had the time to learn from some of the developments that have happened since the MAT standards came in. However, recent figures from Police Scotland have indicated a reduction in deaths. The publicising of some of that information would help people to understand that they are coming not for that label but for the holistic approach.

We have done a lot of work on assertive outreach. A lot of work on safety and stabilisation and motivational interviewing needs to be done before somebody will engage properly with the service.

I am not sure whether that answers your question.

Elena Whitham: Thank you for that. My final question is about the fact that, under the bill, a treatment determination should be made "in person". Would that, in itself, cause any problems? As we know, treatment is, for example, delivered by teleconference in some remote and more rural areas. I do not know whether anybody has a comment to make on that.

Dr Galea-Singer: First, I would like to make a comment on your previous question, if you do not mind.

Before I came to Scotland, I used to work in New Zealand. I did a small study on patients who turned up at the emergency department in my health board area. Those who turned up with, let us say, a cardiac problem and a concomitant alcohol or drug problem were waiting three and a half times longer than those who turned up with a similar cardiac problem but without the concomitant alcohol and drug problem. That tells you that, sometimes, the diagnosis does not help, because of the stigma, the fear and the lack of knowledge of what to do with somebody who is taking alcohol and drugs and also has a cardiac problem.

I will come to your next question. Sorry—what was that about again?

Elena Whitham: It was about a treatment determination being made in person.

Dr Galea-Singer: I feel that that goes against the current direction of innovation, because we are trying to be a bit more digital in our approaches. For example, a young person is less likely to come in for an appointment unless you have already spoken with them using a digital method to break the ice. That provision of the bill goes not in the direction of the innovation on which Scotland is leading but against it.

Eddie Follan: We have made strides in our ways of working by using NHS Near Me, but there is still a way to go. I used to work as a psychiatric nurse, so I have a bit of a clinical background in the area. I am thinking about the sometimes chaotic nature of people's lives. What would happen if they did not turn up? That will quite often be the case in many clinical settings as well. The provision in the bill poses problems.

That also goes back to the point about the bill being quite narrowly focused and Sue Galea-Singer's point about the need to provide more holistic support. You will be aware of the range of services that local authorities provide, from housing to social work to employability. Those all need to be factored in, and I do not think that the bill addresses that at the moment.

Emma Harper (South Scotland) (SNP): Good morning. I will pick up on what Eleanor Whitham said about challenges in remote and rural contexts and stigma. In remote and rural areas, it might be challenging for a single mum with two kids who is experiencing harm from alcohol to voluntarily take treatment because of the worry about having her weans removed from her. Does consideration need to be given in the bill to stigma, access and remote and rural contexts?

Gillian Robertson: The treatment has to be person centred. It has to be about what is right for the individual and provide the environment that will allow them to engage best. I work in Aberdeenshire, and our services cover a range of places, some of which are very rural. It would be about having a discussion with the individual and finding out where they felt comfortable. There needs to be flexibility in the services that we deliver, and the bill is a bit more prescriptive than we need it to be. We need to have the flexibility to deliver what is right for an individual's particular circumstances.

Emma Harper: The timescale in the bill for access to treatment is within three weeks, but the

MAT standards allow access to buprenorphine or methadone through same-day prescribing. Is the bill in conflict with the MAT standards, which are already driving forward the changes that we need?

Eddie Follan: That would be our concern. COSLA is part of the national mission, and we have seen a real drive to push forward the MAT standards. I do not have the statistics in front of me, but I think that up to 75 or 80 per cent of people are seen on the same day. There is still a way to go, and there are definitely improvements that we could make, but we are beginning to see that shift. As it stands, the bill does not align with the MAT standards and possibly conflicts with them. Members might want to look at how the bill can be aligned with the work that we are doing around the MAT standards, because it does conflict with that a bit.

Dr Galea-Singer: I think that it is confusing rather than conflicting. The 24 hours timescale under MAT standard 1 is within three weeks, but, if there is a law that says "within three weeks", that confuses the matter and it is unclear whether the timescale should be within 24 hours or within three weeks.

Emma Harper referred to starting buprenorphine and methadone within 24 hours. We actually do something quite different in Fife, where we have rapid-access clinics, which are not just for starting treatment. If somebody, such as a lady with two kids, to use the example that you gave, has an alcohol problem and is living in a remote area, you can still rapidly provide that person with an appointment—perhaps digitally if that is what will work—to make contact and try to understand what they want. It is not just about providing a prescription, and sometimes you do not do so because it is not safe. You also need to be mindful of the individual's other needs. As my colleague said, the approach needs to be person-centred and about what the individual needs.

Emma Harper: Assertive outreach also works for some folk who are remote and rural.

Dr Galea-Singer: That is right. We have what we call the KY clubs in Fife—the name goes by the postcode. We have drop-in centres run by the third sector in different areas of Fife, and patients can just turn up there. If I know that I have a lady who cannot come to an appointment, for example, I will go to the KY club to see that person.

The biggest problem that we have is, of course, capacity—just making it happen. Although we wish to make it happen, it is not always possible, because workforce issues are very much a reality for us.

Emma Harper: I have a final question about taking a trauma-informed approach and third sector organisations being part of the process of engaging people in their recovery. It can take decades for people to recover. There is not a quick fix; they can relapse and then go on to recovery. It can take a long time. I am thinking about education being provided. In my work as a recovery room nurse in a perioperative environment, I thought it was necessary that even recovery room nurses got education about how to look after somebody with a heroin or alcohol problem. As far as I am aware, digital education is now available for everybody—it is not just limited to people who are in alcohol and drugs work. I know that there is a Turas module that anybody can access, and it is free. Would you be a proponent of saying that everybody in the third sector should get support to be educated in trauma-informed practice?

Dr Galea-Singer: Absolutely. There was a little bit of work over the past year or so with the group called WEDG—I cannot remember what that stands for. It has developed some expectations of the education that people should be aware of, and more modules will be available on Turas.

One of the things that it is important for everyone—police, housing officers, operative nurses, whoever they are—to know is how to deliver a brief intervention. As the name implies, a brief intervention is as brief as it can be, so that you do not irritate the individual. If they come to you and you find out that they are drinking alcohol and they have an alcohol problem, you might suggest that, for example, their liver enzymes show that they are doing quite a bit of harm to their liver, and you would ask them whether they would consider seeking treatment for their alcohol problem.

If someone hears that a few times, eventually they seek treatment. A brief intervention is therefore quite a small but important intervention that everyone can learn. As I said, it is very brief, so it is not going to take away from whatever other work you are doing, and it is very effective. In fact, it is so effective that people who try to sell double glazing use it. They phone you a few times and, on the 12th call, you often get double glazing.

The Convener: Elena Whitham has a supplementary question.

Elena Whitham: Yes, it is a brief one about the timescales for treatment that Emma Harper has been exploring. I wonder whether we need more detail in the bill as drafted about when the clock actually starts and what the starting of that clock actually encompasses. If somebody is seeking access to residential rehab, there is usually quite a lengthy pre-rehab phase, and I wonder whether there is enough detail in the bill to encompass that.

Gillian Robertson: On residential rehab, the pre-hab bit is so important. I ask whether we should class that as starting treatment, because getting people into the best place for them to be as successful as they can be during the residential part is treatment. Likewise, post-hab is really important.

09:30

On timing, we already have guidance in our health improvement, efficiency and governance, access and treatment targets on the three-week wait for 90 per cent of people, and there is clear guidance around when waits start and stop. I do not know whether that will continue. The most important thing is people being able to access treatment at a time that is right for them. When people have to wait for three weeks, their motivation can go up and down dramatically. It is about capturing people when they are ready—making the services as accessible as possible, doing the assertive outreach for the people who are most at risk and encouraging them to come into the services.

Elena Whitham: Thanks. That is most helpful.

David Torrance (Kirkcaldy) (SNP): Good morning to the witnesses. I put on record that I am a trustee of the Fife Alcohol Support Service, whose KY8 and KY1 clubs have been mentioned.

What are the witnesses' views on the bill's provisions that require a diagnosis of addiction and that the development of a treatment plan be undertaken by a relevant health professional?

Dr Galea-Singer: Sorry, but I am not sure that I understand the question.

David Torrance: When somebody is diagnosed with an addiction by a health professional, treatment has to start with, and be continued through, that one person.

Dr Galea-Singer: That never happens, because we work very much with our third sector colleagues. I will give an example. We have a daily allocations meeting with our third sector colleagues. When we receive a referral or a self-referral, we think about who is best suited to meet the needs of that individual, and we keep bringing that person back and working together. If they need a medical input, they will be seen by a medic. If they need more of a counselling approach or a housing approach, there is more social work input. It definitely does not sit with one clinician.

Flora Ogilvie: The point that was raised about trauma-informed practice relates to that question as well. It is absolutely key to make sure that individuals have an understanding of trauma-informed practice so that they can relate to the person whom they are helping. However, it is more important that the system is trauma informed, which is exactly what Sue Galea-Singer has outlined. The system needs to be able to support the person with the most appropriate treatment service rather than have a very prescriptive, medicalised model that is not an overall trauma-informed approach.

David Torrance: The KY clubs have been mentioned. Those provide a wraparound service. Everything is there, from the council to health to counsellors. To what extent do the provisions in the bill align or conflict with the multidisciplinary teamworking that currently exists in substance services?

Dr Galea-Singer: It makes an assumption about diagnosis as a medical task or activity. That goes against current practice, because the diagnosis is often reached in a multidisciplinary or multi-agency way. For me, therefore, it is too narrow.

Eddie Follan: If the medical path is the starting point for the process and journey that people go through, there is a risk of not taking into account the role of the wider multidisciplinary team. The bill probably does not recognise that.

Again, from a local authority perspective, many services are provided by people in housing departments. Housing is a huge issue for people, as is employability. It is therefore difficult to see why you would start on the medical footing, given that you have a wider team to take account of.

Gillian Robertson: I agree. The list of treatment determinations is really quite restrictive. Even the last one—"any other treatment"—is about the health professional's understanding, whereas a much wider offer is out there to address multiple issues. It is not just about substance misuse; often, it is about the trauma that goes before that and the person's current living and family situation. There needs to be a multiple approach, and that may not be so evident in the bill.

David Torrance: I have no further questions.

The Convener: I would like to unpick what Gillian Robertson has just said regarding treatment determination and who can make it. I explored this point a little with witnesses last week. The bill does not say that the person who makes a treatment determination must be an employee of a health and social care partnership. The bill says that an advanced nurse practitioner—a nurse who can prescribe—a medical practitioner or a pharmacist who can prescribe can make a determination, but those people would not necessarily be employees of a health and social care partnership or health board. Does it cause you any concern that someone working privately or in a community pharmacy, who is not employed by the NHS, can prescribe treatment that would have to be implemented within three weeks in your services?

Gillian Robertson: I can give some examples from Aberdeenshire involving alcohol. A lot of the work is done by social workers in our drug and alcohol team, who liaise closely with the general practitioners. A lot of the treatment package is provided in that way, with the GP looking after the person’s health issues, alongside any prescribing that is required regarding the substance use. The wider wellbeing and practical and emotional support are delivered by a social worker. This is perhaps just how I read the bill, but I do not quite see how that would fit within it.

The Convener: What I am trying to get at is whether your organisations have any concern that someone from outwith your organisation could prescribe what treatment options are provided for a patient, which you may or may not agree with, within that timescale.

Dr Galea-Singer: I have some concern around that. Let us say that a private psychiatrist, for instance, is diagnosing people with attention deficit hyperactivity disorder because there is very limited provision for ADHD. The person might also have a problem with stimulant use. The psychiatrist starts prescribing amphetamines, which are also abusable. More harm might be caused if the private psychiatrist is not aware of the treatment options that are available and is not aware that the person is also using stimulants.

The issue is about the joining up of the system; it is a systemic issue. That is where the concern comes from. By law, a private physician could provide that treatment, but that might not have left enough time for adequate collaboration and to have safe prescribing.

Eddie Follan: There is a wider point, other than the clinical one, that is important: that of resource allocation. This goes back to the point that we have all made about multidisciplinary team working. As well as thinking about the clinical provision, thought will also be given to the resources that are available to provide the service to people. If that is being done on the outside, it involves people who are not party to the discussions going on in a multidisciplinary team, nor to discussions on resource allocation. That is my first instinct in response to that question. That might well be an issue.

Sue Galea-Singer has spoken about the workforce pressures that we already have, as well as the financial pressures that our integration joint boards are facing. We are all aware of those.

The Convener: When you talk about the resource implications, you are not exclusively talking about financial resources; you are also talking about staffing resources—you are talking about resources holistically.

Eddie Follan: I am talking about staffing and the availability of whatever is needed to provide the service.

The Convener: Grand. Thank you.

Gillian Mackay (Central Scotland) (Green): Good morning. To what extent does the bill address changing patterns of drug use in Scotland, particularly around polysubstance and alcohol use?

Dr Galea-Singer: I do not think that it addresses those matters adequately. We have seen a number of trends in Scotland, one of which just now is the use of more potent opioids that can be fatal. The need to act quickly in such situations is important, but the people involved tend to turn up more at accident and emergency departments and, if the bill is about diagnosing substance use services, we are not going to reach that population group. It does not quite address the issue properly for people with high and complex needs, particularly given the changes in the potency of substances out there.

Gillian Mackay: Does anybody else want to come in on that question?

Eddie Follan: I am just looking at my notes, but I agree with Sue Galea-Singer. For me, there are two issues. First of all—you might already be aware of this—there was, through the national mission, a survey of the drug and alcohol workforce, and more than 70 per cent asked for better treatment options for drugs other than opioids. The other issue is alcohol and where it sits.

We see both as public health emergencies, but there is an issue in that respect. In the national mission, there has been more of a focus on alcohol. We are working with the Government on the mission’s next iteration—that is, whatever comes next—and I am pretty sure that alcohol will feature fairly heavily in that, too. That is another consideration.

Flora Ogilvie: From our drug-related death reviews in Lothian, we are seeing an average of four substances implicated in deaths as a result, sadly, of drug use. I simply reiterate the point that we are no longer dealing with a single substance. The proportion of deaths in which opiates are implicated is reducing, but we need a holistic, joined-up approach and a range of treatments wider than those that have been traditionally offered.

Gillian Robertson: I just want to add very briefly that the numbers of people on opioids across Scotland are reducing year on year. As a result of the prescribing element involved, people are now taking very different types of drugs that we are just finding out about. We need to do more work on that, and on cocaine in particular, because there is no prescribing involved in that.

Dr Galea-Singer: Can I come back in on that?

Gillian Mackay: Yes, of course.

Dr Galea-Singer: In Scotland in particular, we have had an issue with not just opioid use but benzodiazepine use. That is quite Scotland-specific; it is quite a significant problem here, and I think that it contributes to the amount of deaths that we are seeing in Scotland.

You have to look at polysubstance use, because we are now seeing, for example, pregabalin and gabapentinoids appearing in forensic reports. Those are pain medications that are prescribed generally in primary care. You have to look at this from a polysubstance point of view.

Gillian Mackay: Does the bill strike the correct balance with regard to prevention, harm reduction and treatment? We have already heard a wee bit about that, but I want to dig a bit deeper into it. If the bill does not do so, what do you believe needs to be changed in it to strike that balance correctly?

Flora Ogilvie: From a population health perspective, there is definitely not enough emphasis on primary prevention. That relates to some of the wider issues that we have heard about, such as access to housing, education, skills and employment, all of which are going to have much more prominence as a result of the forthcoming national population health strategy. We need to think about how we support people who use substances to access those things, instead of supporting only their access to substance use treatment. When it comes to prevention, particularly for this specific population, access to harm reduction and evidence-based interventions such as safer drug consumption facilities needs to be considered, too, besides access to treatment.

Dr Galea-Singer: I do not think that there is a good balance in the bill. It talks about treatment but, although that sentiment is important, it is all about the edge of the cliff, and I think that we need to look prior to that. Moreover, I do not think that the bill addresses the social determinants of health that contribute significantly to continuing drug use in families and communities. Indeed, I have already mentioned the issue of poverty; the fact is that there are 15 times more deaths in more poverty-stricken areas.

09:45

Eddie Follan: I agree with my colleagues that the bill is missing prevention. Flora Ogilvie mentioned the population health framework that will be published soon. We have worked closely with the Government on that, and its focus is on prevention. The bill does not address that. We have an indicative list of treatments, which are fairly tightly defined. We are not looking at the pre-treatment phase, and all the public and third sector services that work with people to prevent them getting to that point in the first place. That might not be the purpose of the bill, but it is what we are all trying to do in public and third sector services throughout the country. The bill misses that out.

Gillian Robertson: The bill talks about campaigns, and I totally get that, but there needs to be more evidence about encouraging people to come in, not once they are diagnosed with an illness but when they first have concerns about how much they are drinking or about any substances they are using. It is also about enabling loved ones. There is a bit missing.

Flora Ogilvie: In relation to alcohol, which is a legal substance in Scotland, a huge amount more could be done preventatively, such as restricting access, and restricting advertising and promotion, which are commercial determinants of health. More work on that would be welcomed.

Gillian Mackay: Thank you.

Emma Harper: Dr Galea-Singer has covered this already. It is not just about illicit substances, because people are prescribed diazepam and codeine. You mentioned pregabalin, too. We are thinking about how to address polydrug use. Research is going on into a reversal agent for benzodiazepines.

Dr Galea-Singer: That is right.

Emma Harper: I used it when I worked in a recovery room, although there is an issue with potential seizures. However, that could perhaps go alongside naloxone, for instance. We deal with quite complex issues when we talk about polydrug use.

Dr Galea-Singer: You are absolutely right. There is some innovative work on naloxone patches. That involves looking at naloxone plus flumazenil, which reverses the effects of benzos as well as opioids. You are absolutely right that that can cause seizures, so you really have to have the right therapeutic dose. There is a project happening now, which is supported by the chief scientist's office.

Emma Harper: People sometimes buy benzos thinking that they are 10mg, but they are actually 1,000mg. That, on top of alcohol, ends up being quite a challenge.

Dr Galea-Singer: Absolutely. We have had a recent alert that there is clonazepam around just now. People think that it is diazepam, but it is not—it is 10 times more potent than diazepam. If they take the same number of tablets, they will die. It is just about education and reaching out to people. Information goes around quickly, because they know each other. If you get one death, they very quickly think, “Oh, that’s not a good substance out there. It can kill you.” The issue is our ability to put the information out there as quickly as possible.

Brian Whittle: I have a simple question to start with. What impact would the bill have on staff working in the sector?

Eddie Follan: It is difficult to say at this stage what the impact would be, but we could talk in general terms about the impact that it would have on a workforce that is already under pressure. In Scotland, we have an issue in social work, because we do not have enough social workers. We can see that in a lot of the work that we do on things such as delayed discharges. At this stage, we are unable to deliver the number of care packages in social care that are needed, because of the lack of staff, and the lack of social workers to do the assessments. Our health and social care partnerships are struggling for workforce capacity as well.

We could not talk individually, but our concern would be about the impact that the bill would have on a workforce that is under pressure at the moment. On top of that, we have the financial issues that we face across the public sector. That has an impact, because third sector organisations have a huge role to play and are struggling with finances because of annual funding—one-year rolling funding—which creates a lot of uncertainty.

We would be implementing the bill at a time when the system is under severe strain.

Dr Galea-Singer: I totally agree with Eddie Follan. The Royal College of Psychiatrists in Scotland recently did a report to try to project the number of psychiatrists who would be needed. There are huge shortages. That is an issue not just for psychiatry; it applies to nursing staff, third sector provision and peer provision.

As I said, we need to work together. Unless we work together, we will not move forward but there is not enough. The bill could have a negative effect on the current flow of work. That started with the national mission and the MAT standards. There is a lot of good will, there are a lot of good measures and we are moving forward, but introducing another legal requirement, although it is not totally in conflict with that work, would have unintended consequences on the burnout levels of our workforce.

Brian Whittle: I will expand that point. I completely agree about squeezing the third sector and the importance of that sector in what we are doing. Squeezing the third sector puts more burden on statutory services. I met the psychiatry services only last week. There are other failings elsewhere and there has been, for example, an 800 per cent rise in requests for a diagnosis of ADHD. That all puts pressure on the system. I am slightly confused about how, if that is already happening—which you said in answer to my earlier question—introducing the bill would increase pressure on the sector.

Dr Galea-Singer: Because, by law, you would have to provide certain treatments. I will give an example. Most patients would turn up and tell you that they want a detox. If the bill is passed, you would have to provide that within three weeks.

Often, you know that a detox is not what is needed straight away, because you have to get the patient ready for what happens post detox. Detox is easy. You have 10 days in a hospital, are weaned off your addiction and are given medication. The issue is what happens once you are discharged. Unless you prepare the patient well for how they maintain themselves in that recovered position post discharge from hospital, you will not be successful. Often, they end up going to the off-licence straight after the detox.

If you put in place a legal requirement to provide detox, it goes against the ethos of preparing the patient to have a more positive outcome from, and experience of, treatment. Otherwise, you are setting people up for failure.

Brian Whittle: Does the bill suggest that the patient can demand the treatment that they want? Surely it asks the healthcare professional to deliver the treatment that is required.

Dr Galea-Singer: It does. However, because of the narrowness of the way that it is written, it gives the patient the ability to do that. It is difficult to prove why you would not give the person a detox.

Eddie Follan: That links to the bit about multidisciplinary teams. As we grapple with the current situation in public and third sector services, one thing that we can do, if we do not have the staff, is to look at how we can work better together to provide the services that people need. That has to be done in a multidisciplinary way and in partnership with the third sector. Those of us in public services must also work across any silos and teams that we have, including across social work, employability services, housing services and others.

Our concern is that there is a narrow focus on health professionals or on one health professional making a determination. I made the point earlier that it is not possible to pool resources in a situation where people from outside the multidisciplinary team are making determinations about treatment, because you are getting things from left field that you have never really thought about. The MDT approach of collaboration and partnership would be much more effective than having a narrower focus.

Brian Whittle: I will add another layer to that question. The financial memorandum says that

> “the implementation of the Bill will lead to more completed treatments”

and

> “fewer repeat appointments”,

offsetting the additional staff time required to provide written statements of reasons or second opinions.

I want to dig into the preventative stuff, because I think that contradictory things have been said today. Some of you have said that that is already being delivered, but it has also been said that there are 15 times as many drug-related deaths among people living in poverty as there are in other areas, so the system is obviously not working across the board. Access to services for people in poverty is the important consideration.

There is an idea that we could reduce the workload by preventing people from sliding back into addictive behaviour, but do you agree with that statement in the financial memorandum?

Gillian Robertson: The financial memorandum suggests that 40 per cent of the funding for treatment goes to the NHS, so that does not replicate a multidisciplinary team. I am a service manager and we have just redesigned our services in line with the MAT standards, which are all-encompassing. Although the work was about opiate substitute treatment, we recognise that the benefit of the standards is that they are for everyone, no matter which drugs they are on, and are also for those who are using alcohol.

We do not want to lose any of that if we redesign our services again under a different model, which would also cause more burnout for staff. We have recruitment issues in our rural areas, and having nursing staff prescribing would mean that they would have to do another qualification—because nurses have to be at a certain grade before they can do that—which would create additional pressure and costs. There are lots of implications that probably need to be discussed more.

Flora Ogilvie: The importance of monitoring and evaluation is often not considered. One strength of the MAT standards is that there has been robust data collection, but that has come at a cost to the individual staff who are trying to see patients and to collect an additional layer of reporting information. To go back to Gillian Robertson’s point, that is why it is important that we do not translate from one system, where a huge amount of effort has been put in, to a new system where we are being asked to collect additional monitoring and evaluation information, because that could be a huge drain on staff time and motivation when they should be focusing on patient-facing work.

Brian Whittle: There is so much to unpick, but I know that time is against us so I will leave it there.

The Convener: I have a brief question before I bring in Sandesh Gulhane. Have any of your organisations assessed the resource implications of the bill? I am using the term “resources” in the wide sense that Mr Follan referred to earlier. Would the bill have resource implications for your services?

Gillian Robertson: We have not done any work on that; we would need to understand which people fell within which diagnosis to be able to do that. If everyone in our service were to be seen by a clinical or health member of staff, that would have huge implications for our staffing balance, and we would need to consider whether we would have to pay off and lose some of our other multidisciplinary roles, so that we could recruit in that way. We would also have to consider timescales, and we would need the ability to cover quite a large geographical area. Having all of that in one discipline would be challenging.

10:00

Eddie Follan: I do not think that we have done any work specifically on the bill’s impact. In Public Health Scotland’s survey of front-line staff, two thirds agreed that the national mission had resulted in more pressure on staff; more than half felt that they were under pressure a lot of or all of the time; and 43 per cent felt that they were at risk of burnout. Given what we have already said about the fragility of the workforce and the situation that we find ourselves in, you might come to the conclusion that adding further layers on top of the existing workload—which the bill will potentially do, although we do not know—would not help.

Dr Galea-Singer: The ADP for NHS Fife has done some preliminary work, but, as I do not know the details of that, I cannot really talk about it. I know that it showed that there would be further cost implications.

Sandesh Gulhane (Glasgow) (Con): I draw attention to my entry in the register of members’ interests as a practising NHS GP.

I have been listening with great interest to the panel. My first question is very simple: do you think that the rate of drug and alcohol deaths in Scotland is acceptable?

Dr Galea-Singer: No death is acceptable. Even one death is unacceptable.

Sandesh Gulhane: Dr Galea-Singer, you have talked about how treatment often begins within 24 hours and about the wide range of treatment options that are available, and you have painted a picture of rehabilitation and intervention services being available for every patient. If that is the case, why are drug deaths as bad as they are?

Dr Galea-Singer: That is because treatment is not the only solution with regard to addressing drug deaths, which is what we have been talking about. There are other social determinants of health—I have mentioned poverty and support for families, and there are a number of other aspects, such as education and employment—but the bill does not address them.

Sandesh Gulhane: Eddie Follan, you, too, have talked about the social determinants of health. We have touched on housing, poverty, education and employment. Do you think that it is reasonable for a member's bill, rather than a Government bill, to legislate for and address those huge determinants of health?

Eddie Follan: As I think that I said at the start, there is absolutely no doubt that we support the bill's intention, but we continue to have concerns that it does not address many of the things that we have talked about, such as the role of multidisciplinary teams, social work, housing and all the other social determinants.

We have talked about the bill's resource implications and how it would impact current service provision. We cannot make a definitive statement about those implications, but we know that services are currently under pressure. We have also talked about the narrow focus on health. Someone mentioned the budget. The Finance and Public Administration Committee quoted COSLA's submission and noted our concern that the financial memorandum was weighted towards health boards and didnae reflect the further support—for example, in social work, in housing and in justice—required for people affected by drugs and alcohol. That would be a real concern for us, as it would mean that those services would not get the support that they needed to take that social determinant—in other words, preventative—approach to health.

Sandesh Gulhane: It seems that the social determinants of health are, in fact, covered by the entire budget that has recently been passed.

Dr Galea-Singer, you also talked about enshrining the issue in law and about how we already have the treatment standards. I would just note that the Patient Rights (Scotland) Act 2011 sets out a 12-week legal guarantee for in-patient and day-case treatment, and it was argued at the time that that was not needed. So, we have done this sort of thing before. People are saying that they want this—surely that is a good thing.

Dr Galea-Singer: Absolutely. However, in order to make sure that the individual has a positive rather than an unrealistic outcome, you have to prepare them for their treatment. It is all about preparation; it is not about not giving them the choice or refusing that treatment. It is about being realistic about it.

For example, I recently saw a patient and his mum who were determined that they wanted Buvidal. Buvidal is injectable buprenorphine, which is good, but the number of substances that he was using would have meant that Buvidal medication would have failed him. The mother was upset and angry with us, but, when we explained why we had decided to prescribe methadone, they were both happy, and he is now doing very well.

It is about that kind of preparation—that is, giving the patient a choice but explaining why that choice might not be the right way forward, because it will not necessarily work, although it would remain an option for the future.

Sandesh Gulhane: Indeed, but the bill does not force you to say yes to a specific treatment option. It still gives you the clinical choice, allowing you to say, "Actually, Buvidal isn't good. It isn't going to work for you as a treatment option." The bill does not negate that.

However, let us move on. Do you have an idea of the cost that might be incurred if you are not allowed to refuse treatment on the basis of cost? Will there be a significant increase in the costs associated with treatment?

Dr Galea-Singer: As I have mentioned, there was some projection of what the cost might be with the ADP in Fife. However, I do not know what that is, as I was not part of the work that was done.

Having to refuse treatment because of cost is never a good position to be in. From a clinical perspective, treatment is refused not because of cost but because it is not the right thing to do. A lot of treatment provision for addiction is not terribly expensive. The unit costs of what we provide are not very expensive; they are not like cancer treatments, some of which are so expensive that you have to consider other options. For addiction, that is not the case. The only one that is quite expensive is Buvidal.

Rehabilitation treatment is on the expensive side, but it is no more expensive than a hospital stay. We are talking not about cost being the barrier but about making sure that you provide your expertise to inform the patient, so that they can make the right choice for themselves.

Sandesh Gulhane: Absolutely, and the bill will, I hope, continue to allow that.

I visited an award-winning outreach programme in Glasgow run by a former heroin user who, genuinely, has won awards for his outreach—that is, for the work that he has been doing in the community. He goes out into the community, he knows it and he knows what is happening in it. However, because of the funding situation, that service is being cut. How can we make things better if award-winning services are being cut?

Gillian Robertson: I think that that is where the confusion arises. It is about how we fund all of this.

Going back to the previous point, I agree that Buvidal is more expensive than methadone, but it is unlikely that someone would say, “We can’t fund that.” Residential rehab, though, has very different cost implications, and we would need to consider those costs before we said yes to it. We would not have the amount needed to put everybody who might come through the door into rehab.

It is all about engaging with people properly. You mentioned wider work with the community, which brings us back to the need for a collaborative approach. We are perhaps not seeing that quite so clearly in the bill. A collaborative approach involving the third sector, peer support, harm reduction and everything else makes up the totality of the offer and would, in my view, give us the best outcomes.

Flora Ogilvie: That is one of the reasons why the bill’s opportunity costs need to be considered. We have heard about whether the bill adds anything significant on top of what the system already offers and what resources will need to be invested in its delivery and in funding any front-line provision.

I go back to the point that treatment should not be refused on the basis of cost. That should absolutely not be the only reason why a treatment is or is not offered, but, at a population level, health boards need to make decisions based on cost all the time, and they have to weigh in the balance the benefits and the financial costs.

Therefore, we come back to putting the focus on prevention at the heart of the bill. We will always have increased costs, and potentially an increased number of people who are eligible for—and whom we would want to support through—rehabilitation programmes, if we do not put the building blocks of a preventative approach in place first of all. I appreciate that that might lie outside the bill’s scope, as it is a wider budgetary decision, but I think that we have to look at it in the context of all those wider budget decisions and think about the value of resource specifically in this bill and the opportunity costs of that.

Sandesh Gulhane: I have a final question for Dr Galea-Singer, although I do not know whether she will be able to answer it. You talked about diagnosis in one of your first answers. Given that we are at stage 1, changes can be made to the bill. What wording would you prefer to see in the bill instead of references to diagnosis?

Dr Galea-Singer: That is a difficult question to answer. Diagnosis is just a tool, and I would prefer to see some reference to a collaborative care plan that is determined not necessarily by a diagnosis but by the needs of the individual and, indeed, their family. After all, we cannot forget the family, who are often quite distressed. That aspect needs to be included, too.

Brian Whittle: I have been listening with great interest to what you have said. You have highlighted eloquently that the whole-system approach is currently failing, and we have talked about housing and education. We heard the example of a psychiatrist making a diagnosis without prior knowledge. For me, that is a big issue—communications in healthcare are really poor. There is a whole cross-portfolio issue that wraps around this, and it suggests to me that the system is not working for many people.

If what the bill is highlighting is that the system itself is not working, and if we can amend it to suit, we cannot decide not to proceed with it just because the system is flawed in a cross-portfolio way. As has been said, we have an issue in Scotland specifically, but I keep asking why that is and I never get an answer. If we have that system-led problem across Scotland, surely we need to find ways of addressing it. I think that the bill is capable of being manoeuvred into a position where it will have a very positive effect. We cannot decide not to proceed with it just because the system itself is flawed.

10:15

Eddie Follan: I do not want to rehearse all the areas that I have already covered, but COSLA has worked closely with the national mission and on the MAT standards. Despite all the workforce and financial pressures that we have outlined, we are beginning to see improvements—although not as quickly as we would like. As Sue Galea-Singer has said, one death is too many.

As I have said, we support the bill’s intention, but obviously it is for you to decide where it goes. I cannot stress enough how much pressure our system is under. We are having discussions about that every day at a national level, and I am also sure that there will be similar pressure locally. For instance, our health and social care partnerships are carrying a deficit of about £500 million at the moment. The situation is that serious.

I talked earlier about having to collaborate, pool our resources and use what we have well, because there is no easy answer to the workforce pressures that we face. It is difficult to see how the bill fits with that, but that will be for others to judge.

Dr Galea-Singer: You are absolutely right—the system is not working. However, I am not sure that the bill addresses that. That is the point that I have tried to make: the system needs to be oiled, and we need to work better together. We did so during Covid, and we succeeded to a degree, although there were still a number of deaths. We can do this if we work better together, but I am not seeing anything in the bill that would make that happen.

Emma Harper: I have a quick question about cross-border pathways. Sometimes, folk in Kelso can get in-patient recovery spaces in, say, Carlisle. Does the bill cover how we manage cross-border costs?

Gillian Robertson: A residential rehab establishment opened in Aberdeenshire in January, but before that we did not have any such provision. It comes at a high cost. To get people into residential rehab, staff have to take them there, and staff then have to visit them to ensure continuity of care. It is not generally health staff who do that element of it, but the bill suggests that the majority of the resources would go that way in order to provide something additional. There could be cost implications or an increased expectation of what health staff would do in that area.

Emma Harper: One thing to consider might be cross-border engagement on how we support people. After all, we are taking people away from their homes in Scotland and putting them in England, which has a different health system. That might be something to consider in relation to the bill.

Dr Galea-Singer: Absolutely. I think that that is needed—the bill does not cover that well. There are some specialised units where you will need cross-border provision; it is not ideal, but you will need to have that.

You are absolutely right that you need pathways and ways of communicating with the healthcare provider while a patient is in that area. You must be sure that, when they are ready to come back, they come back to a system of care that will continue to support them. The issue with the bill is that it almost assumes that, when somebody goes in for treatment, the problem goes away. It does not; we are talking about a chronic relapsing condition like diabetes, and the individual will need to continue to work on their addiction problems, whether or not they have been in rehab.

The Convener: I thank the witnesses for their attendance this morning and for their evidence. It is very much appreciated.

I briefly suspend the meeting to allow a changeover of witnesses.

10:19

Meeting suspended.

10:30

On resuming—

The Convener: Welcome back. The committee will continue our scrutiny of the Right to Addiction Recovery (Scotland) Bill at stage 1 by taking evidence from a panel of witnesses comprising representatives of alcohol and drug partnerships. I welcome to the committee Pamela Dudek, the independent chair of the Dundee alcohol and drug partnership; Kelda Gaffney, the chair and interim assistant chief officer of adult services at the Glasgow city alcohol and drug partnership; and Liam Wells, the lead officer of East Ayrshire alcohol and drug partnership.

We will move straight to questions.

Brian Whittle: Thank you for giving us your time. How does the approach taken by the bill acknowledge and integrate the principles of trauma-informed practice?

Pamela Dudek (Dundee Alcohol and Drug Partnership): The bill is very strong on the principles of inclusion, understanding the person and taking a person-centred approach. The wording throughout the bill pays attention to the principle of taking a trauma-informed approach, which is really important.

Another aspect of trauma-informed practice relates to the trauma that is absorbed by professionals who interact with people who have been extremely traumatised, as well as in the context of their own situation. We have to think about that in the round. The bill is quite strong on inclusion.

Liam Wells (East Ayrshire Alcohol and Drug Partnership): The challenge for me is that recognition of the depth of the trauma of individuals is missing from the trauma-informed element. We were a bit unclear when developing our submission, because we did not feel that there was enough recognition of the historical nature of trauma in that trauma can be a lifelong event that stems from childhood, from deprivation and from family circumstances. The bill is not strong enough on a range of adverse childhood experiences, and it does not fully recognise the historical nature and complexity of the trauma that people experience.

Brian Whittle: That is a very important point to make, but is it the responsibility of the bill to reflect the depth of trauma? Is it not the responsibility of the healthcare professional, the third sector worker or the social worker to understand the trauma of the individual who is in front of them?

Liam Wells: That is the challenge. Trauma is historical and complex in nature and is not just the domain of the health professional. The challenge for us is that the complexity of trauma requires a multi-agency response, not one solely or primarily from the health professional.

Kelda Gaffney (Glasgow City Alcohol and Drug Partnership): I agree with my colleagues. Glasgow ADP has a similar stance. We completely agree that the bill takes a trauma-informed perspective and we are really supportive of its principles, but, as Liam Wells has said, we know that addiction, alcohol and drug use and trauma are not single issues, so the bill must be much wider than that. For example, a number of people who are involved with alcohol and drug use require a mental health or distress response, and a number of women who are involved are subjected to domestic abuse or some other form of abuse.

If we are going to have a trauma-informed response, it must be holistic. The bill, in its current form, is trying to address alcohol and drug use, but it is very difficult to look at that as a single issue. With regard to the bill’s principles on the right to treatment through alcohol and drug services, it is very difficult to address trauma on its own without looking at the whole system of care.

Brian Whittle: We discussed the failings of the system with the previous witnesses. What would you do to get the bill into a position in which you were more comfortable with the whole trauma-informed approach?

Kelda Gaffney: What we have available to us at the moment is the charter of rights, which I assume has probably been talked about in the committee previously. There are proposals relating to the responsibilities of duty bearers, which would sit with ADPs and the treatment providers around the table. The charter looks at that holistic approach.

There are two things about the charter of rights that I will point to in relation to supporting the bill. The language that is used in the charter of rights is far more collaborative than the language in the bill, which, if we are looking to work with other agencies and with people themselves, is not very collaborative in nature and is very medicalised. The charter of rights takes away that language, puts rights where they should be—with the people who receive the services—and places duties on the people who provide those services and on the whole system of care. As I said, it is really important that all the partners—including those in mental health, criminal justice, homelessness, housing, social work and health and social care partnerships—are around the table.

Liam Wells: You will, no doubt, have heard of MAT standards, given the amount of evidence on them. MAT standards make reference to the complexities of the experiences that folk have. For example, MAT standard 10 talks about trauma-informed services, and the standards also mention mental health support and tiers 1 and 2 psychological services. The bill could perhaps be strengthened through recognition of the MAT standards, which are much more inclusive and were, in my view, implemented without any need for legislation.

Brian Whittle: I want to reflect on how the bill deals with the role of the third sector. I am aware of the way in which East Ayrshire dealt with the issues previously with its wraparound service, which seemed to be a success, but I am also aware of the pressure that it is currently under. I am thinking about the role of the third sector in facilitating access to treatment. It is very much a gateway or doorway, if you like, before people get to statutory services. Where does the bill sit in relation to delivering a holistic approach with the third sector? Since I started with my specific knowledge of East Ayrshire—one of my colleagues here knows even more about it than I do—I will bring in Liam Wells first.

Liam Wells: In our rapid access to drug and alcohol recovery service in East Ayrshire, we do not use the third sector as a facilitator; it is a key partner. As well as third sector provision, as you are aware, advocacy provision sits within the RADAR service. I am keen not to suggest that, under the bill, the third sector would become a facilitator. I am keen that it becomes an equal partner.

Pamela Dudek: As it stands, the bill feels very focused on health professionals. On one level, that is understandable, but health professionals are only one part of the holistic system. If you think about it from the perspective of a person who comes forward looking for help and is not 100 per cent sure what that help needs to look like for them, you will see that the more points of access to the system, the better. In most systems, there are third sector access points that are really quite good at being open out of hours and at engaging people in a non-threatening way. There are good examples of that.

However, if we limit the focus to people coming in, getting a diagnosis and getting treatment through a health professional, that goes against some of the good work that is already going on and the good access that we provide. Perhaps we need to strengthen the different points of access. Previously, we have had a policy of there being no wrong door, and you could not argue with the principles of that policy. The issue is the implementation and how you make it work in favour of those individuals. A timeous response is really important when somebody is seeking help.

Kelda Gaffney: I will be brief, because my colleagues have covered what I would have said. The third sector is really important. I emphasise that, certainly from the point of view of alcohol and drug partnerships, the third sector is a key partner at the table and is on an equal footing with the rest of the partners around the table. It is also really important in facilitating access to treatment, as are family members, our recovery communities right across the country and other treatment providers. Without repeating myself, other services are involved and offer treatment.

For me, the issue is what the touch point is for a person and whether we provide access to that person. That goes back to Liam Wells's point about where the MAT standards play a part. It is about providing same-day treatment and a choice of treatment. I know that it is a very specific cohort of people who access MAT, but it is about the principles. It is really important to have an open door for treatment services and for all the services that are available to people, so that there are key points of access and the referral pathways are clear for everybody.

The Convener: You spoke about having an open door. Do you see the need to have a diagnosis of an addiction as closing that door?

Kelda Gaffney: The definition of "diagnosis" is one of the issues that has been a real difficulty for us, as an ADP—I would certainly say that on the basis of our work with our lived experience groups in Glasgow and on the basis of the experience of our partners. For a start, what is the definition of "diagnosis"? That would be my first question. That approach is probably also quite stigmatising. That was definitely one of the issues that came out of our consultations, which were broad and included family members.

If we are talking about diagnosis being dependence, that rules out a huge number of people who should have access to a full range of services, from harm reduction to abstinence-based residential rehab and treatment and everything in between. From an ADP perspective and from a personal perspective, using just diagnosis closes the door to people.

The system is not perfect, but we have reached a point at which people are feeling more comfortable with the services. There is more support, including from the third sector and recovery communities. There are lots of building blocks around people, and the networks are really good. If we started to use medical language, it would feel like a backward step.

10:45

Liam Wells: The challenge for us is that there has been a significant rise in the number of cocaine deaths in East Ayrshire, as in the rest of Scotland, but many individuals would not see themselves as dependent cocaine users so would be unlikely to come forward for a diagnosis of drug addiction or dependence. In addition, a number of individuals who come through our alcohol service drink to harmful and hazardous levels but do not consider themselves to be dependent on alcohol so would not seek a diagnosis of alcohol dependence or addiction.

The Convener: Thank you for that clarification.

Emma Harper: I want to pick up on what has been said about the trauma-informed approach. Last week, I visited Stepping Stones community larder in Castle Douglas, which is a membership group where people can pick a grocery basket. The volunteers who work there recognise the need sometimes for distress brief interventions, which can be delivered by anyone. When you were Minister for Mental Health, convener, you took DBI forward as a pilot scheme. It is a multidisciplinary and third sector approach that is about wider engagement. Sometimes, a door is opened for the first time at a community larder organisation. Does the bill need to be amended to widen it out beyond healthcare professionals to people out there in the community?

Pamela Dudek: The bill is limited as it stands, in terms of access, but if you were to strengthen it to reflect a wider system, where people can just turn up, that would support the system that we have been trying to build for quite a long time. As Kelda Gaffney said, we have had some success, but there is still some way to go.

The important thing is that people feel able to engage with somebody and talk about doing something about their issue. That could be somebody from a whole range of people, and therefore we should keep things open and look at where we can continue to skill people up to respond appropriately. The issue then is whether it is easy to connect the person to a more formal treatment programme, if that is the way that they need to go. However, some people will not want a label. With harmful drinking, in particular, some people will come in who cause domestic abuse and a whole host of harms in our society but who would not consider themselves dependent. However, when they pitch up, it is really important that there is an opportunity to intervene at that point—it is almost an early intervention. That is notwithstanding alcohol brief interventions and the importance of a structured approach when physical illness is involved. It is such a broad spectrum, particularly when you get into the alcohol side of things, that you would not want to close any doors.

Emma Harper: Liam Wells said that some people might be drinking harmfully but not consider themselves dependent. In the earlier evidence session, I talked about the single mum who is looking after two weans. If she ends up with a diagnosis, that puts her family at risk of being removed from her. There are sensitivities around diagnosis versus access to whatever care or treatment would be warranted for that person.

Liam Wells: Yes, there are. As has been said, that relates to the benefits of early intervention. The challenge of the bill is that, as it sits at the level of diagnosis, it potentially restricts the opportunities for services, many of which are community based and community focused, such as the community larder that you mentioned. For example, those services could do an alcohol brief intervention for that single mum, which would keep her out of the formal statutory system and process.

The Convener: I put on record again my entry in the register of members' interests. I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

Gillian Mackay: Several stakeholders, including ADPs and individuals with lived experience, have raised concerns that the bill leans too heavily towards abstinence-based treatment, potentially limiting access to harm reduction strategies such as MAT and safer drug use interventions. Given the importance of tailoring support to individual needs, which we have covered, should the bill be amended to better integrate harm reduction approaches with other treatments?

Liam Wells: In our written submission, we deliberately mentioned the weakness of the bill when it comes to harm reduction. There is a significant evidence base for harm reduction, and it is part of the process of recovery. The 2008 road to recovery strategy recognised that harm reduction needs to be part of that process.

Harm reduction saves lives. I am old enough to remember when the harm reduction approach was instituted in the United Kingdom by the UK Government in 1982 and 1983, as a direct response to the HIV/AIDS epidemic. It saved countless lives during that period, via needle exchange and, ultimately, methadone, and it continues to save countless lives.

In our submission, we certainly made the point that the bill needs to be stronger. There is a wee catch-all in the bill that says "any other treatment"; however, we recognise that harm reduction options perhaps need to be strengthened in the bill.

Kelda Gaffney: We recognise that the bill includes a range of options and does not focus specifically on abstinence-based treatments. However, exactly as Liam Wells has said, harm reduction is part of the continuum. Recovery is not and cannot be linear.

We did an audit of people who had been through our abstinence-based residential programme. Twenty-five per cent of those people had achieved sustained abstinence at the end of 18 months. There is no judgment in that, but it raises a difficult issue. Because of all the trauma that we have talked about, recovery is not linear. People will go from harm reduction to abstinence and back to treatment, and we should have systems that are set up to respond to that. A trauma-informed and person-centred system is about meeting people's needs, wheresoever they arrive.

Harm reduction keeps people alive, as Liam Wells said. I am very clear about that. We will not get people to achieve abstinence unless we can keep them alive.

As I said earlier, our recovery communities are a very important part of abstinence. As you will know, abstinence-based programmes are not for everybody, and there are people in recovery who will say that abstinence-based treatment or programmes are not for them. However, there are a lot of people who want access to abstinence-based programmes, and we should be able to respond to that. As a country, we are in a much better position now than we have ever been to respond to people's needs.

As Liam said, harm reduction is as important as every other aspect of treatment and care, including abstinence.

Pamela Dudek: I will not add very much. As Liam said—I am old enough to remember the 1980s as well—some of the formal harm-reduction interventions and treatments that we see have a very specific focus. If we are talking about alcohol and non-opioid drug use, you need to think much more broadly about the different ways in which people come in. However, those treatments are another route and another hook.

I worked on the clinical side of addiction for 20 years. For most of the people who came through, whether you were doing harm reduction or agreeing that the treatment options included going into an active abstinence-based programme, your hope for them and for their families was that they would recover and have some level of stability so that they could live their best life. That was your hope and, from talking to front-line staff, I do not think that that has changed.

The journey is very individual—you have to work with people where they are at. I am not against diagnosis if that is the right thing for the person and it means that you can formalise the treatment plan for them, but the issue is much bigger and broader than that. Of all the people I would see in a year in my clinics, I would put only about 15 per cent through a residential route, and we would work with the rest of them where they were at with their families. They were all different and they all had different outcomes, depending on what they were after. Relapse prevention does not force abstinence, but for many, abstinence would be the best goal to avoid all the chaos that goes with relapsing. Most of us are not that good at behaviour change, so a person who has come away from addictions might not be good at changing their behaviour and sustaining it. You have to understand it in that context.

Gillian Mackay: That is great. Thank you.

There have been changes in recent years around the implementation of the MAT standards, as well as changes to other policies. Could the bill disrupt some of the work that is going on with the MAT standards and rub up against some of the other harm-reduction measures? Do other changes need to be made so that that does not happen?

Kelda Gaffney: I put my hand up quickly because concern about disruption to the MAT standards was one of the strongest pieces of feedback that we received from our reference groups and people with lived experience across the country. As was pointed out earlier, from a Glasgow perspective, we have put a lot of work into achieving the MAT standards, particularly, when it comes to same-day access and choice of treatment. We are then talking about three weeks to treatment. I know that the bill does not intend to disrupt that, but our concern is that it is a backwards step.

We have moved forward significantly with the MAT standards. As you might know, we have introduced a harm-reduction method in Glasgow that has involved having quite a lot of conversations internationally. In Scotland, where we sit in relation to treatment, access to substitute prescribing and the choice of substitute prescribing is much further ahead of other countries that are very good with harm-reduction approaches. We would be really concerned about the disruption to that, as well as to our waiting times. We are obliged to report on our treatment waiting time standard, which is three weeks from access to treatment. That information is published regularly. The treatment standards are published, too, and all areas are held to those standards.

I guess that, for me, it is then about what the bill adds. Obviously, it introduces measures around alcohol treatments. I will let Pam Dudek come in to speak about this from a clinical perspective, but certainly from my perspective it all becomes a wee bit more tricky, because alcohol treatments are very different from medication-assisted treatment. Clinically, how safe would those treatments be, and what does treatment mean? There is the issue of diagnosis, but then there is also the issue of what treatment means in terms of alcohol, because the safety of alcohol treatments requires a huge amount of assessment.

Pamela Dudek: Many moons ago, I worked down in Bristol, in a well-developed and mature treatment system that included all sectors. The third sector did the assessments, which was a group work-based programme that allowed people timeous access to what we might call treatment on a weekly basis. That treatment could involve people speaking to somebody to work out what they needed. However, I moved back to Scotland to a system in which we bring people into an acute setting, detox them and send them out again with no follow-up.

Detox is a credible thing to do with people if they have that level of dependency, but the medical aspect of that is such a small part of what you need to deal with and what that individual has to explore and understand about what is going to work for them. That narrowness comes through in the bill, and it is about whether it can be strengthened in a different way.

Mandating something in legislation feels challenging and difficult in terms of how much it will add for all the reasons that people have given. However, we absolutely want to deal with people in a timely way, because the evidence has suggested for a long time that probably the best moment to intervene is when someone starts to feel that they can ask for help. That is sometimes a medical intervention and sometimes it is not. It is about the timeliness of being able to respond to a person’s individual needs, and I do not think that that has changed.

The challenge for the workforce will be the pressure that that approach brings. Given the pressures as they are at the moment, my worry is that what should be a relational-based interaction, with a lot of thought, empathy and working through, becomes more transactional as a result of the pressure of numbers.

I am a strong advocate for the charter of rights, which I believe is right. The duty bearers’ duties are what I would term good practice. They are what I was taught many moons ago and what most people would say that they are trying to do. That is not to say that the duty bearers get it right all the time, because they are also human beings.

Liam Wells: The challenge in the bill for me is probably organisational and administrative. I am sure that you have heard that the national mission survey of staff suggested that staff are already significantly under pressure and feeling overwhelmed. Are we now asking them to report on MAT standards and the Right to Addiction Recovery (Scotland) Bill? What duties do they have under the bill and the MAT standards?

The challenges are organisational and logistical, and those that are more organisational are probably around governance and reporting, which puts additional pressure on staff who are already overwhelmed.

Brian Whittle: On that point, we know that the system is under pressure right across the board. The financial memorandum mentioned the possibility of less need for repeat treatment. If we get the legislation right, would that not impact positively on the stress and pressure on staff?

Liam Wells: It totally would. No service really wants repeat customers: the aim is to move people through and out of services. That is the ultimate goal.

I do not know whether you want me to touch on the financial aspects. The challenge is that the financial memorandum clearly suggests that there will be savings in other parts of the system. Is that what you are focusing on?

Brian Whittle: The focus is on the preventative angle and the idea that those who seek services work their way through the service until the necessary input is much less than it would be if they returned to full dependency.

Liam Wells: I completely agree. I already highlighted that that is the current aim of services, which are not in the business of generating repeat customers. However, the complexity of drug and alcohol use needs to be recognised. For folk who have had significant trauma, one, two, three or even four interventions might not be enough, and they might need five, six or seven.

People like us will relapse. We all have some sort of dependence, even if it is just dependence on chocolate—I am speaking for myself. There is a recognition in the science that people relapse but that they come round. Prochaska and DiClemente's model of change recognises that people start from a position of being a pre-contemplater and being unready, then move into a process of readiness and then into an action and maintenance stage. However, there is also a recognition that that is circular and that people relapse. Although the ultimate aim is to move people out of a service and prevent them from returning there, we must recognise that there is a risk of relapse and that people need time, commitment and energy to move into a maintained recovery.

That was a long way of saying that I am not sure.

Kelda Gaffney: I go back to my earlier point. With the greatest of respect, there is a naivety to the idea, because making harmful use of or being dependent on drugs and alcohol is not a linear process. People do not go through recovery from here to there and make a final stop.

I know that we have talked about this a lot, but there is a stigma about drug and alcohol use, particularly for women. I see it as stigmatising if the message is that the bill will fix that drug and alcohol use, and if the message in the culture is that someone who has gone through a treatment programme—whatever it is, even if it is not abstinence based—will have their problem sorted and be fixed. I am sure that that is not the intention of the bill, but we need to recognise the issue and to say out loud to people that it is okay to relapse. We have worked really hard on saying that to people in our recovery community.

There is a lot of pressure. People can be abstinent for five years and then find themselves in a difficult situation, and the way that trauma works for many people is that they just need that trigger. It is the same for mental health. It is really difficult to talk about how financial gain will be achieved until we have gone through that process.

I cannot speak for my colleagues but, from a Glasgow perspective, very few people want to access services but do not get access to them. Quite frankly, I am yet to see evidence of people saying that they need access but are not getting it. I base that on the provision in the bill that says that people are to be assessed as appropriate for whatever treatment. We are challenged quite a lot on that, and we go away and look at circumstances.

I point back to the audit that we did of our abstinence-based project in Glasgow. Again, I am trying to highlight the cyclical nature of addiction. More than 72 per cent of people who accessed that abstinence-based programme during the audit had been in the alcohol and drug treatment and care system for more than 10 years; 36 per cent had been in it for 20 years or more. That is not everybody. As Liam Wells said, we absolutely want to support people out, to recover fully and to continue that support in the community, but we need to recognise that that is not the journey for everybody.

Pamela Dudek: I think that the complex end has been covered. My colleagues have really—

The Convener: Could you be very brief? A lot of members want to ask questions.

Pamela Dudek: The challenge that exists at the complex end has been covered. However, prevention happens earlier, and healthcare professionals in more generic settings are very well placed to pick up some of that.

Elena Whitham: Good morning. I want to spend a bit of time discussing families, carers and advocacy. The bill provides for family members to be included when treatment is sought in the first instance, but it is silent on the whole-family approach and family-inclusive practice. If the bill proceeds, does that aspect need to be strengthened, to reflect what local areas are already doing? You will all be very familiar with family-inclusive practice. Who would like to comment on that? I will start with Kelda.

Kelda Gaffney: I agree. Although mention is made of it, that aspect would need to be strengthened, in line with some of the work that has already been done. It is an area of practice that we absolutely need to focus on. We need to embed the whole-family approach and family-inclusive practice to ensure that we work alongside our families in communities. The bill provides for people to be assessed for whatever treatment they might need, and we need to include families in those assessments.

I point to the charter of rights and the importance of whole-system care. As was mentioned earlier, we have done a lot of work nationally to manage some of the stigma around women and their caring responsibilities. That would absolutely need to be strengthened in the bill to ensure that we look at people in a holistic way.

The issue is about recognising people’s needs as they present, as we have said previously. It is also about recognising that what families might want for their son or daughter might be different from what the person themselves wants. That is what needs to be recognised. With whole-family wellbeing and whole-family support, it is absolutely recognised that there can be tensions in the system, but it is a case of including families, as well as speaking to the people affected and carers.

Elena Whitham: It is partly about assessing the family’s need.

Kelda Gaffney: Absolutely.

Elena Whitham: Referring back to the earlier points about how you support someone once they get to the abstinence stage of treatment, do you think that it is a question of people being rooted in a support network that includes their family and the wider community back at home?

Kelda Gaffney: Absolutely. Being able to access a positive network of people around them is a really important part of somebody’s journey, but that is not easy for everybody. We know that there are lots of families in which relationships are very disrupted or are not very healthy, and they need some support to mend those relationships.

We talked about trauma. Some of that trauma can come from early experiences, and we need to recognise that. Again, the issue comes back to individual needs. Families are different and individuals are different, so those needs will be different, which means that the assessment of family is really important. If you are to build a community around a person, that community needs to be fairly strong and the members of it need to be on the same page and need to support one other.

11:15

Elena Whitham: Thank you—that was very helpful. Do the other witnesses have anything to add?

Liam Wells: I have nothing to add, other than to say that Kelda probably stole my point. I feel a wee bit like a broken record in saying that drug and alcohol problems and issues are complex and do not sit in isolation. For an individual to recover, they need not only community support and community networks, but family support and family networks. It is not just about the recovery of the individual; it is also about family recovery.

Elena Whitham: That complexity is key, and it leads on to my next question, which is about advocacy. We know that people require advocacy when they come to deal with such issues. MAT standard 8 is about the independent advocacy and social support that are required. That includes thinking about housing and other, wider factors that we know impact on people’s lives.

Do you think that the bill provides adequate reassurance on the need for independent advocacy and on factoring that into people’s journeys, or do you think that it needs to be strengthened in that regard?

Kelda Gaffney: We need to be absolutely explicit on advocacy. Without explicit reference to advocacy, it would be very difficult. I am a strong supporter, as is everybody on the panel, of advocacy for people. Independent advocacy is really important.

I fully believe that staff work very hard to meet people’s needs—people can come from different perspectives, and that is okay—but, when people are very vulnerable, it is really important that individuals and families can tap into advocacy around the wider issues and also around treatment. The bill talks very clearly about the medical professional and assessment, so there is definitely a need for independent advocacy within that. I would say that in relation to anybody who accesses any of our treatments, in fact. Everybody would benefit from advocacy.

There is a need for a holistic approach, but we would need to be very explicit about that, as is the case in the MAT standards.

Elena Whitham: Do you think that that reflects the human rights-based model of practice that we are seeking to ensure that we have, so that people can realise their rights and the duty bearers are taken to task, with an independent advocate who is available?

Kelda Gaffney: Yes.

Pamela Dudek: The issue is how that interaction is facilitated. When someone is in a really difficult place where their addiction and, if you like, their chaos are at a peak, it is difficult to have the conversation that you might need to have. It will depend on where they are from a confidence perspective, which is generally quite low at that stage, and how they have come to survive—their behaviour in their survival—which can be a barrier from the individual's perspective.

As Kelda said, it is important to have advocacy on offer to help people to navigate the system and to give us feedback on where it did not feel as it should have felt. If the advocate is struggling to navigate or is getting an unhelpful response, it is useful to have that feedback. Mostly, it is about being able to facilitate and manage that conversation and assert appropriately with the individual where possible. Our most vulnerable would benefit the most, but I agree that most people would probably benefit from having some level of advocacy in navigating the system.

Elena Whitham: As someone who used to work as an independent advocate in this area, I think that that is helpful. If something is formalised—MAT standard 8 has started to do that underpinning work—that gives weight to what an independent advocate says to services, which has not always been the case. Would that help in the long run?

Kelda Gaffney: Absolutely. I have to be frank: bringing in advocacy is one area that we in drug and alcohol services have not got right for a long time. From service provision, I certainly see that being part of the MAT standards and the need to report on that has meant that a huge amount of work has had to be done on independent advocacy.

As an ADP, we have been supporters of independent advocacy for a long time. Embedding that has been more challenging. However, we now have the vehicle for doing that. Again, reporting on that and asking how we are managing it also opens up the conversation about why we are not doing it, which has been helpful for me. It is in the charter of rights. It is a human rights approach. We should ask why we would not offer it. Independent advocacy has been really helpful, and we need to be explicit about it.

Elena Whitham: I will hand back to the convener, because I know that we are short of time.

The Convener: Thank you. I will bring in Sandesh Gulhane.

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

Kelda Gaffney, I will start with you, given that you are based in Glasgow. What is your budget like? Has it been cut or increased?

Kelda Gaffney: I take it that you are referring to the budget for drug and alcohol services. The IJB meeting took place last week. I do not have the figures to hand, but we were very clear about services when it came to budget restraint and retraction. Alcohol and drug services were the same as all our other services in being subject to some of those savings. Savings on our ADP budget were put forward and approved at the IJB. I can go into that in more detail if you would like.

We are currently reviewing our crisis outreach services—we will look at those. That is similar to the situation in all other health and social care partnerships and IJBs, I think. There is a need to manage within the budget that we have.

Obviously, as an ADP, we are not entirely content that we need to look at saving any money from treatment services—or from any services, across the board—but it is the same for mental health services, for which I am also responsible, and for children's services. Financially, this is a very difficult time.

Sandesh Gulhane: There have been cuts of £100 million over the past three years, and there will be cuts of a further £120 million in the coming three years. Seventy-five full-time members of staff will lose their jobs, including staff in the supported living service, counsellors at the Sandyford clinic, health visitors and people in the central parenting team, and roles will be lost in trauma, learning disability and primary care mental health services.

Given everything that Liam Wells has said about trauma services and everything that you have all said about the multidisciplinary team approach and all the services that are offered, when such cuts happen, what will happen to people who have addictions?

Kelda Gaffney: We have looked at a very wide range of services across the health and social care partnership. I will say exactly what we said about savings at the integration joint board last week: in order to present a balanced budget from a health and social care partnership perspective—I am coming out of my ADP role; I hope that that is okay—it is necessary to manage around that, so savings have to be put forward. We would never want to be in the position of having to retract any service without a review, unless that was absolutely necessary. As a health and social care partnership, we spent a lot of time, across all the care groups, looking at the options that would have the least impact, how we could mitigate some of that, and some of the work that is going on around that.

Without going into every single one of them, there is a broad range of mitigating factors. There will, of course, be equality impacts for most of the services that you have mentioned, other than those that are subject to review, and there will be equality impact assessments for those. We will look at that as we go on.

You are right to highlight something that is public because it is in the paper. Based on the current trajectory, we suspect that we will have to save another £118 million in the next three years, so we will have to manage within that budget and there will be reviews of the whole system of care.

Sandesh Gulhane: My next question is for the whole panel. If the bill were to come into force and put the individual’s rights into law, much as the Patient Rights (Scotland) Act 2011 gave people the right to receive in-patient and out-patient care within 12 weeks, would that not bolster your ability to maintain your budgets or even to have them increased in order to help people?

Kelda Gaffney: I would like to quickly follow up on that. As far as the financial memorandum and the Glasgow ADP’s response to it are concerned, I would say that I totally understand the principles of the bill and why those are being pushed forward, but, as you know, we have to work within our budgets, and there are concerns that no cognisance has been taken of the impact on other parts of the service. What will happen when people need mental health support?

Sandesh Gulhane: It has been cut.

Kelda Gaffney: There is a massive budget for mental health. Savings have been proposed in the budget for the primary care mental health service that deals with the distress end. There will be a review to see what that will look like. We are hoping that it will not have an impact on the number of people who access the service, but I cannot tell you that until we have done that review.

You have made the point that there have been cuts to budgets. Without going into the financial background, the health and social care partnership receives money from the Scottish and UK Governments. We have to work to a budget, and that will be the same for my colleagues. The response on the financial memorandum that was submitted by our finance colleagues included concerns about the pressure that the bill would place on other aspects of the system and of care. I must be clear that our reference panels and our lived experience consultation also raised some concerns about that, not from a financial perspective but because of stigma if there was an impact on other parts of the service.

Pamela Dudek: There is a lot of concern in Dundee about the impact on our budget and about what might happen in the future. In the short term, we have been passed the money that comes in for the ADP. As an independent chair, I have been trying to challenge how that connects to the wider system spend, because the ADP spend is relatively small in comparison with the wider systemic spend. Nevertheless, this is a tricky time, and the accountants are working with lots of people in order to understand that differently to ensure that we are spending the money as appropriately as possible for those who are most in need. We are delving into the strategic commissioning approach that should be the bread and butter of HSCPs.

I have also asked for a review and refresh of our strategic needs to understand the capacity and the demand, so that we can make better decisions, but I think that we will still probably find—given the way that we work in the current system—that demand is outstripping capacity.

The other aspect on which we are still in the foothills, or perhaps a little further up, is that of taking an integrated approach to public protection. By that, I mean considering the combined resources that are available for the most vulnerable groups of people, many of whom will have experience of mental health, drug or alcohol problems, poverty or domestic violence—they will have a whole range of issues going on in their lives—to see whether a different way forward could optimise our budget.

11:30

There is no doubt that both we and our third sector partners are currently very concerned. Obtaining recurring funding is always a challenge, but it is even more of a challenge when we see the stark figures that are being put out.

Liam Wells: I do not have much more to add. I will pick up on Kelda Gaffney’s point about shoving the pressure elsewhere. If the bill brings in a legal right to an assessment by a health professional, there is a danger that the cost will be transferred on to health professionals. We already see increased costs in health services, which are often more expensive than some of our third sector and community treatment services.

Sandesh Gulhane: Thank you.

Emma Harper: We have touched on MAT standards and multidisciplinary teamwork. If the bill is implemented, will it provide additional benefits for individuals who seek treatment for drug and alcohol problems, compared with the position under the existing MAT standards?

Pamela Dudek: It is difficult to say, because it goes back to the discussion on advocacy and how people are able to exert their powers and make requests for treatment, and what the effect of the bill might be on the relationship and the dynamic between a professional and an individual.

I can think of examples of people having come to us and demanded treatment. When we sit down with them and spend an hour listening to what is going on for them, we sometimes find that what they are demanding is not the best thing for them. That requires having a mutual discussion. There is a real difficulty there. Given the power that you have, as a professional, and the situation of someone who is vulnerable, you always have to strike a balance to keep that mutual relationship going. I am sure that that balance does not always prevail in the way that it should.

I am trying to get my head around what would happen if someone came in to see me and said, "I have the right to treatment. I need this and I want that. You have a duty to give me those now." Given how things have happened in the past, without legislation, and how they have been translated, the legal bit would have had very little bearing on where we got to.

I have sat with people who wanted residential treatment. As I said before, in such cases I have asked them to hang fire on that and work with me for a bit to see what would be right for them. I knew that all the indicators were that, if we were to take them straight in and detox them and then send them out again, it would not do much for them, so their self-esteem level might be even worse.

I am still trying to get my head around all of that. I absolutely agree that we should have a timely response and intervene at the time when people are ready and keen to have such a discussion. However, I struggle a little with whether the dynamic that would result from the bill would be a help or a hindrance.

Going back to the previous point about whether such an approach would give us leverage in the system, again, I am not sure that it would, because the treatment time guarantee has not always done that in any other part of the system that I have worked in.

Emma Harper: I want to pick up on the nature of the people who present themselves to you. I assume that the clock starts ticking when they first show up. However, they might then relapse and disappear for two or three weeks but later come back to the service. When does the clock start again or stop? How do we measure that?

Pamela Dudek: That is the issue. When does treatment really start and when is the engagement part of treatment? As we were discussing, we need to get better with regard to how we get to the really vulnerable people. I am sorry to say this, but I come from an NHS background and there is still a tradition whereby we expect people to come to us. I am not in the NHS now, but that would be the model of care, and we are having a strong chat about that. What would that need to look like instead? We do reach some people, but there are lots of people we do not reach, particularly when it comes to deaths—people dying alone. Who was connected?

Emma Harper: Turning to the financial aspects, pages 11 and 12 of the financial memorandum say:

> "the percentage of people in Scotland who self-report having a current problem with their drug use is fairly low. However, it is generally accepted that people who use drugs are in part a hidden population".

Public Health Scotland and the University of Bristol are doing some research to see where the hidden population is. That has an impact. If we continue to take the stigma away from people who come for support, that might mean that the hidden population becomes unhidden, and that could mean further demand. There might be some challenges in considering the projection of the number of people who may need to present.

Pamela Dudek: That relates to placed-based communities. It is important to understand communities at a deep level and to work with them to see how to create a slightly different environment for people. We also have to consider the stigma side of things. It can be really difficult for people in smaller and rural communities. There is no one-size-fits-all solution, but I think there is something here for us.

There is a lot of good work going on in the various communities in Dundee, but we still have significant challenges around how things are for individuals in what is a really difficult space.

Emma Harper: I am glad that you mentioned remote and rural communities, as that point came up with the previous panel of witnesses. It is important that we tailor the support on the basis of where we are in Scotland.

Pamela Dudek: When MAT standards came out I was in Highland and in Argyll and Bute. It was a real challenge to deliver same-day prescribing in island communities. Was there a way to respond appropriately? Perhaps that could not be shaped in exactly the way it might be in an urban area.

Communities are at the heart of all of this work, and the more that we can strengthen the environment for people, the better. The determinants that could make a difference in the long term are much wider. It is a matter of how we deal with people who are in a terrible place and how we try to move them on while trying to prevent that for the next generation.

I was in a school in Dundee this week, speaking with teenagers who are affected by parental substance use. It is really difficult for them. They are lovely kids, and they were quite vocal, but they are in a really difficult place. How do they get their hope, at 14, when they are surrounded by awful circumstances or if they are caring?

Carol Mochan (South Scotland) (Lab): The witnesses have already touched on some of the stuff that I was going to ask about the financial memorandum, but I would like to go back to it. As we know from written evidence, although there are some areas where we know that there will be increased costs, there could be benefits further along the line by way of costs. Could the witnesses speak a little bit about whether they think there is clarity in the bill about what additional spending there will be and what we might see in the future, in terms of spending? Is there a balance that could work?

Kelda Gaffney: I would point to the earlier answers. The Glasgow ADP has recognised some challenges in the financial memorandum regarding evidencing the costs. We know that a lot of the costs that are caused by alcohol and drug issues are attributed to acute settings, including presentations in accident and emergency departments, acute admissions and involvement with Police Scotland and the Ambulance Service. If we follow that journey through and see people recovering—and recovering well to be better than they are just now—we would expect to see an impact on services in other parts of the system.

The challenge that is faced across the health and social care partnership is that those savings are made in other parts of the system and are not necessarily routed back to the ADP. However, as others have said, we obviously always want to see people recovering, wherever future savings are achieved. I go back to the earlier point about it being difficult to evidence savings or financial returns without seeing how that plays out.

Our ADP has responded to say that we do not necessarily see the bill bringing any additional long-term financial savings. We might see more people going through treatment, care and recovery, but that is cyclical for a lot of people, if not for everyone. We always want to see as many people as possible in sustained recovery—and in abstinence, if that is what they choose and want—so that they can build a life in their community, but that is not what we see. We do see a number of people managing that, but a number do not manage.

Carol Mochan: That was helpful.

We are talking not just about financial benefits. Do you, or any of the witnesses, see the bill being helpful to other parts of the system, such as policing, healthcare or accident and emergency? Is there anything in the bill that would be beneficial to those services?

Liam Wells: I will pick up on Kelda Gaffney’s point. If fewer people ultimately went to prison, that would absolutely benefit and bring savings for justice services, and if fewer people went to hospital, that would absolutely benefit and save money for our health services.

The challenge that Kelda outlined is about how to quantify that resource and then how to release it. Will it be recycled within the hospital, the prison or the police? How do you realise that resource and can you release it for what you might call the small world of ADPs?

Carol Mochan: I take your point.

If there is to be additional funding in the context of the bill, where would you target that to get some of the benefits that you talk about?

Pamela Dudek: If I think about the bill as written at the moment and look at the dependent end, good pathways for opiate use are emerging through the MAT standards and we are exploring pathways for non-opiate users. If we focus on alcohol, the trends are telling us that we need to intervene quite significantly there, because the country does not have a great track record in our relationship with alcohol.

I feel quite strongly, regarding not only drugs and alcohol but also lifestyle and resilience, that we have to ask how we can help our children make better choices and have better destinations as they move through school and into adulthood.

11:45

There is plenty of evidence that early prevention models bring pound savings in the long term. Whether that money is released to invest elsewhere has always been a challenge on many levels and in many different guises. However, the bottom line is that we want a healthy population. The use of the health service and social care will be determined by the health of the nation when it comes to people being able to grow old and still be fit and well. Any funding therefore needs to make a bold commitment to prevention, because we do not really do that. We do lots of things but, often, on short-term money—projects or pilots—then, lo and behold, there is no mainstream money, and services that we see value in have to stop.

We need to do something to make our system more mature. If money comes, although the approach has two prongs, alcohol needs to be brought to the fore. Alcoholism causes significant harm in huge numbers across our society.

The Convener: I thank the witnesses for their evidence this morning. You are free to go, but the committee will continue its work.

Assisted Dying for Terminally Ill Adults (Scotland) Bill: Stage 1

11:46

The Convener: The third item on our agenda is consideration of testimonies from individuals who are living with a terminal illness, as part of the committee’s stage 1 scrutiny of the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

Since it commenced taking oral evidence on the bill last year, the committee has also engaged with a number of organisations that are involved in providing front-line care and support to individuals who have a terminal illness. The purpose of that engagement was to explore whether any such individuals would be willing to contribute personal testimonies about their experience and their views on the bill.

Throughout that process, the committee has made every effort to take a sensitive approach to ensure that the autonomy of the individuals concerned is respected, that they are suitably supported and that any associated practical barriers to participation are appropriately addressed. I place on record the committee’s sincere gratitude to Alzheimer Scotland, Age Scotland and Marie Curie Scotland for the helpful and thoughtful way in which they have engaged with the committee on such a sensitive topic. I make it clear that those organisations take a neutral position on the issue of assisted dying and neither support nor oppose the bill.

As a result of our engagement, the committee has received two testimonies from individuals who are living with a terminal illness, which have been published on the committee’s web pages. I express my sincere thanks to both individuals for their important contributions to the committee’s scrutiny of the bill at stage 1, as well as to individuals who have contacted me directly as convener of the committee or as a constituency MSP, to share their views and experiences.

There is now an opportunity for other committee members to put on record some of their thoughts.

Joe FitzPatrick (Dundee City West) (SNP): I add my thanks to the individuals who wrote in and to all the constituents and other folk who have contacted me personally in my role as a constituency member. I have had representations from people with differing views. All of that is really helpful as we look through the evidence and make a decision on what is a really important matter. Thanks to them all.

Emma Harper: Convener, I agree with you and Joe FitzPatrick about the amount of contact from constituents, as a lot of people in the South

Scotland region have contacted me. In addition, from reading the evidence to the committee, I know the commitment that people have and I know that it is, obviously, a very serious issue. People care deeply about the process, the debate that we are having and the information. It is absolutely necessary that I put on record my thanks to everybody who has been involved. I will continue to make sure that I pay full attention to the issues as we go forward.

Paul Sweeney (Glasgow) (Lab): I reiterate my thanks to the wide variety of people who have made representations on a challenging area of potential legislation. The more that we have delved into the complexities of the issue, the more fraught the considerations have become. In the correspondence that the committee received, I noted a story of someone whose life had been set on a negative trajectory because of dementia, which led to their early retirement. That brought to the fore the wider implications of how we manage people’s healthcare in a wider setting. Similarly, if people have a sense that they are a burden on their friends and family, it might mean that they are inclined to support assisted dying, but it also raises questions of coercion. That is the moral conundrum that we are trying to contend with. Representations that we have heard reflect many of the difficulties that we face in trying to find a way through to the right course of action.

Elena Whitham: I thank the individuals who engaged with the committee on the issue and who have sent representations to individual MSPs. I also thank the clerking team for their efforts to engage with those who have living experience of the situation, to try to ensure that their voices could be heard, which is not an easy task. That was one of the things that I felt was missing from the evidence that we took, but it was not for want of trying by the clerking team.

Sandesh Gulhane: I remind members of my entry in the register of members’ interests, which states that I am a practising NHS GP and the chairman of the medical advisory group on the bill. It is incredibly brave for any individual to be willing to come forward and put their thoughts on record in a parliamentary setting. Personally, I take that seriously in my reflections on the bill, so I thank the individuals who have done so, as well as the organisations that have engaged with the committee on an incredibly difficult topic. I am sure that we have all had multiple people contacting us on behalf of those who are on both sides of the debate.

Subordinate Legislation

Health and Care Professions Council (Miscellaneous Amendments) Rules Order of Council 2025

11:52

The Convener: Agenda item 4 is consideration of a negative instrument. The policy note states that the purpose of the instrument is to provide the Health and Care Professions Council with the power to increase the fees that are charged for processing and scrutinising applications for admission to its register, renewal of registration and readmission or restoration to the register.

The instrument also rectifies errors made by the Health and Care Professions Council (Miscellaneous Amendment) Rules Order of Council 2023, which will give HCPC chairs, practice committees and appeal panels the power to arrange virtual preliminary meetings. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 11 March and made no recommendations in relation to the instrument, and no motion for annulment has been received.

There are no comments. Does the committee agree that we do not wish to make any recommendations on the instrument?

Members *indicated agreement.*

The Convener: The committee will not meet in public next week, but we will meet in private to consider our future work programme. After the Easter recess, the committee will meet in private to consider a draft stage 1 report on the Assisted Dying for Terminally Ill Adults (Scotland) Bill. With that, I close the public part of the meeting.

11:54

Meeting continued in private until 12:06.

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