OFFICIAL REPORT
AITHISG OIFIGEIL

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

Wednesday 2 February 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 2 February 2022

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CRIMINAL JUSTICE COMMITTEE
5th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP) (Health, Social Care and Sport Committee)
*Audrey Nicoll (Aberdeen South and North Kincardine) (SNP) (Criminal Justice Committee)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP) (Social Justice and Social Security Committee)

DEPUTY CONVENER

Natalie Don (Renfrewshire North and West) (SNP) (Social Justice and Social Security Committee)
*Russell Findlay (West Scotland) (Con) (Criminal Justice Committee)
*Paul O'Kane (West Scotland) (Lab) (Health, Social Care and Sport Committee)

COMMITTEE MEMBERS

Jeremy Balfour (Lothian) (Con) (Social Justice and Social Security Committee)
*Miles Briggs (Lothian) (Con) (Social Justice and Social Security Committee)
Stephanie Callaghan (Uddingston and Bellshill) (SNP) (Health, Social Care and Sport Committee)
*Foysol Choudhury (Lothian) (Lab) (Social Justice and Social Security Committee)
Katy Clark (West Scotland) (Lab) (Criminal Justice Committee)
Pam Duncan-Glancy (Glasgow) (Lab) (Social Justice and Social Security Committee)
Jamie Greene (West Scotland) (Con) (Criminal Justice Committee)
Sandesh Gulhane (Glasgow) (Con) (Health, Social Care and Sport Committee)
Emma Harper (South Scotland) (SNP) (Health, Social Care and Sport Committee)
Fulton MacGregor (Coatbridge and Chryston) (SNP) (Criminal Justice Committee)
*Gillian Mackay (Central Scotland) (Green) (Health, Social Care and Sport Committee)
Rona Mackay (Strathkelvin and Bearsden) (SNP) (Criminal Justice Committee)
Marie McNair (Clydebank and Milngavie) (SNP) (Social Justice and Social Security Committee)
*Pauline McNeill (Glasgow) (Lab) (Criminal Justice Committee)
Carol Mochan (South Scotland) (Lab) (Health, Social Care and Sport Committee)
Emma Roddick (Highlands and Islands) (SNP) (Social Justice and Social Security Committee)
Collette Stevenson (East Kilbride) (SNP) (Criminal Justice Committee)
David Torrance (Kirkcaldy) (SNP) (Health, Social Care and Sport Committee)
Evelyn Tweed (Stirling) (SNP) (Health, Social Care and Sport Committee)
*Sue Webber (Lothian) (Con) (Health, Social Care and Sport Committee)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Angela Constance (Minister for Drugs Policy)
David Strang (Scottish Drug Death Taskforce)

CLERK TO THE COMMITTEE

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

LOCATION

Virtual Meeting

Scottish Parliament

Criminal Justice Committee

Wednesday 2 February 2022

[The Convener opened the meeting at 10:00]

Decision on Taking Business in Private

The Convener (Audrey Nicoll): Good morning, everyone, and welcome to the second joint meeting in 2022 of members of the Criminal Justice Committee, the Health, Social Care and Sport Committee and the Social Justice and Social Security Committee to consider the progress that is being made in implementing the recommendations of the Scottish Drug Deaths Taskforce.

There are no apologies. I ask members to ensure that mobile phones are switched to silent and to wait for the sound engineer to switch their microphone on before speaking.

Our first item is consideration of a decision on taking in private item 3, which is consideration of the evidence heard. Are we agreed to take item 3 in private?

Members *indicated agreement.*

Reducing Drug Deaths in Scotland and Tackling Problem Drug Use

10:01

The Convener: Our next item is our second evidence session on reducing drug deaths in Scotland and tackling problem drug use. I refer members to papers 1 and 2.

I welcome to the meeting David Strang, who is chair of the Scottish Drug Deaths Taskforce. Thank you for your written submission, David. I invite you to make brief opening remarks. Please speak for around three minutes.

David Strang (Scottish Drug Death Taskforce): Good morning, convener and members. Thank you for inviting me to this evidence session and for the opportunity to make a few opening remarks.

Three weeks ago today, I was appointed to chair the task force, so I am new in the post. However, the task force itself is not new; it has been going for more than two and a half years and it has achieved a great deal in that time.

Scotland's drug-related deaths have rightly been described as a public health crisis or emergency. Every premature death as a result of drug use is a tragedy for an individual, a family and a community. The deaths demonstrate an urgent need to improve how we respond to the crisis. We need to change what we are doing.

The task force's role is to examine the evidence and make recommendations that will lead to reducing the number of people who die from drugs and improving the health of people who use drugs.

The task force has already achieved some major milestones, including an increase in the availability and use of naloxone as an emergency response to save lives. It has made recommendations on drug law reform, developed the new medication-assisted treatment—MAT—standards and published a strategy to tackle stigma that is associated with drug use.

However, a great deal of work remains to be done to address the challenges that Scotland faces. Those challenges are not just for the task force, health services and the criminal justice system; they are for all of Scotland—government at national and local level, partner organisations, businesses, the third sector and communities.

The new vice-chair of the task force, Fiona McQueen, and I look forward to working with the task force members to continue this important work for the next six months.

The Convener: Thank you very much, David. I will start off with a very general question. You mentioned that you were appointed as chair just a matter of weeks ago—I think that you said that it was three weeks ago—and you outlined the role of the task force in gathering evidence and making recommendations, and the milestones that the task force seeks to achieve. I am interested to hear your early views on, in particular, the remit and terms of reference of the task force. Are they fit for purpose? Is the focus of the task force the right one? Are the timescales for delivery that have been set by the Scottish Government achievable? That was a bit of a roll-up of questions, but I am interested to hear your views.

David Strang: It was three weeks ago today that I was appointed. I chaired my first meeting of the task force the following Wednesday, which was a fortnight ago. That was the task force's 19th meeting.

The task force has been on a bit of a journey. It was launched in the summer of 2019 after the publication of the 2018 drug deaths statistics. It was to run for the length of the parliamentary session, so its anticipated end date was in May last year. However, following the election, that was extended so that the task force could continue its work.

It is a matter of judgment how much is included in the remit of a task force such as this, because—I am sure that we will go on to discuss this—although the focus is on drugs, the topic is much wider than that. I mentioned that the issue is not just for health services, the police and the criminal justice system; it requires much wider support and all arms of government, national and local.

It is reasonable that, because the remit is about reducing the number of drug deaths, it has a clear focus on people who are using drugs in a serious way, to stop them going down a pathway towards death. The focus is inevitably on things such as the emergency response, support and treatment for people who are using, as well as trying to be effective in meeting their needs and supporting them.

There is a whole other agenda about prevention—how we prevent people from going down that track. I have views on that and I am sure that the task force does, too, but that is not the main focus—our focus is on reducing the number of drug deaths, so we are concentrating on that high end.

You asked me about the timescale, convener. We have a work plan and, in the summer of this year, our final product will be a road map that will lay out what needs to happen over the next five years or so. The problem will not be solved in six or 12 months—-you would not expect me to say that it will be—because we are talking about making a major culture change in Scotland, reshaping services to support the needs of people who use drugs and changing what we have been doing. The task force will complete its remit by making its recommendations, but the work and implementation of the recommendations will continue beyond the life of the task force.

The Convener: That is a helpful overview. I have a quick follow-up question. Where does the task force currently sit in delivering the tasks that it has been set? I would be interested to hear your views on that.

David Strang: I am really interested in what happens next. I have been looking through the reports that the task force has produced over the past two and a half years, and there are already more than 100 recommendations. That is the role of the task force—we are about looking at evidence and making recommendations. It is not our responsibility to implement or review them, but, as the incoming chair, I am really interested in what has happened with the recommendations. Have they made a difference? Some of them were made as early as April 2020—nearly two years ago—so I would expect to see some change as a result. That is a question that I will be asking; I do not know the answer to it yet.

I hope that things have changed and that the recommendations of the task force have led to improvements. If they have not, we will comment on that when we get to the final report and the road map. If we have made recommendations about something, we will consider how well they have been implemented.

Implementation is for others. Beyond that, there needs to be scrutiny and oversight to encourage the implementation of the recommendations.

The Convener: Thank you for that. I open up the questioning to members and will bring in Paul O'Kane.

Paul O'Kane (West Scotland) (Lab) (Health, Social Care and Sport Committee): Good morning, David. Welcome to your role—we appreciate that it is a fairly new one for you.

I will follow on from the convener's previous question about the delivery of the task force's recommendations and scrutiny of whether they are being delivered. There has been criticism from some people that the task force has seen itself as an advisory body only. Do you think that it should have more powers to press stakeholders on delivery? You referred to the scrutiny of delivery and looking at whether recommendations have been implemented. Is it your view that the task force needs more power to follow up?

David Strang: I do not think that there needs to be more power for the task force, because change has to be delivered by existing institutions, organisations and structures. We give advice and make recommendations—we are advisory. I imagine that the Government would not have set up a task force with a view to not listening to or taking on board its advice.

After the election, the task force entered phase 2. In the first phase, it was more operational. It funded projects, made decisions about research and commissioned work. In the second phase, we are looking at those projects and the results of the research and we are making recommendations. The Scottish Government drugs policy team, which supports the task force, has increased in size and has a more active role in implementing policy.

Some of the projects that the task force kicked off will continue into 2023. That is what I meant about the need for a mechanism to continue gathering the learning from the projects that have been started and to ensure that that learning is implemented. I am not arguing that the task force should have more power, nor that it should be extended; I am just saying that one of the questions that I will be asking is how that work will be overseen. It might be by a different scrutiny body or it might be a role for the Government itself.

Paul O'Kane: I think that this is the first time that we have come together as committees on these issues, and I think that it is a helpful forum. We are keen that the Parliament has a strong role in the scrutiny of the minister's delivery on the national mission. Of course, the minister will join us in the next evidence session.

Is scrutiny by Scottish Parliament committees and this sort of forum one of the avenues that we could take to analyse the recommendations and track their implementation?

David Strang: Definitely. I would be delighted if the Parliament took an active role in following up on the task force's recommendations and sought reports from the Government and others on what has been implemented and, perhaps more importantly, what the impact of implementing the recommendations has been—whether services have increased and drug users are getting better treatment and care. I would welcome the Parliament taking the role that you suggest.

The Convener: I will now bring in Russell Findlay, followed by Gillian Martin. Over to you, Russell.

Russell Findlay (West Scotland) (Con) (Criminal Justice Committee): Hello, Mr Strang. Your predecessor, Professor Catriona Matheson, and her deputy, Neil Richardson, both quit, saying that the Scottish Government's strategy was "counterproductive". Have you had any contact with either of them, have you evaluated their concerns and, if so, what are your views on those concerns?

10:15

David Strang: I do not want to comment on my predecessors' views. In answer to your specific question, I had a good conversation with Catriona Matheson. We talked about the work of the task force to date and what remains to be done. I found that conversation helpful.

I said little about timescale in my answer to the convener's question. Timescale is a matter of judgment. The task force has been going for three years. We are not the only source of advice for the Government. There are other experts in the field, including a network of academics who research drugs. We have a specific task to do, and will complete that by July. That will be the work of the task force, but the work of tackling Scotland's drugs problem will go on and must be addressed by a wide range of organisations and official bodies. It will not stop when the work of the task force finishes.

Russell Findlay: The Drug Deaths Taskforce has recommended the introduction of so-called "tolerance zones". We heard that Police Scotland has concerns about those. What is your personal view? Do you support the task force's recommendation?

David Strang: The task force is recommending that tolerance zones should be considered and examined. A number of the recommendations have involved radical new thinking. I welcome that. The task force has not gone into the detail of exactly what such zones would look like. There is a link to safer consumption facilities.

The strength of the response to drugs depends on everyone understanding what is being done and why. Police Scotland is right to raise the issue of policing style and policing activities and to consider whether and to what extent those activities would support the work on safe consumption facilities or whether they would be counterproductive. If there was a very heavy police presence and the police were searching everyone who came near the zones, that would be counterproductive. What would be the point of that?

Police Scotland is very involved in the task force. I know that the committees have received evidence from Assistant Chief Constable Gary Ritchie. He is very supportive of a public health approach to responding to Scotland's drugs crisis. I am confident that the police will be supportive of what we are doing and recommending.

Russell Findlay: It seems that tolerance zones would be around drug consumption facilities. Police Scotland has also expressed concern about the practicalities of those facilities. Can you expand on what those might look like? How many would there be? Where would they be?

David Strang: I am sorry—I missed your question. Are you asking about the safe drug consumption facilities?

Russell Findlay: Yes, I am asking about the proposed drug consumption facilities. Can you expand on how many of those would be needed and where they might be? Do you have that kind of detail?

David Strang: I do not think that we have gone into that amount of detail. It is a radical proposal. In my briefing from and discussion with the minister last month, she encouraged the task force to be radical and to push the boundaries of ideas.

If you were to go down the road of safe consumption rooms, that would need to be a matter for local communities. It would be agreed in principle and all the legalities and practicalities would need to be worked out at a national level. However, local authorities, local health boards and local police would have a view on it, and they are the ones who would decide, rather than the task force saying exactly how many there should be and where they should be.

Gillian Martin (Aberdeenshire East) (SNP) (Health, Social Care and Sport Committee): Welcome to your role, Mr Strang.

As you said, the task force has put together many recommendations, which are based on the huge amount of evidence and research that it commissioned. As a result of that research, do we have a clearer understanding of why we have this particular Scottish drug deaths crisis?

David Strang: What we know is that there is no simple answer to your question, although it is a good question. People ask, "Why does Scotland have three and a half times the number of drug deaths as the rest of the United Kingdom?"

In 2020, which is the last year for which we have figures, 1,339 people died in drug-related deaths, which is more than three a day. Every day in Scotland, more than three people are dying from drugs, which is an absolutely shocking and scandalous number. It is also the highest ever. For the past six years, the numbers have been increasing year on year, and last year, 78 people under the age of 25 died drug-related deaths.

It is a crisis, but the answer to why we have such a crisis will be contested. There will be people with different views. The issue has been a long-standing challenge for Scotland. We know that the contributing factors are things such as poverty and inequality, early abuse and trauma, and mental ill health, and there are other common factors such as offending, homelessness, relationship breakdown, loneliness and violence. All those things are associated and linked with the issue. Saying that there is not a single answer to why Scotland has such a big problem means that there is no simple solution whereby, if we just did that one thing, it would solve it.

In understanding the underlying causes and factors, we need a broad response that addresses each of them.

Gillian Martin: Of course it is a complicated and complex situation, as you said, but are we really at the point at which we have to try myriad interventions, some of which are quite radical? Do we need to look at learning from other countries or cities that have had particular problems with drug deaths and have tried things that have yielded results?

David Strang: That is a good question, and it is one that I have asked of the team. I have asked where we can learn from. Undoubtedly, we can learn from elsewhere, and I know that the task force has done some work on international comparators.

You asked whether the situation needs multiple responses—it will do. The most significant shift in response that I have seen in recent years has been the shift to seeing drugs not simply as a crime and justice issue but as a health issue. In my opening comments, I was just repeating words that I have heard elsewhere, but this is indeed a public health crisis. I do not know about the Parliament, but that is certainly the Government's position, and I agree completely with it.

I used to be in the police. Forty years ago, it was thought that the solution to drug use was more law enforcement and that it was about crime and punishment. We now have a much greater understanding. For 40 or 50 years, we have been trying to deal with drug use as a crime and punishing people, and it is clear that that has not worked. We now have that sort of statement, and there is an understanding that addiction is a health issue that we will not solve by punishing people. They need care, treatment and support.

Clearly, there is a role for the police when it comes to ancillary crimes such as violence, acquisitive crime—theft—and drug trafficking. However, at the very heart of the issue are the people who are dying. It is not the criminals who are dying; it is the people who are suffering addiction, and therefore the solution is to have a change of attitude so that we see drug problems as a health issue and not as a crime issue.

Gillian Martin: Thank you very much.

Pauline McNeill (Glasgow) (Lab) (Criminal Justice Committee): Good morning, Mr Strang, and thank you for the work that you are doing.

My question continues on the law reform issue and is about the review of the Misuse of Drugs Act 1971 and the possibility of creating safe consumption rooms to prevent deaths. You said that it is important to explain to people what we are doing in any reform. In 2018, I hosted a visit by Nanna Gotfredsen, a street lawyer from Denmark who led the charge in the Danish Parliament to change policy on safe consumption rooms. She is very much behind what is going on in Glasgow. I have researched the issue and found that there are 66 cities with such rooms where, apparently, there have been no deaths and there is no evidence of increased drug use.

Do you agree that it is important to have credible evidence on the issue so that we can make a judgment about whether safe consumption rooms are one of the tools that we can use to stop deaths?

David Strang: The task force has recommended safe drug consumption rooms. Obviously, that was not in my time, but it was satisfied that there is sufficient credible evidence, so that is the recommendation, and I agree with it.

On your wider point, if we are to change public opinion and political views and get political buy-in, credible evidence is important. That is at the heart of what the task force has been doing—it has been looking at the evidence and using it. I have given evidence to committees of the Parliament before, and have heard people saying, "That might be the evidence, but I don't believe it—I still think it's right to lock people up." People are not necessarily persuaded by the evidence.

I was struck by a lot of the emergency changes that had to be made because of Covid. There was no evidence of what the impact of the vaccine would be after five years, because that was not available, but we went ahead and did what had to be done. I do not in any way minimise the need for evidence, because I absolutely believe that evidence is very helpful, but we have lots of evidence for the recommendations that the task force has made. I suppose that I am slightly reluctant to agree that we need more evidence, because I think that the evidence for supporting drug consumption rooms is overwhelming.

Pauline McNeill: Yesterday, we heard from the United Kingdom Minister for Crime and Policing, Kit Malthouse, and a number of us had an exchange on this subject. He said that it is a very complex issue. As you know, our Lord Advocate might consider the question and she is already consulting the police and so on. Kit Malthouse asked, "If we set up an overdose prevention site in Govan, would you arrest someone who was travelling to Govan from Edinburgh?" I think that there is quite a simple answer to that, but I want to ask you, as a former chief constable.

In Glasgow, we had tolerance zones for what was then called street prostitution. It is not complex, to my mind. If you set up a zone in which you disapply the law, anyone outside that zone would be breaking the law. Is it your view that the question is too complex? I know that you support the setting up of tolerance zones. The minister who is in charge of the 1971 act says that it is really complex. I am not sure that I agree with that.

10:30

David Strang: He mentioned travelling from Edinburgh and from Bearsden, which are two places where I have lived.

It is always possible for clever people to find reasons if they oppose something. Whatever challenges there are to implementation, the police, working with the Crown Office, will come up with a working solution. You can imagine that, if there was a zone where people would not be searched and detained for possession, drug dealers might move in and start dealing drugs in that area. If that happened, it would get picked up and the police would intervene.

A tolerance zone would not be a free-for-all and an encouragement to drug dealers. Whatever practical objections or challenges there are, it is entirely possible to overcome them. The point is that having such zones will save lives. It might reduce the number of people who are arrested but, if it saves lives, that is a win-win.

Miles Briggs (Lothian) (Con) (Social Justice and Social Security Committee): Good morning, Mr Strang. Thank you for joining us. I will ask about a few issues that relate to Community Pharmacy Scotland's role in the public health crisis. In your opening statement, you highlighted naloxone. Why has some of the work that was meant to be done on access to single records for individuals not been done?

David Strang: That is too detailed a question for my level of knowledge at the moment. However, I am happy to get an answer from the task force for you.

Although I do not know the answer to that question, I know that the task force has commented on the role of pharmacy and whether some of the restrictions on some medications should be relaxed. Naloxone has now been given into the hands of families of users. The nasal application is considered to be more user friendly than a needle injection. There has been a sea

change in the past five years in having relevant medication close to where it is needed.

Miles Briggs: That is helpful. Perhaps I will take up that detail with the Minister for Drugs Policy in our next evidence session.

All of us at the meeting support the naloxone programme, but it has not gone where we wanted it to. Part of the frustration about the task force is that some of the key recommendations that the Government accepted do not seem to have been implemented. I fully understand that you are new to the role, but can you tell me why those discussions with Community Pharmacy Scotland have not taken place?

David Strang: I absolutely want to hear from Community Pharmacy Scotland, because it has a key role to play. I have asked for an update on what has happened on the 100-plus recommendations.

At the most recent meeting of the task force, which was my first, we had a presentation from the police, supported by an evaluation from an academic, on the naloxone pilot that took place last year at three different sites where police officers were trained to use naloxone and carried it. The results of that evaluation are due to be published soon, but I know that the naloxone was used more than 50 times and there was a sense that, potentially, 56 lives had been saved. The results will show that the pilot was overwhelmingly successful, and I think that it will be rolled out across Scotland.

Miles Briggs: That is helpful. Any details that you can provide to us of what that looks like would be very useful.

I want to move on to the issue of addressing stigma, which you touched on in your opening statement, and the role of trauma-informed services. I will specifically focus on local government. There are concerns that budgetary pressures will mean that the task force's recommendations and local authorities' work in trying to turn around the public health crisis will not necessarily be carried out. I fully accept that there are pressures because of the pandemic, but why do you think that that is the case? Given the cuts that we are seeing to local council budgets, are you concerned that the issues that we need local authorities to address—housing is often one of the key issues—will not necessarily be addressed? How will the task force recommend that those aspects are given the priority that they need?

David Strang: You asked about stigma. We have found that stigma prevents people from coming forward to services. We have even heard very disappointing stories about how people have been treated when they have gone to services. There is still quite a punitive view that the person had made a choice. Unlike people with other illnesses, who are treated with compassion and sympathy, people with drug issues are often blamed. It is said that it is their fault, and they are not trusted. People think that they will be dishonest and that there are more deserving cases.

That reminds me a bit of our attitude to mental health problems. As you might know, I chaired an inquiry into mental health services in Tayside. It was interesting how often we heard from people in mental health services—there is an overlap with substance misuse services—who felt that they were not taken seriously, that they were somehow attention seeking and that they were not deserving patients, whereas they felt that a person who had had a heart attack or had a broken leg were seen to be a deserving patient. Stigma is important, and it is a barrier to tackling the issue.

I am interested in your mentioning housing. I said that homelessness is a factor for people with mental health and substance abuse issues—I do not know whether that is a cause or whether there is a correlation. The lesson is that we cannot treat all those problems as a single issue. A council will have a housing policy, a health board will have a mental health policy, we will find a substance use policy somewhere and there will be a trauma-informed policy, but they will not deliver. That is why we need to look at the whole person and ask, "Have they got a housing issue? Can they get into employment? Where are their support mechanisms?"

You asked about what more can be done. Is more than 1,300 deaths a year not enough motivation to free up some budget? I understand your question. Money is given for housing, health and education—that is how local government is organised. However, the challenge for people who lead and make decisions on those issues relates to the person and what they need. There is a need to ensure that things are joined up.

My experience in that regard is of people coming out of prison. They often need medication, accommodation and benefits, and we require them to be in three different places on the day of liberation. We need to get much better at joining up support for individuals and providing support that cuts across the traditional funding mechanisms.

Miles Briggs: Finally, before I hand back to the convener—

The Convener: I am afraid that I will have to jump in. I have been very reluctant to do that, but we could come back to you if there is time at the end, Miles. I am keen to keep to time so that everybody can come in. I want to bring in Elena Whitham, to be followed by Gillian Mackay.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP) (Social Justice and Social Security Committee): I welcome David Strang to his role.

We know that there are strong links between poverty, deprivation, inequalities and problem drug use. In Scotland, we can trace that back to the economic policies of the 1980s. The people who grew up during that period, who are now in their late 40s and early 50s—my age cohort—and who live in deprived areas have the highest risk of drug deaths. How crucial is the Scottish Government's anti-poverty work to tackling the drug deaths crisis, and do you recognise the need to work across policy areas and Government departments, local authorities and the third sector? You have already touched on that a bit, but I want to gather your thoughts on that area.

David Strang: I agree with your question, and you are right that middle-aged men feature highly in the drug deaths statistics. However, the number of young people who are dying from drugs is increasing—there were 78 during the last year for which there are figures. The problem certainly relates to the cohort that you described, but it also affects young people.

That longer-term solution of focusing on prevention absolutely tackles the issues that you talked about, for example through anti-poverty measures, reducing inequality, providing more opportunities and providing support for people who are traumatised. Brain injury is another feature. Young men in HMYOI Polmont have five times as many brain injuries as the rest of the population.

There are a number of factors that we absolutely need to address in a joined-up way for the long-term prevention of drug problems. However, I also apply that to the treatment and care of people who are at risk of dying from drugs. That is a much more immediate and short-term issue, for which services also need to be joined up. Tackling poverty will not save someone's life tomorrow; however, our services—housing, benefits, welfare, care and so on—absolutely need to be joined up, so that people get the support that they need.

The answer to your question is yes. We need to be joined up both in the short term, to save lives, and, if we are to make a major impact on prevention in the longer term, right from the beginning of someone's life.

Elena Whitham: Thank you for that answer. I want to revisit an issue that my colleague Miles Briggs brought up: stigma. That is a huge force that drives people away from services.

I previously worked for Scottish Women's Aid, in support of women fleeing domestic abuse. Many faced addiction issues that were born of self-medication. They faced stigma and the fear of losing the custody of their children not only due to the abuser's actions but due to bringing their addiction to light—that is, their letting it be known that they had such an addiction. That fear was palpable. How can we address stigma and the harm that it causes? Surely a true public health approach must not seek to retraumatise or stigmatise.

We can also think about people who are stopped for simple possession and then find themselves incarcerated for a time. Again, a true public health approach should take a different path. Does the Drug Deaths Taskforce believe that as well?

David Strang: I spent five years as Her Majesty's chief inspector of prisons. Our prisons are full of people who have addiction problems and poor mental health. We have one of the highest rates of imprisonment in Europe. Again, I say that that is not working. Going down that model of crime, prosecution and incarceration is not reducing our drug deaths and drugs problems.

Recently, someone told me that, when he was using drugs—that was in his history—he went to his general practitioner, said that things were getting too much and asked for help. The first question that the GP asked him was, "Do you have children?" Of course we should be concerned about children—child protection is hugely important—but that question communicated to him the stigma that is associated with drug use, so it was an immediate barrier to him coming forward for help. I entirely understand that child protection is a factor that needs to be taken into account, but it should not be the first question when someone walks through the door to ask for help.

10:45

Elena Whitham: What are your views on a community justice or smart justice approach? Do you see that as being soft-touch justice or as a crucial part of how we tackle the crisis that we are facing?

David Strang: In 2007-08, I was a member of the Scottish Prisons Commission that produced the report "Scotland's Choice: Report of the Scottish Police Commission July 2008", which recommended the abolition of short sentences. Over more than a decade, I have been entirely consistent in arguing that we should be much smarter; that short-term imprisonment, in particular, does more harm than good in most cases; and that we need to be much more creative about how we respond to offending behaviour and harm. I am not saying that we should do nothing, and it is not about being soft. Community

sentences have the potential to be much tougher than an easy stretch in prison for people who are in and out of jail the whole time—that is self-evidently not a deterrent.

Similarly, there is evidence that diversion from prosecution is much more likely to lead to someone getting the support and help that they need rather than their being prosecuted, appearing before the sheriff and being sentenced. The police and the Crown Office have been very supportive of diversion from prosecution, which is part of the work that the task force is doing.

The Convener: I will hand on to Gillian Mackay, and then I will bring in Sue Webber. I ask that questions and answers are as succinct as you can make them.

Gillian Mackay (Central Scotland) (Green) (Health, Social Care and Sport Committee): It is clear from yesterday's joint committee evidence session with Kit Malthouse MP that the Scottish and UK Governments take a very different view on the causes of drug use and how that should be addressed. What impact will that have on the two Governments working together on drug-related deaths? What, if any, changes need to be made to improve partnership working?

David Strang: I do not know the answer to your question on what impact that will have on the Governments working together. I would hope that, on as serious an issue as this, there could perhaps be behind-the-scenes negotiation to get a satisfactory solution. We are the Scottish Drug Deaths Taskforce and our remit is to try to change attitudes and actions in Scotland—I do not think that our remit extends to persuading the Government in London to change what it is doing.

I entirely understand your question. I heard Mr Malthouse's evidence yesterday. The emphasis on heavier policing as a route to tackling our public health crisis is not the right way forward. We have tried that for 50 years and this is where we are.

I hope that there can be sensible negotiations between the two places. I know that we are exploring what can be done in Scotland under the current legal framework. People are being as creative and constructive as they can be. I am not insisting that the UK Government changes its policies on what happens in England and Wales. If something could be negotiated that makes what we are advocating in Scotland more likely, that would be very helpful.

Gillian Mackay: Convener, Mr Strang managed to pre-empt my supplementary question, which was about whether we need a change of policy by the UK Government to make things easier. I will hand back to you.

The Convener: Thank you very much, Gillian. I thought that you would still try to get another question in. I will bring in Sue Webber, followed by Foysol Choudhury.

Sue Webber (Lothian) (Con) (Health, Social Care and Sport Committee): Colleagues spoke at length earlier about the need for radical interventions and learning from elsewhere. I am concerned by that. I think that we should look far closer to home and at what is working well to save lives in Scotland now. My colleague Miles Briggs mentioned naloxone. There were representations this week from the Royal Pharmaceutical Society about the lack of consistency with naloxone. Should we not be looking at accelerating and embedding services that are doing well and are saving lives in Scotland now, but which are not provided across the country? Do you see that as a priority?

David Strang: I absolutely see that as a priority. I mentioned a pilot of having naloxone being carried by the police, which we considered at the task force. I know that we will be making recommendations about the roll-out of naloxone. That is part of our discussions with Community Pharmacy Scotland. I do not think that we have a choice. It is not a case of either looking internationally and doing what cities elsewhere are doing or implementing the good things that we know work in Scotland. We have to do both.

Lots of good things are happening in Scotland. There is the recovery network, peer mentoring, the navigators work and the pathfinder project in Inverness. There is a lot of work going on in family support. Those things are often not run by official Government bodies. They are support networks and local initiatives.

You raised the important idea of the inconsistency of services across Scotland. That might be a feature of having many different health boards and 32 local authorities. There are two ways to look at that. If you like local flexibility, you will be in favour of that sort of variance because it can match local need. However, you could also describe that as a postcode lottery. Why is it possible to get a disposal from court or find a support network in one local authority, but not in another?

The question whether we want absolute consistency across Scotland or should allow flexibility is not straightforward. I want to ride both horses and to say that there should be consistent services to meet people's needs, but that service requirements in Glasgow will be different from those in Shetland.

Sue Webber: We could take a short-term approach and replicate what is working well to address the immediate crisis. I am glad that you

alluded to some of the services that are provided by non-governmental agencies. The third sector is key. How could we help the third sector organisations that are carrying much of the burden and have done so throughout the pandemic? What can we do with financing? How can we give them longevity and security of funding?

David Strang: We should be listening to them. Those organisations have been represented on the task force and on some subgroups. As part of our early work as chair and vice chair of the task force, Fiona McQueen and I are visiting some third sector projects in order to learn more and to hear what they have to say.

We can extend that more widely. As we develop drugs policy, we should be listening to people who have lived experience and know what this is about. We should listen to their families. The task force includes three people who represent groups that have experience of supporting people with drug problems, or of having such problems themselves. I agree that we should hear their voices and support the third sector because it has an important part to play.

Sue Webber: Convener, can I ask another question?

The Convener: Very quickly.

Sue Webber: Is the task force looking specifically at the role of cocaine in drug deaths? Are Scottish treatment services for cocaine sufficiently skilled in addressing that important factor in drug-related deaths?

David Strang: I would like to respond to you on that in more detail, because cocaine has not appeared highly in the toxicology for drug deaths. I do not want to give a quick answer to that question about cocaine and treatment, so I will make sure that you get a proper answer.

Sue Webber: Thank you, Mr Strang.

The Convener: We move to questions from Foysol Choudhury. If we have time, I will open the session up to a couple of supplementary questions before we finish.

Foysol Choudhury (Lothian) (Lab) (Social Justice and Social Security Committee): Good morning, David; it is nice to see you in your new role. I have only one question for you.

The National Records of Scotland publication, "Homeless Deaths 2020", showed that more than half those deaths were drug related. There were 151 homeless drug-related deaths, which was up from 68 in 2017. In 2020, homeless drug-related deaths accounted for 10 per cent of all drug-related deaths. Can you confirm what action has been taken to reduce homeless drug-related deaths and ensure that people who are homeless and suffer from drug-related harms can access key support services, including drug treatment services? What is being done to reach out to that population?

The Convener: Mr Strang, before you come in, I am not sure that that question relates completely to the work of the task force. It is a legitimate question but, in my view, it is a much wider question. Members should make sure that questions remain on track.

David Strang: I would like to respond to that, because it has a link with drug deaths. The question illustrates my point that we cannot deal with those issues as single issues. Homelessness has a wider definition than just rough sleeping, but people who have a housing need—and, as you said, substance misuse treatment needs—often have mental health needs. We need to make sure that we join up those services, so that that one person has the support that they need, without needing to go into three offices at three different times for appointments that they will probably not keep. There are a lot of initiatives, such as Streetwork, which provide support to people who are rough sleeping. In Edinburgh, there is a GP access point that supports people who are homeless. Mr Choudhury, you raised an important issue about supporting wider needs for food and accommodation. I support the thrust of your question that those services need to be joined up in order to provide a whole-person approach to support.

The Convener: Thank you. We have a little bit of time in hand, so I am happy to bring Miles Briggs back in, because I cut him off a bit earlier on.

Miles Briggs: Thank you, convener. I appreciate that.

Mr Strang, I was taken with what you said earlier about your work in mental health support in Dundee and the inquiry that you undertook there. Would you support a legal right to rehabilitation for people in Scotland? Is that a piece of work that the task force will start to look at? As you highlighted, it is very important that we make sure that people have the right to access those services and that they can take those decisions for themselves and drive their treatment. What is your view on that?

11:00

David Strang: I think that the central thrust of what you are asking is whether I agree that people should be consulted and have some sort of choice in how they are treated.

That is the direction in which health services have moved. Rather than the doctor always knowing what is best, she will now ask what your

views are and say, “These are the options.” A decision about someone’s care tends to be much more of a joint decision, rather than the doctor simply saying, “This is what you need—take these tablets.” The same should apply to people who have health needs as a result of addictions. They should be involved and engaged, perhaps along with their families, if that is appropriate.

Of course, everyone should get appropriate treatment. That goes without saying. Is that not a basic human right? It might not be in the Human Rights Act 1998 but, certainly in Scotland, people have a right to receive the treatment that they need. They should be consulted, treated with dignity and respect, and listened to. In my experience of speaking to people who have accessed mental health services and drug services, they do not feel that they have been respected and listened to. They do not think that their voice was heard. I have heard complaints about people being overmedicated. They wanted a different route, but that was all that was offered.

We still have a way to go on treating people with dignity and respect, engaging with them to discuss their treatment needs, and supporting them in delivering treatment.

The Convener: Elena Whitham has a follow-up question.

Elena Whitham: We heard from Minister Kit Malthouse that the UK Government is still not convinced about the use of safer consumption facilities for public health purposes. What is your feeling about that? In my experience, such facilities are a gateway for people to access services. People who might be afraid to come forward or reach out in other ways can be signposted in a setting where they are actually looked after and kept safe—and, hopefully, kept alive if something terrible happens. What are your thoughts on the use of safer consumption facilities as a public health and safety measure within the basket of measures that we are convening?

David Strang: The evidence shows that, once people are in services, they are less likely to die, so we should be doing all that we can to engage people in services. I do not know enough about the actual workings of safer consumption facilities, but it is clear that enabling safer injecting and so on has a health benefit. If they also encourage and enable people to be referred to other services and be supported, that is positive.

I can think of some other settings in which things have changed in recent years. The first is the criminal justice system. When someone is detained at a police station, there will often be a navigator or arrest referral scheme. If the person has alcohol or drug addiction problems that they want support for, that can often be a trigger point. Similarly, when someone who has previously ignored the treatment that they need goes into prison, that can open a door. When someone goes into hospital—not because of their drug use, but for other reasons—that can also be a point of contact.

Any point of contact with any service should be an avenue for someone who has problematic drug use to get into treatment and services. We should try to enable that in all services.

The Convener: I will bring in Gillian Martin, and then I will bring the session to a close.

Gillian Martin: I will keep my question very short. Yesterday, I asked Minister Kit Malthouse about his response to the task force’s recommendation on consumption facilities. In the response, he said that they might give the impression of condoning illegal drug use and that they might become magnets for drug dealers or even encourage people to take drugs. What is your response to that response from Kit Malthouse and the UK Government?

David Strang: I will keep my answer brief. To me, it reveals a mindset that drug use is about criminality. He is talking about encouraging crime. The argument for such facilities is about tackling Scotland’s public health crisis. People who are addicted are unwell and they need medical care, support and treatment. That is nothing to do with encouraging crime.

The Convener: Thank you very much indeed. I am going to bring the session to a close, but I want to pick up on a point that you made about the implementation of the task force’s recommendations. You said that you would be looking for an update on that, and I wonder whether it would be possible for that to be shared with the committees. We would be really interested to know about that, so if that would be possible, it would be appreciated.

In the meantime, many thanks for attending. It has been an interesting session. If members have additional matters that they would like to follow up on, we will do that in writing.

We will have a short suspension before we hear from our next witness. We will reconvene at 11.15.

11:06

Meeting suspended.

11:15

On resuming—

The Convener: I welcome to the meeting the Minister for Drugs Policy, Angela Constance, and, from the Scottish Government, Morris Fraser, who

is head of the delivery and support unit in the drugs policy division, and Henry Acres, who is the Drug Deaths Taskforce support team leader.

I thank the minister for her written evidence and invite her to make some brief opening remarks. Minister, you have around three minutes.

The Minister for Drugs Policy (Angela Constance): Thank you very much, convener, and good morning.

I am grateful to the three parliamentary committees that have come together to work across their portfolios and for the opportunity to update them on our actions to implement the recommendations of the Drug Deaths Taskforce.

I would like to start by saying that every life lost to a drug-related death is unacceptable, and I once again offer my condolences to those who have lost a loved one. I give my continuing commitment to work across the Government, the Parliament and beyond to save and improve lives.

I put on record once again my gratitude to the task force for its work to date. Its focus on evidence-based recommendations has helped to inform our response to this public health emergency. I emphasise that its work sits within the context of a wider national mission, and we will consider its recommendations in line with those of our other expert groups.

The task force has supported a wide range of innovative tests of change, and those projects have undoubtedly had a positive impact in the localities in which they have operated. The focus now is on learning from the projects and on rapidly expanding and rolling out what we know will make a difference.

I very much believe in evidence-based policy making, and I am committed to following the evidence as it emerges. I have taken on board all of the task force's recommendations to date and am working to take them forward. A prime example of that is the MAT standards, which set out what people should expect and can demand of services. Their implementation across Scotland will give people access, choice and support through services.

Through partnership with the task force, naloxone is now more widely available, with its distribution to the police and the Scottish Ambulance Service, as well as expanded family and peer-to-peer distribution. Since the start of the Police Scotland test of change, 53 lives have been saved by police officers.

Also crucial are the task force recommendations on stigma, which, as we know, is a barrier to accessing support. Following those recommendations, we launched in December 2021 a national campaign to tackle the stigma that is associated with substance use, highlighting that drug and alcohol problems are a health condition and that people who are struggling with them should receive support and not judgment.

Many of the changes that are needed have been talked about for decades but have not been delivered. Ultimately, what really matters is the impact of implementing the task force's recommendations as part of the national mission, which is why I am acting quickly to accelerate delivery and why I have asked the task force to provide its final recommendations by July. I recognise that that presents an additional challenge, but I am confident that, with the experience that David Strang and Fiona McQueen bring to the task force's work, that ambitious goal is achievable.

Thank you. I look forward to discussing with committee members the implementation to date and the next steps. I know that we can work together to tackle this public health emergency.

The Convener: Thank you very much, minister. I will kick off the questioning with a general question, if I may.

Obviously the work of the task force, the wider work of the national mission and the delivery of the task force recommendations have been subject to on-going focus and scrutiny and, within that, there has been some focus on the timescales that you mentioned towards the end of your statement. Are you satisfied that the task force is on course to complete its work within the timescales that have been set, or should they be reviewed at some point down the line?

Angela Constance: I have discussed that matter with the new leadership of the task force and the task force membership more broadly, and I am confident that it will produce its vital recommendations by the summer. The Government is actively supporting the task force's work with, for example, a team of civil servants who support it with secretariat tasks and so on.

It has always been the case that we will need to look after the legacy of the task force's work. Some tests of change will not be completed, but they would not have been completed by the end of this year, which was the original timescale in the task force's recommendations. Arrangements will therefore have to be made, and we will do that in consultation with the task force and others to ensure that we continue to learn from the evidence as it emerges.

I have made it clear that I am committed to evidence-based policy, but I am also clear that we cannot wait for evidence to be complete, because that will never be the case. We have to take what we know, implement it and be prepared to adapt and change as we move forward.

The Convener: As a quick follow-up question on that point, I note that you have talked about the importance of following the evidence. In the previous evidence-taking session, David Strang highlighted in response to a question from Sue Webber the need to look not only at the wider—perhaps international—context but at what is happening closer to home. He certainly felt that we should be doing both things. Is that your view, too, minister?

Angela Constance: Absolutely. International evidence is crucial, because many other countries around the world have a far higher drug deaths rate than that in Scotland, and we should be looking at the very best practice not only in Scotland and across the UK but internationally. We have a lot to learn, and I make no bones about that.

The Convener: Thank you. I will now open up the questioning to Paul O'Kane, first of all, to be followed by Russell Findlay.

Paul O'Kane: Good morning, minister. I just want to follow up with you the theme of the task force's role and purpose that I pursued with David Strang.

It is fair to say that there has been criticism of the fact that the task force initially regarded itself as having only an advisory role. Mr Strang reiterated some of that position, but he also acknowledged that there would have to be a mechanism by which the task force could review work and come back on that. Do you think that that criticism is fair, and what more needs to be done to drive the task force's recommendations into action?

Angela Constance: I very much concur with the view that it is for the Government and this country's institutions to implement changes, and it is imperative for our democracy that we are guided and scrutinised by the Parliament and parliamentary committees.

Notwithstanding that, there is a role for external organisations and experts in various fields, in particular people in the lived and living experience community, academics and people who provide services on the ground.

The terms of the task force's remit changed when I came into this post. The task force had been in operation for 18 months when I became the Minister for Drugs Policy, and, at that time, I was very clear that two things were missing or needed to be corrected. Drugs policy should not be seen in isolation and must be connected with every other Government portfolio. Drugs policy needs to be joined at the hip with justice, housing, homelessness, mental health, primary care, education, prevention, poverty and inequality policies, and that is a far bigger job than that of the task force.

I was aware from my early engagement with stakeholders and various party spokespersons and MSPs that there was concern about how the Government was performing in relation to tackling drug deaths and that there were concerns in and around the task force. My view was that the Government had outsourced its responsibilities and that I would not do that. I wanted to support the evidence-led work of the task force. My view was that any criticism of the task force should rest, rightly, with the Government and not the task force, which comprises individuals and citizens who give their time and talents to work with the Government. Therefore, there was a refocusing of the role and remit of the task force.

Paul O'Kane: We are all keen to ensure that parliamentary scrutiny is at heart of this. You might have heard my follow-up question about ensuring that committees of the Parliament have a laser focus on the issues. It is clear that, as minister, you are keen to engage in that scrutiny and not to outsource—I think that that was the word that you used—the national mission. I have spoken in the chamber about ensuring that there are regular opportunities for scrutiny. Will you outline how you would see a committee such as this joint committee operating? Would you welcome that in relation to scrutiny of the task force's work and the overall work of the national mission?

Angela Constance: It is, of course, not for a Government minister to indicate to committees how they should proceed with their business. I will say that I very much embrace scrutiny; although it is not always comfortable, it is absolutely necessary, and I assure you that it always leads to better outcomes.

I welcome the joined-up approach that is being taken by the three parliamentary committees that are involved today, because it reflects the work that we are embarking on in the Government to ensure that drugs policy is joined at the hip with other crucial public policy areas and is not seen in isolation. We are trying to get our services to take that joined-up approach in communities.

There is a role for parliamentary scrutiny of the Government on the Drug Deaths Taskforce, the residential rehabilitation group, how we implement MAT standards and the national implementation group, and I am sure that people will be interested in the new national collaborative, too. The national mission is bigger than any one group. There is a lot to scrutinise and a lot to engage with.

Russell Findlay: Yesterday, Kit Malthouse spoke passionately about the need to support people with drug problems and the vital role of the criminal justice system. For example, he spoke

about a “ring of steel” being put around the community of Blackpool, as part of the addiction, diversion, disruption, enforcement and recovery—ADDER—project. Every day, Police Scotland and the National Crime Agency work hard to target the organised crime gangs that make so much money from killing people in Scotland with their products.

Do you agree that it is not a question of one or the other, and will you give a commitment to Scottish communities that they will enjoy robust policing and the targeting of people who deal drugs?

11:30

Angela Constance: I am grateful to Mr Findlay for that question, because it highlights the important role of the police in upholding the law. He might be aware that there is a serious organised crime task force, and much of what he describes is firmly in the remit of the Cabinet Secretary for Justice and Veterans. Nobody would demur on the importance of interrupting the supply of drugs or bringing to justice those who pose the greatest risk to individuals and our communities.

Again, looking at evidence from around the world, we know that more punitive approaches—those in which a criminal justice system is focused solely on enforcement—can result in additional harms and barriers to treatment. I do not know whether the member is aware of the work of the Conservative Drug Policy Reform Group, which recently produced some interesting findings and spoke about how it is important that different policies do not work against one another. It is important that policing and how our criminal justice system operates do not become a barrier to people’s access to treatment, and that they do not add to the harms that people are already experiencing.

There is more work to do on engaging communities on what will make them safer. Ensuring that people have access to better and quicker treatment is a huge part of that. Again, all the evidence points to a public health approach as being better for smarter justice in our community and for making communities and individuals safer.

Russell Findlay: Many prisoners are unable to break their addiction, due to high levels of drugs in prisons. Some prisoners go into prison without a drug problem but leave with one. Will we ever get close to eradicating drugs in prisons, and what immediate steps can be taken to do something about that?

Angela Constance: I am sure that Mr Findlay will have discussed in detail with the justice secretary things such as Rapiscan scanners. The safety and wellbeing of prison staff and prisoners is of the utmost importance.

It is reflective of what we know about the wider community that we cannot arrest our way out of a drug deaths crisis. It has to be about addressing the root causes of people’s substance use and the bigger and broader agenda of homelessness and poverty. It is also about ensuring that people have access to the treatment that is right for them. Access to treatment and support in prison is crucial when it comes to healthcare. An important survey of prisoners’ health and social care needs will be completed by the spring, if I recall correctly.

Really important work is being led by the recovery community in our prisons. I have visited a number of recovery cafes. We must be focused on addressing the needs of individuals.

There are also broader issues about overcrowding in prison. I think that most commentators would be of the view that our prison population is too large.

Russell Findlay: Do I have time to ask one more quick question?

The Convener: Yes.

Russell Findlay: Last September, the Cabinet Secretary for Justice and Veterans told the Criminal Justice Committee:

> “Prison governors in England and Wales have stated that it is not possible to have a drug-free prison. I would like to test that to see to what extent it can be achieved.”—[*Official Report*, *Criminal Justice Committee*, 1 September 2021; c 36.]

Is that realistic?

Angela Constance: I am not going to contradict the cabinet secretary for justice. However, I routinely provide challenge to my colleagues on what more we can do to ensure that people have access to treatment and support to address their use of substances. For example, I am very clear that, as we work to implement the medication-assisted treatment standards, they must apply in prisons, too. A key and fundamental part—although not the only part—of improving and saving lives is ensuring that our prison population gets better access to healthcare, and that includes drug treatment.

Gillian Mackay: Good morning—[*Inaudible*.]—UK Government—[*Inaudible*.]—Is the minister confident that there is still a way forward for Scotland to launch a pilot?

Angela Constance: Yes, I am. Sorry, Ms Mackay, but I do not think that I caught all of your question, but I am sure that it is about safer drug consumption rooms and the evidence that Mr Malthouse gave to the committee yesterday.

It is a matter of public record that work is being done on a pilot for a safer drug consumption facility in Glasgow. A proposition for that pilot has

been made by the health and social care partnership in Glasgow. Very extensive work is being done between the Crown Office, the police, us—the drugs policy division—and our local partners in Glasgow.

Mr Malthouse and I come from different positions on this. I am strongly of the view that there is no disputing the evidence that safer drug consumption facilities can save lives. I refer members to the evidence paper that the Government produced not long ago and that I am sure that we shared with the Criminal Justice Committee at the time. I have also shared an exchange of correspondence between Mr Malthouse and me. He sees more problems than I see. There are undoubtedly issues that need to be resolved, and that is what we are actively engaged in doing.

There are three avenues to pursue with regard to drug consumption facilities. The UK Government could introduce primary legislation, perhaps in the way that Ireland did a number of years ago. It could devolve powers to Scotland and enable us to introduce legislation. The third option is for us to pursue what we can within our powers to bring forward a proposition that is clinically and legally safe for those who use and work in the service.

It is delicate and detailed work, and it has its difficulties, but it is progressing. We are absolutely committed to doing everything that we can, where possible within our powers, to implement evidence-based interventions that save lives.

The Convener: Did you want to come back in, Gillian?

Gillian Mackay: Just briefly, convener.

In his evidence at yesterday's joint committee meeting, Kit Malthouse said that he did not recognise poverty as a driver of drug use and argued that drugs and violence drive poverty. I am deeply concerned about the apparent equating of drug use with violence and the UK Government's belief that poverty does not drive it. What impact will that clear conflict between the Scottish and UK Governments' understanding of the causes of drug use have on your ability to work together on the issue and on efforts to tackle the stigma surrounding drug use?

Angela Constance: It is no secret that Mr Malthouse and I have different views on harm reduction interventions, and we will have different views on the lens through which drug use should be viewed. I very much recognise the role and relationship of poverty and other matters in relation to this issue, and a lot has been written and published about the impact of concentrated levels of poverty and social deprivation.

Where I agree with Mr Malthouse is that there is a moral obligation on us to address poverty. However, as well as addressing the bigger structural changes that need to be made to society, we need to focus on the here and now, and that can be seen in the work that we are doing to invest in and reform services and to move matters forward as much and as quickly as we can.

Gillian Mackay: Thank you.

Elena Whitham: Good morning, minister. Following on from my colleague Gillian Mackay's questions, I note the argument that the high drug deaths rate in Scotland is partly a delayed health effect of circumstances in the 1980s. How should current anti-poverty policies respond to that, and do we need more of an emphasis on whole-community regeneration with a public health and wellbeing approach right in the heart of our communities to reduce stigma and ensure that everyone gets support, including those experiencing problem drug use?

Angela Constance: There is a lot in that question. First, some care needs to be taken with the 1980s narrative. I always find it somewhat triggering to talk about the 1980s, but there is no doubt that those years had a scarring effect. That is something that we need to bear in mind, as we did in response to the financial crash and the spike in youth unemployment, which we knew would have a scarring impact on people's life chances. In the recovery period following any recession or, indeed, pandemic, we need to focus on reducing the risk of such long-term impacts on our society and our communities.

There is a clear relationship between drug use and poverty. Indeed, last year's annual report on the drug-related deaths statistics showed that people in our most deprived communities are 18 times more likely to die a drug-related death. That said, I would always urge a bit of caution about looking only at the structural issues in and around poverty. That can make people feel helpless, but no one should feel powerless in the face of poverty, which is, after all, man-made.

In that respect, I should mention the work that we are doing on child poverty and social security. I know that members of the Social Justice and Social Security Committee are present, so I will not go through all of those things in detail, but I will just point to one example—and not just because I introduced it. Under the fairer Scotland duty, all public agencies must ensure that the drive to reduce poverty is at the heart of allocating resources and making big strategic decisions.

Ms Whitham also raised an important point about regeneration. In our child poverty delivery plans, the focus of evidence is on, for example,

income, work and reducing the cost of living, but the first plan—which I was involved with and which will be updated soon—also looked at not only the impact of drug use, particularly on families, but quality of life. Community regeneration is therefore really important, as it is as much about the resilience of communities as it is about community action.

11:45

Elena Whitham: As a member of the Scotland prevention review group, I understand the clear need to prevent homelessness in the first place, and I am glad to see that a public consultation is under way on the prevention duties. Minister, do you, like me, recognise the need for wider public bodies to have a duty to ask and to act when it comes to preventing homelessness, and to work across departments and sectors to support individuals and families? How do you see such an approach helping to reduce drug deaths and the devastation that they cause?

Angela Constance: I have recently had some meetings with Ms Robison on strengthening the homelessness prevention duties. There is something very simple, powerful and fundamental about the ask and act duty, because it should not just be a case of asking somebody and then acting by referring them on somewhere else. That might be appropriate at times, but the whole ask and act philosophy is also about how you can act before you refer someone on. It is culturally important in giving a sense of ownership and ensuring more collegiate working across the different workforces.

I am looking closely at the work that Ms Robison is leading, because it contains something important that we might be able to learn from and implement in our drugs policy, and which also connects with the MAT standards. It is all about how we make people's rights real in reality.

The Convener: I call Sue Webber, to be followed by Foysol Choudhury.

Sue Webber: Since the introduction of the recorded police warning scheme, which effectively decriminalised class B and C drugs, the number of cannabis users admitted to psychiatric hospitals has increased by 74 per cent. In light of that, do you still support the policy and, indeed, its extension, which has effectively decriminalised class A drugs?

Angela Constance: Yes, I continue to support the use of recorded police warnings, which were recently extended to cover class A drugs such as heroin and opioids. It is essentially a discretion that the police have, and it is based on a wealth of international evidence that shows that, at every twist and turn, our justice system should provide opportunities to divert people from the criminal justice system into diversionary activities or treatment.

I know that Ms Webber and I disagree fundamentally on that approach, but where I think that we can find common ground is on the increase in hospital admissions involving cannabis. Although cannabis is rarely implicated in drug-related deaths, statistics show that it features heavily in hospital and psychiatric admissions, often because of synthetic cannabinoids. The relationship between cannabis use and mental health is, I think, something that we can agree on.

The increase in hospital admissions because of cannabis use can be seen in all ages, but I have some concerns around young people in that respect. Young people have different patterns of drug use. Increasingly, they are moving away from risky behaviours. However, those young people who use drugs are far less likely to use opiates and more likely to use cannabis, MDMA or cocaine. Work is being done to develop bespoke services for young people. That feeds into our work on the prevention material for reaching young people not just in schools but in other settings.

We have a national mission to consider the harms and risks of all drugs, and the best way of reducing those harms and risks. Often, at its nub, that is about getting more people into the right treatment at the right time.

I apologise for the length of that answer, convener.

Sue Webber: Thank you, minister, for that reply. We have had a few very productive sessions in our joint committee meetings. My recollection of yesterday's session with Mr Malthouse might be a little different from that of others, because I felt that it was quite collegiate and that he was always seeking to work collaboratively with you.

However, from some of today's questions, and from the focus in particular of the Scottish National Party and Green Government members, I am concerned that the argument and positioning around consumption rooms are now there just in order to stoke a grievance, and that they have created something that can be used to prevent us from tackling the issue and from adopting new policies and tactics that we can use now to stop people from dying. Will you comment on that, minister?

Angela Constance: It is often important to work harder to engage with those with whom we disagree. It is no secret that Mr Malthouse and I have different perspectives on the implementation of a public health approach and on some harm reduction interventions—safer drugs consumption facilities being but one of those. In all fairness, I

will say that I have had a number of discussions with him. I have participated and engaged in a number of four-nations meetings, through the British-Irish Council or the UK drugs summit, and we have had lots of correspondence—yes, I am a persistent correspondent of Mr Malthouse. My ethos is to engage him and his Government on the evidence. My correspondence with him on safer drugs consumption facilities has always been about the evidence that they work.

What has been useful about our more recent correspondence and, I suppose, Mr Malthouse's appearance yesterday, is that he has spoken more, and in more detail, about what his concerns are, and that gives me the opportunity to refute those concerns with the evidence, because the evidence is crystal clear. Again, I can point to evidence from across the world that has been produced by other experts, as well as to our own evidence paper. He sees more obstacles to implementation than I do but, if there is a way for us to work together to overcome any obstacle, my door to that is open. I stress that I seek to engage on the evidence and not the politics.

Foysol Choudhury: Good morning, minister. In November, the Scottish Government published "Pathways into, through and out of Residential Rehabilitation in Scotland: Results from the Residential Rehabilitation Providers Survey".

One concern that was raised in the survey was that homelessness services are under pressure to reduce figures, and those who are homeless but in residential treatment are still classed as homeless. That means that they might need to leave residential treatment earlier than advised, due to the pressure on the homelessness sector to reduce the figures. It is unclear from the survey whether that is a localised issue or a wider problem. Has the Scottish Government investigated that concern in more detail? If so, what were its findings, and has any action been taken to address those concerns, given the potential adverse impact on those who are receiving care?

Angela Constance: I really appreciate that question, because there are a number of issues around residential treatment, and I am committed to taking a balanced approach to securing a whole system of care. Residential rehabilitation is an important part of that. It has historically been supported and funded less, and this Government is now seeking to address that.

When I made my statement to Parliament in November last year, a whole suite of information was also published, some of which was meant to shine a light on where things were not operating as they should be. Some of it was also about the work that is being done to improve access to funding and improve access pathways, and some of it was about how to improve accountability, within the Government but also at a local level, so that people could see where the funding was going and how many places were being funded by alcohol and drug partnerships in each area.

I know that the pandemic had an impact on some services. I am not sure whether I picked up correctly what Mr Choudhury said, but I am not certain about any on-going concerns. The residential rehabilitation working group continues to liaise very closely with residential rehab providers, and where there are issues to iron out, they will be proactive about it. There is a housing support fund to ensure that people do not have to choose between maintaining their tenancy at home and going into residential rehab. That was set up to mitigate some issues in which the rules for housing benefit were implicated.

I hope that that answers Mr Choudhury's question.

Foysol Choudhury: It does. Thank you.

The Convener: I hand over to Gillian Martin.

Gillian Martin: Good morning, minister. My question is on people who require drugs treatment.

First, is there any estimate of the number of people who are not in treatment who could probably benefit from it? Secondly, what is the Scottish Government doing with partners to improve and expand the capacity for a range of treatments? The minister will know that I have a particular interest in treatment for people who have caring responsibilities. There must be alternatives that fit in with their caring responsibilities.

Angela Constance: Some of the work that we are actively engaged in is on updating prevalence information. We need to update our understanding of the extent, or prevalence, of drug use in our society. There is some existing data; just before Christmas, I announced funding to update it. We need to understand more about prevalence in Scotland. That information is important because it is crucial to introducing our treatment targets.

In direct answer to Gillian Martin's question—I think that this is a fair critique—I will say that we do not have enough of our people in treatment and we do not do enough to retain them in treatment or to follow them up if they fall out of it; hence, our investment in, for example, non-fatal overdose pathways and outreach. The new treatment target and the indicators that underlie it will therefore be crucial in improving and scrutinising the number of people who are in treatment. As I said to Parliament, we will announce that in the spring

12:00

With regard to capacity, much of our work on MAT standards and residential rehabilitation is about not just improving our ways of working but increasing capacity. Workforce capacity is important, so right now we are mapping the shape and size of the workforce in order to identify gaps and to look more at training needs.

The issue of stigma is very pertinent to the workforce; workers, too, often feel quite stigmatised. We will consider a recruitment campaign, but that has to be joined up with other big national workforce strategies across the Government.

Gillian Martin: Thank you very much for that.

I will follow up on my question about wider families. I know that there has been a range of work to support families who have a family member with drug-use problems. Can you expand on some of the things that have been done in that respect?

Angela Constance: Absolutely. We have tried to take a belt-and-braces approach. The new funds that are available to stakeholders and third sector organisations include a specific children and families fund, which is managed by the Corra Foundation, to which services and third sector organisations can apply for direct Scottish Government funding. Direct-funding opportunities have been very popular. I also point out that, before Christmas, we published our whole-family approach framework, which came with a funding package for ADPs.

Again, all the evidence from home and abroad indicates that we need to support families not just as a whole but as individuals, whether they be children or parents. We know that for every person with a drug or alcohol problem there is an impact on 11 other people. Supporting families and, where possible, keeping them together, is therefore crucial. The involvement of the family in an individual's treatment needs to be considered as an appropriate option and choice for that individual. This is about services working with the family as a whole, which some do very well, as well as being about serving individuals' needs.

Last year, we announced our national family residential service, which will support up to 20 families at any one time. Of course, that is part of our work to keep the Promise. I will not go into detail, unless I am pressed, but I will say that the Promise is highly germane to the work that I am doing.

We also need better standards of service and more bespoke services for women, because there has been a gap in that respect. Although it is mostly men who lose their lives, the number of women who are losing their lives is rising at a disproportionate rate.

Gillian Martin: Thank you. I will hand back to you, convener.

The Convener: I call Miles Briggs, to be followed by Pauline McNeill.

Miles Briggs: Good morning. I have a few questions about the naloxone programme and Community Pharmacy Scotland. We all support the naloxone programme, but I have been frustrated by the progress of the work of the task force in making a difference in that respect. Why is naloxone not included in the national supply line for pharmacists to access through Pharmacy First? On the task force's recommendations, why has a single record for patients not been developed, given that we have a public health emergency, and given the improvement in outcomes that that measure could deliver?

Angela Constance: There are three aspects to that. I will deal with the devolved aspect first; there is also a reserved aspect.

The point about the recommendation on single records needing to be addressed is well made. I have met Community Pharmacy Scotland and the Royal Pharmaceutical Society, and they rightly point out that, with better linkage of records, they could do more. My officials have raised that issue with the chief pharmacist and the health division. I absolutely accept the point. The pharmacists are absolutely correct to raise it, and I want a resolution to be found, because I think that pharmacy services can bring much more to the table.

That links to the issue of naloxone being registered as a controlled drug, on which our engagement with the UK Government is important. If naloxone was classified differently, different options would be available. It could be provided as part of a pharmacy service. People can have an individual consultation with a pharmacist about a range of medications; they could do that in relation to naloxone and kit that involves a needle, in particular.

The pharmacists also make the argument that if nasal naloxone was reclassified, it could be sold in chemists in the same way as decongestion products are sold. That would require changes at UK level, but it would help in widening distribution and acceptance of naloxone.

Over and above that, the task force has done really good work. The reach of naloxone is up to about 59 per cent. If you would like a technical explanation of how that is worked out, I will hand over to Morris Fraser. As a result of our naloxone campaign, 4,000 kits have been distributed. The work of Scottish Families Affected by Alcohol and

Drugs on the click and deliver service is first class, as is the work of the police. The Scottish Ambulance Service has given out 1,000 kits. As well as distributing take-home naloxone kits, its work in connecting people to services is also relevant.

The task force has done good work in and around naloxone—naloxone is also becoming available to people in prisons, prior to their release—but there is more to do on pharmacy. There is also much more that we could do on mental health services. There are areas in which there can be improvement; the point about pharmacy was well made.

Miles Briggs: It would be helpful to get an update on timescales. I was a member of the Health and Sport Committee in session 5, and we understood that the work would be moved forward quite quickly. The opportunity to provide some sort of traffic-light warning system for patients was discussed, but that does not seem to have materialised. I hope that that will become a genuine priority and that progress will be made on that.

I turn to review of available treatments, on which I have corresponded with you for some time. I am thinking about the potential availability of treatment such as neuro-electric therapy. Where is the Government with the work to enable people to feel that they are genuinely able to take decisions about what is best for them and their families, given where they are with their addictions, and to support their decision making and empowerment?

Angela Constance: On the latter point, we are on track in developing our public health surveillance system, which builds on existing warning systems and is broader than a traffic-light system or distribution of naloxone. We are also waiting to hear the results of the UK-wide consultation on naloxone. We will certainly endeavour to keep Mr Briggs and the committees informed about what is happening.

With regard to treatments, I say that it is crucial that they be based on evidence. That has to be a priority. On NET, we have corresponded with Mr Briggs about it and we have pointed people in the direction of the chief scientific officer with regard to pursuing trials.

Mr Briggs made a fundamental point about informed choice, which is a core part of the medication assisted treatment standards. All patients who receive a healthcare service make informed choices and are supported in that by clinicians and practitioners. People should be able to make informed choices around medication assisted treatments and other types of treatment. The whole purpose of MAT is to make the connection between the options and possibilities in pharmaceutical interventions and those in psychosocial interventions. Mr Briggs's point about the need for a balanced approach and for implementation of what works, based not only on the evidence but on what meets individuals' needs, is important.

The Convener: We move to questions from Pauline McNeill. Are you there, Pauline?

Pauline McNeill: I am sorry, convener—the connection cut out for a second.

The Convener: Can you hear us?

Pauline McNeill: Yes.

Good afternoon, minister. I hope that it goes without saying that I realise that the challenge is huge and complex. I am interested in the overdose prevention safety issue. I have hosted Nanna Gotfredsen, who is a street lawyer from Denmark who pioneered that country's drugs policy and has been influential in the debate in Scotland.

There have been quite a few exchanges on the subject—you probably heard the comments from the UK Minister of State for Crime and Policing at yesterday's meeting. In response to Gillian Martin's line of questioning, the minister of state seemed to put across that he is concerned that, if the 1971 act were to be reviewed to include the ability to pilot safe consumption rooms, that would send out the wrong message. Will you respond to that?

Angela Constance: I am very much aware of Ms McNeill's work in the area; I frequently meet stakeholders who talk about her work and events that she has hosted in the past.

With regard to Mr Malthouse's comments about services such as safe drug consumption facilities sending out the wrong message or encouraging drug use, I point out that there is simply no evidence for that. We hear people verbalising that concern, but there is no evidence for it, whereas there is evidence to show that safe drug consumption facilities reduce overdose deaths and save lives. They reduce transmission of blood-borne viruses, reduce infection in wounds and improve wound care, and they help in reaching people who inject drugs and who might not otherwise engage with, or be visible to, services.

12:15

Ms McNeill is a Glasgow MSP. Much of the campaign that is coalescing around safe drug consumption facilities came about because there is also a community benefit from reducing drug-related litter and drug use in public places. There is evidence that such facilities work and about their benefits. They are not a magic bullet—nothing ever is. However, in Scotland, we need all

the options. I have views about the Misuse of Drugs Act 1971, but we want all the available options to help us to address this national scandal and crisis.

Pauline McNeill: The minister of state went on to say that he thinks that there are complex questions that need to be answered if we are to legislate in that way. I recognise that, ideally, reform of the 1971 act would be the best position—for other reasons, as well.

As the minister said, provision of safe drug consumption facilities is not a magic bullet. Nothing is. However, the Lord Advocate is on the record saying that she will consider whether it might be in the public interest. It would be complex for any Lord Advocate to make a decision about whether, in the public interest, you would not prosecute under the 1971 act in certain areas if it was a public health issue and prevented deaths. My question is twofold. Do you think that those complexities can be overcome? If the Lord Advocate—who is yet to make a decision—were to make a decision in that vein, would it negate the immediate necessity to reform the 1971 act, because it would have the same effect?

Angela Constance: There are a number of issues there. I hope that the convener will give me a wee bit of latitude in answering properly.

My view is that the Misuse of Drugs Act 1971 is old—it is nearly as old as me—and that it was written for another time. A lot of the evidence that the task force gathered showed that people feel that it is rooted in drug use being all about personal failings and in the need for punishment. A root-and-branch review is therefore needed because—in my view—the act impedes our taking a public health approach. Other people might argue that it is completely contradictory to a public health approach. It impedes not only work around safe drug consumption facilities, but other harm reduction work. I can give the committee examples, if need be.

The Lord Advocate made a very clear statement to the Criminal Justice Committee last year that she would be prepared to reconsider what is in the public interest, and making another application. However, she also scoped out what needs to be addressed and considered. She spoke about the need for evidence, which I think is the most straightforward part, because the evidence is clear cut. However, she also spoke of the need for detail and precision, and about how all the partners need to be on board, including the police. That is why we are working across all the boundaries.

There are issues and complexities—I will not make any bones about that. I will not rehearse the correspondence that I sent to Mr Malthouse and the correspondence that he sent me. However, I think that the committee will see that it was, in some ways, helpful that he put on the record his concerns, many of which I think can be rebutted. Nonetheless, there are issues around how safe drug consumption facilities are policed, in and around their vicinity.

There is also a need for us to work through all the potential scenarios with our partners. That is why we need to look in detail at operating procedures, at staff training and at information for service users on what is and is not permitted. This is detailed and precise work, and there are difficulties around it.

It would be easier if the UK Government were either to legislate on the matter or devolve powers; I will continue to pursue the matter on the basis of the evidence. However, I am actually more invested in doing absolutely everything that we can to find our own solutions. If we can get to a position where the police and the Lord Advocate are content, so be it.

Pauline McNeill: Thank you.

The Convener: We are almost at the end of our session; it has been a long but very informative morning. I ask for members' forbearance so that I can ask one more very quick question of the minister, before she goes.

We are aware of the recent announcement regarding the national collaborative. Can you make a few points about the remit and purpose of the collaborative? How might it work alongside the task force, which also has members with lived experience contributing to its work?

Angela Constance: I am really excited about the national collaborative. I was committed to bringing it forward—in part due to my experience in social security and the work that we did around lived experience with experience panels, and in part because of my days in education, where I saw the benefits of the early years collaborative.

I think that it is absolutely crucial that there is a vehicle that is owned by the voices of the experienced—that it is theirs. I am delighted that Professor Alan Miller, who is Scotland's leading human rights expert, has agreed to chair the national collaborative. He comes with independence. He is well placed to understand the impact of trauma and has worked with survivors of in-care abuse, through which he brought forward a programme of work that amplified their voices and ensured that change happened. I am thinking in particular of the redress scheme.

I am very confident about the national collaborative. Professor Miller is now involved in a series of engagements—introductory and one-to-one meetings with the sector and with people with lived and living experience. He will work with them

to develop a programme of work, including milestones and timescales.

The national collaborative is a very important part of the national mission, because we need to ensure that voices of experience are plugged in to every aspect of that mission. It is also about enabling those voices to inform and drive change, and about what we do being informed by a human rights approach.

The Convener: Thank you for that helpful update, minister. We look forward to hearing more about the progress of the national collaborative. That completes our evidence session. I thank the ministers and their officials for attending. If members have more questions, we will follow up with them in writing.

12:24

Meeting continued in private until 12:46.

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