OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Health, Social Care and Sport Committee

Tuesday 18 March 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
9th Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Eleanor Deeming (Scottish Human Rights Commission)
Neil Gray (Cabinet Secretary for Health and Social Care)
Dr Peter Rice (Royal College of Psychiatrists in Scotland)
Dr Tara Shivaji (Public Health Scotland)
Hilary Steele (Law Society of Scotland)
Christopher Thompson (Scottish Government)
Lyndsey Turfus (Social Work Scotland)
Dr Chris Williams (Royal College of General Practitioners Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 18 March 2025

[The Convener opened the meeting at 09:32]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the ninth meeting in 2025 of the Health, Social Care and Sport Committee. I have received apologies this morning from David Torrance.

The first item on our agenda is a decision on whether to take in private item 5 and equivalent items relating to evidence on the Right to Addiction Recovery (Scotland) Bill on future agendas. Do members agree?

Members *indicated agreement.*

Right to Addiction Recovery (Scotland) Bill: Stage 1

09:32

The Convener: The next item on our agenda is an evidence session on the Right to Addiction Recovery (Scotland) Bill. The committee will hear from two panels of witnesses—the first will cover the legal and human rights aspects of the bill and, from the second, we will hear the views of professional organisations.

I welcome our first panel: Eleanor Deeming is a legal officer at the Scottish Human Rights Commission; Dr Tara Shivaji is a consultant in public health medicine, and is here from Public Health Scotland; and Hilary Steele, who is a solicitor, is representing the Law Society of Scotland. We will move straight to questions from Sandesh Gulhane.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising national health service general practitioner. I thank the witnesses for coming here this morning.

I have questions around existing rights and the provisions in the bill. Do you—especially Dr Shivaji—think that we are in an acceptable position when it comes to drug and alcohol deaths in Scotland?

Dr Tara Shivaji (Public Health Scotland): Thank you for the question. We recognise that drug and alcohol harms are at very high levels in Scotland and that there is a pressing need for us to take action on those harms. Although we have made progress, there remains a lot to be done, as is evidenced by the high rates of drug-related harms, drug-related deaths and alcohol-specific deaths in Scotland when we compare ourselves with our neighbours.

Sandesh Gulhane: Public Health Scotland has talked about “measurable outcomes”. What measurable outcomes do we currently have and what measurable outcomes would you like to see?

Dr Shivaji: At the moment, at an individual level within services, we have a range of outcomes that services use to assess whether people have benefited from them. There are outcomes tools, including the Outcomes Star, which involve looking at a range of recovery measures, from a person’s individual clinical response to their family relationships and their housing situation. It is quite multidimensional, which is appropriate given the nature of addiction.

What we do not have at the national level is a population-level view of those outcomes. Currently, we assess the quality of services by using the medication assisted treatment standards. The focus of the MAT standards is on the processes that services have in place in order to achieve those standards, and it is moving towards consideration of whether the changes in practice have changed the experience of individuals. At the moment, we do not have a single quantitative measure of outcomes.

Sandesh Gulhane: What measurable outcomes are we looking at for the Thistle centre?

Dr Shivaji: The Thistle centre is a specific service that has been set up to provide harm reduction and a safer consumption space specifically around injecting, so we would be looking at a number of outcomes, including individual clinical outcomes and the impact on the wider community. At an individual clinical level, we are thinking about the occurrence of overdose and death but also about the transmission of blood-borne viruses and whether we see any change in that. At a community level, we are looking at the physical environment—for instance, in terms of discarded paraphernalia—and whether the centre impacts on people and on the community. There is also the local business dimension.

Sandesh Gulhane: Could we use those outcome measures in the bill?

Dr Shivaji: Potentially. We would need to think about the community dimension.

Sandesh Gulhane: This is more of an open question, but I will put it first to you, Dr Shivaji. Do you feel that establishing an individual's right to treatment would potentially improve outcomes?

Dr Shivaji: Although we, in Public Health Scotland, agree with the vision, the ambition and the principles that underpin the proposed legislation, we are concerned about whether it would deliver a difference on the ground. There is also the risk of unintended consequences, and we welcome the opportunity to explore that today.

Sandesh Gulhane: Eleanor Deeming, will you explain how the bill would intersect with existing human rights?

Eleanor Deeming (Scottish Human Rights Commission): The policy intent of the bill, which is to reduce the loss of life by increasing access to state-provided interventions for those who are affected by drug and/or alcohol use, is laudable. We support the intention behind the bill.

As drafted, the bill is likely to support state compliance with its human rights obligations. I highlight article 2 of the European convention on human rights, which protects the right to life. There are also the wider international human rights treaties that are not yet incorporated into domestic law but that are still legally binding on the United Kingdom as a signatory and, by extension, on the Scottish Government. An example is article 12 of the United Nations International Covenant on Economic, Social and Cultural Rights, which is the right to health.

In our written evidence, we highlighted the applicable human rights framework as it relates to treatment for people affected by substance use. There are then other wraparound things like the national collaborative, which sets out a fuller framework that is applicable to the issue in wider terms.

The SHRC is supportive of the intent and the aim of the bill, but we think that it would benefit from further work to align it with international human rights frameworks. The access to justice and accountability measures could also be strengthened. Alongside a human rights budget assessment of the proposed impact, which the SHRC is also focused on, that would ensure that there would be a consistent approach to treatment and the promotion of the highest attainable standard of health, in accordance with human rights obligations.

Emma Harper (South Scotland) (SNP): A range of treatment options are set out in the bill. Do you think that the bill effectively integrates harm reduction approaches within the proposed options?

Eleanor Deeming: The SHRC's expertise and my expertise and experience do not really allow us to comment specifically on the scope of the treatments that are proposed. However, we noticed the omission of mental health support in the bill's listed treatments. The Mental Welfare Commission for Scotland highlighted the importance of joined-up support for individuals who are experiencing mental ill health and those experiencing substance use. The findings of the national collaborative's call for evidence about people's experiences of substance use and human rights also highlighted the importance of access to support for mental health. That ties in broadly with international human rights standards and guidelines, particularly for human rights drug policies. That would be our only comment on the treatments that are listed in the bill.

Tara Shivaji: Public Health Scotland feels that the treatment options would benefit from further detail setting out some of the key characteristics that we would expect, such as services being trauma informed. Recent evidence shows that people have increasingly complex presentations and are using food banks and crisis services. It would be useful for there to be recognition of that within the treatment options of the wider services that might be required to support individuals.

A final consideration would be to think about how treatment options reflect a pathway to recovery rather than a single intervention. For example, alcohol detoxification could be considered as a treatment option. Someone who is dependent on alcohol would engage with a medical service to clear alcohol from their body, and that would be supervised to ensure that they did not have seizures or experience other complications. They would then require on-going treatment to address the root causes of their alcohol dependency. If that support was not provided, there would be a risk of relapse and complications. We need to consider how we can ensure continuity of care and the expectation of continuity of care within the treatment options that are offered.

Emma Harper: A lot of work has already been invested in the MAT standards and the alcohol and drug partnerships. That work is complex and requires trauma-informed practice, and there is variation according to the individual circumstances that have led someone to seek, or not seek, assistance to either reduce harm or pursue abstinence. Will the MAT standards still work under the bill, or will they have to be ripped up in favour of something else?

09:45

Tara Shivaji: The bill should sit complementary to the work that has already been done.

There are some areas of potential tension within the MAT standards. The first treatment standard is about providing care as soon as possible—potentially on the same day as an individual is seen. The question is how we can ensure that the standards work towards that instead of creating delays or barriers because of confusion about whether it is appropriate for the person to wait for three weeks. We are getting feedback that the ambition is that people using drugs will be seen as quickly as possible and that services are working towards that. However, the existence of a three-week waiting time target creates confusion around that. There needs to be clarity about what is important and what is good care in that context, and we need to make sure that the framework around it allows us to progress towards that.

Emma Harper: Okay. Thank you.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): I want to take us back to the charter of rights, which has been mentioned. We know that the national collaborative worked for quite a long time with people with lived and living experience and with partner agencies to draw up the "National Collaborative Charter of Rights For People Affected by Substance Use" and its toolkit, which was launched this past December. The charter draws from international guidelines on human rights and drug policy that set out best practice as identified by the UN. We anticipate that the proposed Scottish human rights bill, which will perhaps be introduced not in this session but further down the line, will underpin the charter. I am wondering how the bill that we are looking at today will intersect with the charter of rights. Could they work together? Is there any way that the charter of rights, as intended, could strengthen the bill?

In the absence of rights holders being able to realise their rights, we are seeing a gap in service provision for individuals. Can the witnesses speak to how those two things will interact with each other and how they could possibly strengthen each other?

Eleanor Deeming: As you say, the national collaborative charter draws on international guidelines on human rights and drug policy. It is intended to provide a guide to adopting a human rights-based approach in more general terms. The bill focuses on the time limits and the time standards for treatment, but the national collaborative's work on a human rights-based approach to substance use goes wider. Obviously, it focuses on access to treatment, but it also sets out human rights around other things, such as freedom from arbitrary arrest or detention and the right to a private and family life. The human rights framework also goes into the rights of the families of people who are experiencing substance use.

The charter does not create new rights as such; it draws together existing rights as they relate to substance use. Some of those rights are already protected by the ECHR and through the Human Rights Act 1998 and the Scotland Act 1998, so they are already enshrined in domestic law. However, some of them, such as the right to the highest attainable standard of physical and mental health, which I mentioned earlier, and the right to an adequate standard of living, are set out in international human rights treaties and are not yet incorporated in our law. They are legally binding, but there is no mechanism to enforce them through the courts. They were to be incorporated through the proposed human rights bill, which would have addressed a significant accountability gap. However, given the uncertain future of that bill and taking into account the urgent need to address drug and alcohol deaths, the committee might want to strengthen the bill that we are considering today by looking at the wider human rights framework, to ensure the best outcome for rights holders. Some of the wider framework could be brought into the bill to make some of the wider human rights enforceable.

Elena Whitham: You have outlined that some rights need to be brought into domestic law. Do you feel that the bill could be the vehicle to realise that? Could the rights that you mentioned, such as the right to the highest attainable level of health, be incorporated in the bill in order to realise those rights for people, or would we still need a human rights bill to incorporate those aspects?

Eleanor Deeming: This bill could do that—obviously, it is possible to do that through legislation—but there is a wider point about the interconnected nature of all human rights. The Scottish Government is still committed to introducing the human rights bill, and work is going on to incorporate the wider international treaties. Bringing in certain rights now would be taking a more piecemeal approach, which would risk confusing the legal framework. It could be done, but the initial thought behind the charter was that the rights that it mentions in the wider human rights framework would all be brought in through the human rights bill, with all the implementation and work needed to support that.

Elena Whitham: Unless any of the other witnesses has any thoughts on that, I will stop there. Thank you.

Brian Whittle (South Scotland) (Con): Good morning. I will start with Hilary Steele. As drafted, does the bill make clear which bodies would be held accountable for upholding the rights that are set out in the bill?

Hilary Steele (Law Society of Scotland): The difficulty in the way that the bill is drafted is perhaps that it does not particularly align with the medico-legal position on how treatment is provided. For example, in the McCulloch case, which was decided by the UK Supreme Court, the court stated clearly that it is for a medical professional to decide what is a reasonable treatment option for a patient who is accessing treatment. Under the bill as drafted, it would be for medical professionals to explain a series of treatment options, some of which they may not consider to be reasonable for the patient.

The question then becomes who would be liable if the patient does not get access to the treatment that they require or, more importantly, that they request. Who would be responsible for that? Would it be the health board or the GP who is recommending treatment? Potentially, a variety of healthcare providers would be accountable, because the bill would allow diagnosis to be given by pharmacy prescribers, nurse practitioners and medical professionals in the NHS and in GP practices.

Brian Whittle: It seems to me that the approach is not about what treatment the patient requests but is about what the healthcare professional decides is best for the patient. Is that right?

Hilary Steele: Yes, that is absolutely right. The way that the courts deal with the issue is that there is a professional practice test, under which a medical professional looks at the treatment options available and does not have to include every treatment option. An example is the recent Scottish case of McCulloch, which went to the Supreme Court. The case, which was addressed by Lord Boyd at first instance in the Court of Session, involved a patient who died in hospital following a delayed diagnosis of pericarditis, which is an inflammatory condition that affects the heart. The doctor had not prescribed a common non-steroidal anti-inflammatory drug, ibuprofen, and the family raised a legal action against the doctor for not giving the patient that option.

When it went to the court of first instance, Lord Boyd considered that it was for the doctor to decide what a reasonable treatment option was and that it was irrelevant whether the patient would have taken that treatment. When it went to the UK Supreme Court, that was upheld by the UK Supreme Court as well: that is, that it is for the medical professional to decide which options are reasonable, based on risk and benefit to the patient.

The Supreme Court gave the example of the fact that, although there may be 10 options available for treatment of a condition, if the doctor or healthcare professional thinks that only four of those are reasonable, then only those four need to be presented to the patient, and they will not be negligent for presenting only those four.

In the bill, we see that the medical professional or healthcare professional would be responsible for providing an explanation of each option that was available, then saying why they are not considered to be reasonable treatment options, which has the potential to overwhelm patients. That issue was raised by the UK Supreme Court.

Brian Whittle: Under the bill, the patient has the right to seek a second opinion on the options, given that medicine is not an exact science. Is there sufficient protection for healthcare professionals?

Hilary Steele: There is perhaps a difficulty with the right to seek a second opinion. In clinical negligence or mental health tribunals, for example, a person may seek a second opinion from a consultant psychiatrist, if they saw a consultant psychiatrist the first time round. The potential difficulty is in relation to getting a second opinion from a healthcare professional from a very different area of practice.

If we consider addiction services, as some of the responses to the committee’s call for evidence on the bill note, there can be quite dangerous complications from the withdrawal of, say, alcohol for patients. An addiction specialist or a consultant psychiatrist might see many complications from a treatment, but those complications might not be considered by somebody who provides a second opinion and comes from a different area of practice. It is important for the bill to provide a clear pathway to identify who is able to make those decisions and to provide a second opinion when it involves something that could be dangerous to a patient.

Brian Whittle: That raises the question of how those rights could, or should, be enforced.

Hilary Steele: It is difficult to see how a right to, for example, residential treatment can be enforced if there is a lack of residential facilities available. I struggle to see how a right to treatment could be enforced in the current situation.

For example, in my area of practice, I work with patients who are cared for under the Mental Health (Care and Treatment) (Scotland) Act 2003. On one particular night two weeks ago, according to one of the psychiatrists I was dealing with, there were zero beds in Scotland for patients who were detained under the act. In that situation, a patient required treatment and to be detained under the mental health legislation. The patient then had to be transferred to a hospital in Aberdeen, although she had presented in Edinburgh. Under the bill, the question would be: would that need for enforceability allow one health board to move a person to another health board, or to another area of the country, to provide treatment? I am struggling to see how that right to treatment could be enforced without the facilities or the funding being present to allow for that care and treatment.

Brian Whittle: Does anyone on the panel have anything to add?

10:00

Eleanor Deeming: On justice and accountability, one of the areas where the bill could be strengthened is the accountability gap. It is silent on how people who seek treatment can challenge decisions and access justice if they do not receive treatment in line with the obligations in the bill or the wider human rights obligations in the area. Therefore, we think that the bill would be strengthened with the inclusion of appropriate enforcement or specific challenge mechanisms.

If the bill remains silent on the matter, the risk is that the known access-to-justice barriers that we have in Scotland will be perpetuated. The bill's policy memorandum points to NHS complaints mechanisms and the possibility of legal action by way of a judicial review.

Access to justice is a key concern for the SHRC, and barriers to such access affect everyone—especially those who are marginalised or whose rights are most at risk. We know from our work in this area that people currently experience a variety of challenges in accessing justice, ranging from challenges in accessing independent advocacy, to challenges in accessing specialist advice, including legal advice, to challenges arising from inaccessible complaints processes, right through to the significant financial and other implications that arise from instructing lawyers to raise court proceedings.

My view, therefore, is that it is not realistic for most people to pursue judicial review as a means of challenging decisions. Steps should be taken—there could be an opportunity to do so through the bill—to bring access to justice closer and make it simpler and easier.

More broadly, the proposed human rights bill would plug some of the accountability gap, but the bill presents an opportunity to consider what complaints or challenge mechanisms should be in place that do not lead an individual down the route of the NHS complaints process or having to raise a legal action, which is not realistic for a lot of people.

Brian Whittle: Hilary Steele said said that on one particular night there was no access to a hospital rehabilitation bed. How can we possibly hold the NHS to account if no beds are available when a patient requires one? That is a concern for me. In my head, we could not hold the NHS accountable for that.

Hilary Steele: I appreciate what Eleanor Deeming has said. Although judicial review would be open to a patient who was not able to access treatment, I do not think that it would be an option in that situation. I imagine that most patients in that situation would go down the route of a bringing a clinical negligence case, which at least would give them some compensation, which would allow them to access treatment privately.

The reason for doing so is that a lack of resource does not mean that a person should not be able to access treatment, if there is a right to that treatment. If, for example, a person who, it was determined, needed residential treatment but was unable to access it because the health board did not have such facilities available, and then suffered injury or took an overdose and passed away as a result of being unable to access a place, their family would, I believe, be able to raise a clinical negligence action. There would have been a breach of the duty of care, because the bill would give a right to treatment, and there would be causation, in that the delay in accessing treatment caused the person harm. The health board could be held accountable. However, is that what the bill wants to happen, given that there is already financial difficulty in providing the resource? There could be the unintended consequence of significant litigation.

The other thing is that, in terms of access to justice, many of the patients who are accessing or who might need to access treatment already have other difficulties, which means that they are already receiving benefits or are living in poverty, and so would have access to funding from the Scottish Legal Aid Board. So, the bill might have an unintended consequence of increasing the requirements on public funding for claims or litigation.

Brian Whittle: Thank you.

Emma Harper: I am thinking about people in rural areas. What if someone didnae want to go to their GP or speak to a pharmacist because in small rural places everybody knows everyone’s business? What effect would the bill have on individuals who are seeking treatment but who do not want to go to their GP or a health professional?

Hilary Steele: The Law Society’s concern in that area relates to stigma and whether, for treatment to be delivered under the bill, somebody would already have to have a diagnosis. If so, there could be the unintended consequence of people who need to access treatment being unable to get it because of the pressure on health boards or other practitioners to make sure that they meet the timescales that are provided for in the bill so that they avoid legal or reputational sanctions.

Emma Harper: It might be that somebody is holding down a job, has a family or has other things going on and might not like the word “addiction”. Would a person not qualify for treatment if that language had not been used in any of their diagnostic case notes or anything like that?

Hilary Steele: That could be an unintended consequence of the bill, although I think that it also refers to “dependence”. It would not necessarily need to be “addiction”. My colleagues might be in a better place to answer that question.

Dr Shivaji: There are a couple of considerations there. We know that stigma and the stigma of seeking help are still important barriers, particularly for some subgroups within our population. You mentioned people in rural communities, but there are particular issues for women and ethnic minorities.

It is difficult to set out a clear position. There are potential risks and unintended consequences, but there are also potential benefits. If we can articulate clearly to people their eligibility for support, what that support is, and ensure that it is available, that would overcome some of the barriers that people describe to us in respect of not knowing what services are available and how to access them.

The other side of that is the impact of having a diagnosis and carrying a particular label that could continue for the rest of that person’s life, and that has wider consequences. Particularly in the case of women and those with young families, describing and identifying yourself as someone with dependence or someone with addiction can be challenging, and it can be a barrier to accessing services. We therefore need to provide services in a way that is accessible to those people and that responds to those concerns.

I guess that the other question would be about low-threshold access and making that as easy as possible, and the impact that the need for assessment would have on low-threshold access.

Eleanor Deeming: Taking a human rights-based approach recognises that there is no one-size-fits-all approach to any issues that impact on human rights. However, taking a human rights-based approach to the issue, with the views of rights holders at its heart, and reframing issues such as the right to the highest attainable standard of physical and mental health, would go some way towards reframing the treatment under the bill and viewing it appropriately as a healthcare and human rights issue.

The international guidelines on human rights and drug policy address the issue of stigma. As Dr Shivaji said, what one person finds to be an issue might not apply to others, but reframing around a human rights-based approach would be helpful, as it would view the issue as the healthcare and rights issue that it is.

Emma Harper: Our briefing from the Scottish Parliament information centre refers to the charter of patient rights and responsibilities. That already exists, and people already have a right to seek a second opinion. Would the bill build on that? Is it required? Rights to access person-centred treatment already exist. We know that, when people who are being harmed by alcohol or drugs are treated, it can take years for them to recover, and it is complicated. We know that engaging people has to be about partnership, collaboration and building relationships. Given that patient rights already exist, does the bill not muddy the waters?

Eleanor Deeming: Our view is that establishing a specific legal right to access treatment would likely support the state’s compliance with key human rights, particularly the right to life—we are talking about loss of life here—and the right to health. I do not think that it is necessarily problematic to articulate that.

Obviously, the issue is part of a much broader picture, and the human rights framework shows that the bill is one policy intervention. There is a lot of other on-going and forthcoming work in the area, which absolutely should not be discounted.

Our view is that the bill would be one piece of the puzzle, and that in particular it is likely to support article 2 compliance. I do not see a particular problem with establishing the right in law.

Hilary Steele: The other thing to bear in mind is that the bill would potentially provide a measurable standard that could be applied across the country, which could encourage collaboration between agencies to achieve more joined-up thinking on how services can be provided in individual communities.

Emma Harper: On standards across the country, I know that people who are in the Borders get their residential care in Carlisle, or elsewhere south of the border. Would “across the country” mean Scotland only? How would that work with the cross-border requirements that are already part of people’s residential recovery?

Hilary Steele: I am afraid that I would need to come back to you on the cross-border arrangements. Those vary depending on the types of treatments that are offered to patients, as far as I am aware.

Emma Harper: Okay. Thank you.

The Convener: I have a point of clarification for Hilary Steele on the McCulloch case, which she mentioned. I am also aware of the Montgomery case. Is there potential that the bill as drafted, if it became law, could run counter to those judgments, given that it specifies that certain treatment options must be offered?

10:15

Hilary Steele: We are not sure that the bill specifies that the treatments listed have to be offered, but they have to be discussed, as far as we can see. The question is whether there is a benefit in discussing treatment options that are not considered to be appropriate. Does that provide the person with clarity on what their care pathway might be?

Some treatment options could be appropriate further down the line, but perhaps not at the beginning of a person’s journey. Residential detox might be the preferred option for many people who suffer from addiction issues, but it could be considered completely impractical, given what the medical professional or healthcare professional wishes to do in terms of accessing treatment.

Sorry—could you repeat the question?

The Convener: You mentioned a particular legal case. I am trying to establish whether you see the provision in the bill on healthcare professionals having to discuss all available treatment options as running counter to that Supreme Court judgment and previous judgments on medical treatment options?

Hilary Steele: Yes, I think that there is a difficulty, in that the bill would run counter to that. The bill also adds in the phrase

“any other treatment the relevant health professional deems appropriate.”

That could pose difficulties for clinicians, with treatments being offered to patients that are perhaps clinically inappropriate or lacking an evidential basis for treatment.

The Convener: Thank you for clarifying that.

I will just get you to clarify something else, although this might be an opinion rather than a total clarification. The bill as drafted talks about “dependency” as well as addiction. Could that potentially cover other drugs such as nicotine or caffeine?

Hilary Steele: The question of whether those two would be covered might be better put to the public health professional who is here.

Tara Shivaji: I am happy to come in on that. We commented on the definition of dependence and addiction. Further detail on that would be important for the bill. Without further clarification, the term is open to interpretation, so the bill could include those other drugs. If you use, for example, DSM-5—the fifth edition of the “Diagnostic and Statistical Manual of Mental Disorders”—and some of the criteria of dependence that are set out in that, such as a strong desire to consume the substance, a need to take more and more to get the same effect, finding it difficult to stop and experiencing withdrawal symptoms, I guess that the bill would be open to being indifferent to the substance.

Our recommendation would be that it is important to consider the impact that the use of a substance has on an individual’s life. Rather than the presence of symptoms, the presence of negative consequences in someone’s life are important factors to consider. Those are included in the DSM-5 classification of substance use.

An important point is that the nature of substance use is changing in Scotland. To remain future proofed, there is a need to consider a definition that would enable support to be provided to people for whom regular or daily use and the classical features of dependence are not the prominent features of that use, but they are still experiencing harm. That might be the case with cocaine use, for example.

The Convener: Thank you.

Sandesh Gulhane: I will go back to a couple of things that you said, Dr Shivaji. On the issue of MAT standards versus the provisions of the bill, is three weeks not a maximum, which would not prevent treatment from being given on the day or faster, if required?

Emma Harper talked about rural areas, and you mentioned access to services. What is the current position on access to services? Do we have access to the services in the way that you described that you would like to see?

I am sorry to ask a third question, because you have just talked about this, but the “International Classification of Diseases 11th Revision” defines “Disorders due to substance use” as a cluster of cognitive, behavioural, and psychological features reflecting an internal driving force to use a substance, causing clinically significant harm to physical or mental health, or leading to harmful behaviour. Again, that could include use of nicotine—ICD-11 does not exclude it. Sorry for the three questions in a row.

Dr Shivaji: I will start with the question about the MAT standards and the bill’s provisions. My view is that the two sit alongside each other. However, we need clarity about what the expectations are and what is important, so that we do not create an artificial ceiling of three weeks, when we know that, in many cases, we need to offer treatment faster. It is about communication and clarity around what is important and what needs to be achieved by the system.

On the question about access to services and the position at the moment, the situation is quite mixed across different areas. Multiple factors are contributing to the difficulty in accessing services. As I described, from the perspective of individuals with problematic substance use, factors include lack of awareness about what services are available. We are told that word of mouth is still very important in understanding how you access support and navigate the system.

From the point of view of providers, there are issues about the location of services and the timing of appointments, because people might be working and not able access appointments while they are doing that. As described, there are also issues around stigma. The issue is multifaceted. Although the bill would go some way towards recognising the importance of timeliness, there are wider issues that we need to address.

On your point about ICD-11, for us, it would be helpful to have clarity of definition and the expectations around what conditions would be eligible under the bill. It is always difficult to provide an all-encompassing definition, but it would be helpful to have a definition that allows identification of people at an early stage in their use of problematic substances and that is adaptable as substances change, but is also specific, to allow us to focus on improvement in the areas where we know that improvement is needed.

The Convener: Before we move on, I declare an interest: I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

Brian Whittle: We were talking about the definition of addiction. You can be addicted to just about anything, but when the bill refers to substances that cause intoxication, would that not preclude nicotine from being covered by the bill?

Dr Shivaji: I would need to come back to you on that. We would not consider nicotine to be a psychoactive substance, so that interpretation might be helpful, but I suppose that it is possible to have nicotine toxicity.

As for what we mean by “intoxication”, I appreciate that it sounds as if we are very much going into the detail of the semantics in all of this, but the meaning of the terms that we use is very important if we are to provide clarity to people about who is eligible under the bill.

Brian Whittle: Thank you.

The Convener: I call Gillian Mackay.

Gillian Mackay (Central Scotland) (Green): Good morning, panel. I want to return to the rights issues that Emma Harper was exploring earlier. You have already acknowledged that we do not normally have a right to particular treatments in the NHS, but do you believe that there are any potential drawbacks in providing such a right? Some of you have also touched on the imperative that it would put on Government to provide such services. Is there a danger of a focus on compliance distracting from the range of treatments that we would like to see? Perhaps Dr Shivaji can go first, if that is okay.

Dr Shivaji: On your second question, on whether there is a danger of a focus on compliance restricting treatment options, I think that one of our key considerations is the need for adequate resource in the system to be able to offer high-quality treatment. From all the work that we have done, that is what people who work in the system want to offer, but it requires adequate resourcing and a supported workforce. If there is a legal expectation of a right to certain types of treatment, but inability to provide such treatment due to inadequate resourcing, the risk is that it will not only demoralise the public and result in trust being lost in what we are providing, but demoralise our workforce, too.

Eleanor Deeming: I think that I have made it clear that we view this right as perhaps aiding compliance with key fundamental human rights, particularly article 2 of ECHR, which protects the right to life. However, another recommendation that we make in our submission relates to the importance of human rights budgeting. Looking at the financial memorandum, we would acknowledge the already complex programme of drug and alcohol services funding, and we would, of course, support any increase in expenditure that furthered the fulfilment of the highest attainable standard of health, but I think it relevant to have a human rights-based budget assessment of the whole picture, given some of the critiques of the bill from some civic society organisations, which have noted that the bill would not guarantee any new services. Indeed, we touched on that in an earlier discussion.

The "International Guidelines on Human Rights and Drug Policy" recommends that a human rights review and budget analysis be part of any such policy process, and it specifically says that

> "States should ... Undertake a budgetary review to ensure the progressive realisation of the right to health in relation to drug use and dependence"

and

> "Carefully consider ... any cuts in the allocation of resources".

It is one part of the picture, but if there were a full human rights-based approach to the whole policy area, there would have to be a much wider consideration of funding and services. I do know that a lot of work on that is on-going.

Gillian Mackay: With regard to funding and other services, many people with drug and alcohol addiction have co-existing mental health issues, previous trauma and things like that to deal with. If there is a focus on compliance and on needing to fund these particular services, are we in danger of other services potentially being underfunded, because of the need for legal compliance in this area?

10:30

Hilary Steele: Health boards could potentially find themselves in that difficult situation. There could be an increase in stigma, for example, if resources are taken from another area of healthcare and moved into this area.

Also, given that the use of treatments, the number of determinations and how the service is working would be reportable, there is the added risk that this could be looked at quite negatively in the media as resources being moved into an area with deliverables that are not particularly positive. That could increase stigma for those who are accessing care and treatment in this area. I agree with Eleanor Deeming and Dr Shivaji that budgeting is key to avoiding those unintended consequences.

The Convener: I think that Dr Shivaji wants to come in on that point.

Dr Shivaji: I want to reflect on the question of whether there is a risk to other services. The Audit Scotland review of alcohol and drug services found that there have been unintended consequences for alcohol services because of a lack of focus on them, which means that even without a legal imperative, there have been unintended consequences in the alcohol area.

When we have spoken to alcohol and drug partnership co-ordinators as part of our evaluation work on the national mission, they have described to us the need for two areas of priority. One is wider support services for people who are affected by complex issues that move beyond opiate-substitution treatment, and the other is the need to invest in recovery communities. They recognise that other agencies, such as housing and justice providers, have an important role to play in this, but the challenge that they have, which comes back to the accountability issue that we discussed earlier, is leveraging that change at the local level. Thirty per cent of them said to us that they do not have the necessary leverage to deliver some of the priorities and make the changes that are needed. Those remain key systemic issues that need to be considered if there is to be this expectation of provision of certain types of treatment.

Joe FitzPatrick (Dundee City West) (SNP): You have, all three, talked about stigma, which is the area that I will cover. We know that stigma is really damaging in terms of getting people to come forward for support and that it costs lives. One of the things that we have done in Scotland for a number of years is to try to move this whole area, and particularly the treatment of addiction, away from the justice sphere and into the health sphere. There is a concern that, by having the bill single out addiction services, we are removing those services from the sphere of mainstream healthcare, and therefore there is a danger that they will be additionally stigmatised.

Can you talk more about stigma and the concern that the bill could increase stigma and therefore cause further harm? I know that that is not the bill's intent.

Eleanor Deeming: As I said earlier, I agree that reframing substance use as a human rights issue and a healthcare issue is important. The work of the national collaborative evidenced that different people have different views around stigma. The human rights-based approach highlights the need for health service provider training on drug dependence treatment and the need to integrate training on stigma, discrimination and respect for people's rights into the on-going workforce education and training programme. That is an important point.

It is partly because the policy intent of the bill concerns the reduction of deaths related to drug and alcohol use that we think that it may aid compliance. The state has certain obligations, particularly under article 2 of the ECHR, which applies in the healthcare sphere, albeit in a more limited fashion. Where the state knows, or ought to know, of a risk to life, there is a specific obligation to take targeted steps to prevent that loss of life. I am not a healthcare expert, but I know that that would also apply to a lot of areas of healthcare. Our view is that the specific proposal in the bill would likely aid compliance with article 2.

Joe FitzPatrick: So, you do not have any concern that there might be a hierarchy of which treatments are achieving that most. There does not appear to be a definition in the bill of what “recovery” is. The Thistle centre, for example, is absolutely saving lives—I have no question in my mind about that—but it might not fit the definition under the bill. It should do. It saves lives.

Eleanor Deeming: We want to see the incorporation of the right to health, as protected by international treaties such as ICESCR—the International Covenant on Economic, Social and Cultural Rights. That would result in a broader, more enforceable and all-encompassing right to health, and that is our end goal. Given the uncertainty around the proposed human rights bill—although I acknowledge that there is still a Government commitment on that bill—the issue is whether we should now be considering specific, targeted proposals where there is a known risk or a known issue with loss of life.

Dr Shivaji: We recognise and accept that stigma is still a very important contributor to drug harms, and stigma is complex. There is the self-stigma that people experience, and there is the stigma that individuals experience within institutions.

We have talked about the complexities that exist underneath or together with substance use. We recognise that health inequalities have causes and contributors, which include poverty, exclusion and being involved in the justice system, and people do experience stigma.

One of the opportunities that the bill brings involves recognising the importance of people’s participation in services. That is an opportunity to both recognise stigma and address it. We would need a bit more detail about how that would be operationalised. Services are making that move, particularly through the medication assisted treatment standards. They can use the tools that are available through the human rights lens, such as the availability, accessibility, acceptability and quality—or AAAQ—toolbox, which is proving extremely useful in understanding people’s experience of services, their availability and their acceptability. Stigma runs through that like a golden thread. It is important that it is at the heart of quality improvement and performance improvement. I see that there are opportunities for that.

Is there a potential risk of increasing stigma? We need to recognise the pressure on our workforce. Many people report being very close to burnout, and pathways into substance use services are stretched. Placing additional expectations on the workforce without additional resourcing will lead to a further sense of moral injury and pressure, which could have unintended consequences, including around stigma.

Joe FitzPatrick: Hilary Steele, you also mentioned stigma.

Hilary Steele: I support what Dr Shivaji said about the opportunity to engage fully in treatment. On stigma, there is a possibility, which was also raised by other members of the panel, regarding the use of independent advocates—which is an extremely effective part of mental health legislation—and the opportunity to request a second opinion. As someone who has worked with doctors for many years, I know that requiring the written reasons for a refusal of treatment would certainly focus the mind on ensuring that there is not unintended discrimination in accessing treatment.

Joe FitzPatrick: Thank you.

The Convener: I call Emma Harper.

Emma Harper: My questions have been answered.

The Convener: Thank you—I call Sandesh Gulhane.

Sandesh Gulhane: What is the definition of drugs in relation to the MAT standards in other legislation?

Dr Shivaji: I would need to come back to you about the exact definition within the MAT standards. However, we have taken a broad approach to any psychoactive substance that is considered under the Misuse of Drugs Act 1971 or the new Psychoactive Substances Act 2016. What is key is when someone who is experiencing harm could benefit from treatment.

It is important that all 10 of the MAT standards reflect a broad person-centred approach. It is not just about opioid treatment and opiate substitution treatment; it is also about recognising the importance of psychological therapies, advocacy and harm reduction. That can be applied to a broad range of substances, but we are clear that, at this stage, it does not go as far as substances such as nicotine or behavioural addictions.

Sandesh Gulhane: Could you write to us about that?

Dr Shivaji: Yes, I can write to you afterwards.

Sandesh Gulhane: Thank you.

The Convener: I thank the witnesses for their attendance at the meeting this morning. The meeting will be suspended to change panels.

10:42

Meeting suspended.

10:52

On resuming—

The Convener: Welcome back. We are continuing to take oral evidence as part of the committee's stage 1 scrutiny of the Right to Addiction Recovery (Scotland) Bill.

The committee will now hear from a second panel of witnesses, comprising representatives of professional organisations. I welcome Dr Peter Rice, who is a former chair of the Royal College of Psychiatrists in Scotland; Lyndsey Turfus, who is chair of the substance use sub-group at Social Work Scotland; and Dr Chris Williams, who is vice-chair of the Royal College of General Practitioners in Scotland. We will move straight to questions, and we will start with Sandesh Gulhane.

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

I will start by looking at diagnosis. One of the things that the committee has focused on is the definition that could be used for the diagnosis of drug addiction. We looked at that with the last panel of witnesses. The committee is trying to establish whether there is a definition that could be used. Is the definition in the bill tight enough?

Dr Peter Rice (Royal College of Psychiatrists in Scotland): The term that is usually used is "assessment"—it is a broad process—although diagnostic categories are useful for research and for tracking trends and so on.

With regard to the day-to-day work with patients, diagnosis in and of itself is not a particularly crucial step. Most people who come for treatment will already recognise the nature of their problem and will be looking for a solution to it. Psychiatry is different from areas of medical practice in which someone might say, "I don't know what is the matter with me. Please do some investigations and figure it out." Typically, psychiatry is not like that, and the process of diagnosis is not a central part of the treatment pathway for most people.

Sandesh Gulhane: Let us concentrate on psychiatry. You have said that the word "addiction" is too vague. The bill also refers to substance "dependence". What term would you prefer?

Dr Rice: "Addiction" is a term that survives and is widely used. We are the faculty of addictions psychiatry, so we think that the word has its use and value. However, in diagnostic categorisation—according to the ICD, which is used in the UK—the term that is used is "dependence", and a key feature of dependence would be an impaired control over use of the substance. People might say, "I'll just have a couple of drinks tonight and that'll be me," but, once they start, the snowball keeps rolling down the hill.

An individual continuing to use a substance, even though they recognise its harm, is at the centre of the phenomenon—they are tugged between feeling that they cannot do with it and feeling that they cannot do without it. There is also the business of what you might call "neuroadaptation"—if people do not have the substance, they miss it—which can result in a very serious clinical situation. An individual using more and more to get the same effect is on the same side of that coin.

Those are the three central characteristics, but they all exist on a spectrum. None of them is black and white or categorical; they are all shades of grey in between. A dependence diagnosis would be based on the extent to which those characteristics exist.

My own work has been on alcohol harm, and we know that many people who come to considerable harm or die from alcohol will not have been dependent on it. For instance, many people who have alcohol-related liver disease—a diagnostic event—are able to quit drinking and do not experience any great cravings. They might not experience much in the way of withdrawal, yet they come to harm. Some of that group will not recover from their liver disease and may well die from it. In our written response, we mention that it is not just dependence that leads to harm, and that is particularly true for alcohol. A lot of harm is non-dependent. In Scotland, some good things have been done—brief interventions in primary care and so on—to get to that group.

Sorry—that is a bit of a complicated answer, but I am filling in the picture.

Sandesh Gulhane: We certainly have that picture, but when it comes to writing something, we have to put the words down and decide what we are doing. If "addiction" and "dependence" are too vague, what should we put down? What does the Royal College of Psychiatrists in Scotland think that we should put down? Should we talk about harmful patterns of use? Should we put down something about repetition, maladaptive behaviour and an increase in severe dependence? Do you want to see those things in the bill?

Dr Rice: My own view is that "substance use disorder" is the best term. Without getting too much into the niceties, DSM-5 is probably going to drop the term "dependence" altogether and talk about substance use disorders that are of mild, moderate or high severity. That is my suggestion.

Sandesh Gulhane: Dr Williams, the bill sets out that a GP must say that somebody needs treatment and must give them options. I know that the RCGPS has specific worries about GPs doing that.

Dr Chris Williams (Royal College of General Practitioners Scotland): We would be worried if GPs were acting simply as gatekeepers. We know that a lot of information and support is made available to people so that they do not need a formal diagnosis, which means that they can recognise patterns in their behaviour or circumstances, or friends or family might point those things out to them. You can, for example, look on the A Local Information System for Scotland—ALISS—website; you do not need a medical professional or even a link worker to point you in that direction, and you can find sources of help there, either by type or location of service. There are lots of ways for people to find out whether they have a dependence on alcohol or other substances, or whether they have other types of addiction that are not mentioned in the bill—such as gambling and smoking addictions, to name but two.

11:00

Where does general practice sit in all of this? We often see people who have what I suppose could be called secondary problems. They might have had a pattern of harmful alcohol use and be encountering gastritis or other physical effects, and a general practitioner might pick up on that and see something that someone else cannot see. We, in general practice, have a long-term relationship with patients, communities and families, and it is often the case that someone might, over time, build up the confidence to approach us and ask about a problem that they now see in themselves. Sometimes, as I mentioned, we also need to walk someone through a problem that they cannot or will not see or cannot understand.

It is also important to highlight the fact that there is a lot of stigma in this landscape. Even without a diagnosis, people can still access help for all sorts of substance or alcohol use problems.

Sandesh Gulhane: We will be coming on to that issue, so I do not want to touch on it just yet.

I suppose that this is more of an open question. When it comes to clinical decision making and a patient wanting a specific treatment—I am thinking of other areas of healthcare and somebody wanting a specific type of treatment for, say, cancer—doctors or other healthcare professionals might not tell them that they can have it. However, what the bill proposes is slightly different in that it sets out a requirement that a response be given to such a request. Is that helpful?

Dr Williams: I do not know that it is helpful; it does not seem to sit alongside the other frameworks that we use in our shared decision making on healthcare.

I am absolutely in favour of people being informed about the range of different treatment options that are available or where different types of medication or other therapies might sit. That might not be a linear journey—with alcohol problems, we often see people being afflicted over the course of a lifetime. As a result, clinicians might advocate different strategies at different stages, or a sequence of different interventions might be warranted or justified or have a higher chance of success with regard to certain outcomes.

I absolutely want shared decision making. Currently, there is a drive for value-based health and care, to ensure that we do not offer treatments if they do not work. It is very much about knowing what treatments are effective in certain circumstances. We do see the phenomenon of people reading or seeing something about a treatment journey that somebody else has gone through and thinking, "Will this work for me?" Often, as clinicians, we need to explain to people why we think that certain treatments or interventions will not work for them, on account of their individual circumstances.

Sandesh Gulhane: Thank you. My final question—

Lyndsey Turfus (Social Work Scotland): Sorry, but may I comment on that?

Sandesh Gulhane: Yes.

Lyndsey Turfus: From a multidisciplinary perspective, it is really important that there is choice. I totally agree that a person should be informed, and it would be good to see a duty to ensure that they are informed of all their choices. However, we already have something similar in the MAT standards, and the role of advocacy is important as well. That is possibly not quite reflected throughout the paper.

Dr Rice: I agree with both those points.

A stepped care model is the norm for much of the treatment activity that is discussed in this sector. As Dr Williams said, you do not know what is going to work for people and you have to adapt. The treatment determination is a process, not an event.

Intravenous drug use, particularly involving opiates, is different from that. It is almost the outlier activity in this field. We see that in the approach of the MAT standards and the various imperatives to reduce people's risk quickly—hence the same-day prescribing in the MAT standards. That is a particular set of circumstances for a particular type of problem. It is a very important problem, but it is not the whole picture.

A stepped care model rather than a matched care model is much more common for non-opiate problems. It is about seeing how people progress and then adapting the agreed treatment process in the light of how they get on. Often, that means getting pleasant surprises. You might think, "Oh, it's going to be a long journey for this person," and then they actually get into recovery very quickly. It is very heartening when that happens, and it happens pretty frequently, certainly in the alcohol field.

Sandesh Gulhane: I would certainly hope that, when people get into treatment, they are then able to move on. I would hope that it would not be a case of saying, "This is the one path—and that is you done."

My—

Lyndsey Turfus: I am sorry, but, before you move on, I have a point to make in relation to diagnosis. You will have to forgive me. I have not been to one of these meetings before, so I was not sure what the flow would be like.

As a social worker, obviously I cannot give a diagnosis, but we frequently come across people who are in very desperate situations, and it is very clear that they are not making informed choices. One of the comments that was made by my colleague who wrote our submission was about cross-cutting legislation. We need to look at things such as how we work with the Adult Support and Protection (Scotland) Act 2007. The revised guidance takes a lot of account of the impact of trauma and substance use, which is really important. We need to have that flexibility in relation to working with our multidisciplinary colleagues. We also need to understand that it is not as straightforward as going into recovery. There is that period in between, when we need to stabilise somebody, which I do not feel is reflected.

I am sorry—I was not sure when to bring that in. I apologise if I am speaking out of turn.

Sandesh Gulhane: Thank you.

If I may, I will turn to my final question—

The Convener: Could you hold that, Mr Gulhane? We have a few supplementary questions and you have already had a fair chunk of time.

I invite Brian Whittle in.

Brian Whittle: Good morning.

Dr Rice talked about the use of the word "addiction". I understand why, because I am pretty sure that the bill is not here to be a source of treatment for gambling or smoking. The bill talks about substances that cause intoxication. Does that cover enough? Does that say enough about the direction of travel that I am pretty sure the bill is trying to go in? Is that helpful?

Dr Rice: You draw a meaningful distinction between intoxicating substances and addictive behaviours. It is pretty clear in the bill that it is dealing neither with addictive behaviours nor with nicotine. We could argue all day about that, but that seems to me a sensible distinction.

Intoxicating substances—alcohol, opiates, cocaine and benzodiazepines—are sensibly grouped together. However, I feel that they do not always completely go together and that there is a need for substance-specific responses. I might say a bit about that later. However, I agree with your demarcation.

Brian Whittle: Is the bill, as it is drafted, strong enough to make that distinction?

Dr Rice: I think that it is, but, as I said to Dr Gulhane, an awful lot of problems occur in people who would not regard themselves as, or be regarded as, addicted or dependent, and it is important not to forget that. Some important harms that are caused by intoxicating substances are not covered by the bill as drafted.

The Convener: I have a short, sharp question about the clinicians who are involved in making those treatment determinations. My assumption, which is based on the bill and on listening to the previous witness panel, was that the clinicians would be NHS employees. However, if we look at who can actually make a determination, the list includes doctors, who may not be employed by the health service, and pharmacist prescribers, many of whom work in community pharmacies and are therefore contracted to the NHS for some, but not all, services. What is your opinion on that cohort of healthcare professionals, including advanced nurse prescribers, being determined in law as being able to make treatment determinations?

Dr Rice: I can say one thing that might shed a bit of light on that. Today, there will be about 70 admissions to Scottish acute hospitals of people with a primary diagnosis related to alcohol. They will come in through accident and emergency or through acute medicine—

The Convener: I am sorry to interrupt, but please go back to that specific group of healthcare professionals.

Dr Rice: I was going to say that many of the healthcare professionals involved will not be working in specialist services. That is the point that I was about to make.

The Convener: The question was not about specialist services; it was about people who are not working for the NHS.

Dr Rice: Okay. Not many prescribing decisions will be made by people who are not working for the NHS—most prescribing decisions will be made by medical and non-medical prescribers working for the NHS. Other treatment determinations, such as those about counselling or family therapy, are often made by people who are not working for the NHS but who work in the third sector. Does that answer your question?

The Convener: I do not want to take up an inordinate amount of time because I know that there are lots of questions, but there seems to be a working assumption, given the cohort of staff defined in the bill, that NHS staff will be making the treatment determinations. However, as I said, some of those healthcare professionals do not work for the NHS. For example, we have GPs and pharmacists who are independent contractors. Does that cause you any concern?

Dr Rice: I may let Dr Williams talk about the independent contractors. That does not concern me because the independent contractors that you spoke about are closely tied into NHS processes. If I understand your question properly, that would not worry me.

Dr Williams: I am certainly quite relaxed about independent contractor involvement.

The Convener: Do you mean independent contractors as opposed to private ones?

Dr Williams: I am talking about general practice and community pharmacy involvement. I am comfortable about that because I know that the governance arrangements are sound.

The Convener: That is fine; thank you.

We move to questions from Elena Whitham.

Elena Whitham: I will explore some issues regarding treatment options. The bill as drafted outlines several treatment options that individuals who have a diagnosis of drug and/or alcohol addiction may access. Those include, but are not limited to residential or community-based rehabilitation, residential or community-based detoxification, and stabilisation services.

Some of the written submissions that we have received from organisations, including from Social Work Scotland and from the Royal College of Psychiatrists in Scotland, express a little concern in their perception that the bill focuses on abstinence-based recovery rather than on harm reduction. I will explore that idea a little. The Royal College of Psychiatrists also has some concerns about unregulated rehabilitation services and how to better protect people in that space.

11:15

Does the bill, as drafted, effectively integrate harm reduction approaches with the range of treatment options that it proposes? We should recognise that people are sometimes not able to access residential rehab when that might be the thing that supports them in the long run, and looking back, they sometimes recognise that it could have supported them at an earlier stage. I am trying to square all that, and wonder whether you can speak to it. I will start with Peter Rice.

Dr Rice: The list of treatments in the bill is pretty broadly described, and there is a kind of catch-all at the end, if I remember correctly. The list covers most of what might happen, and the catch-all term will include a lot of mutual support, recovery cafes and so on. If we were to apply that broad list, it would include harm reduction interventions, which are more important in relation to some substances than to others.

From some of the discussions about the bill, it is pretty clear that many of the people who support it would like to see more abstinence-orientated treatment. However, the list of treatments in the bill is broad enough to incorporate the harm reduction interventions that every bit of guidance says can be important in preserving wellbeing and life.

Elena Whitham: That is slightly contrary to your written submission. At this stage, does the Royal College of Psychiatrists think that that does not need to be strengthened in the bill as drafted?

Dr Rice: I think that a lot depends on the umbrella term at the end of the bill, and there could be an argument that that should go into a bit more detail about some of the other possible options. I suppose that my response is about whether that should be expanded to include a bit more detail, rather than sitting as a pretty general statement, as I recall that it does at the moment.

Elena Whitham: What is social work's perspective?

Lyndsey Turfus: Our overall concern is that these things are obviously already available, and the challenge is that we do not have enough resource to cope with the demand for them. The focus is on the more medical aspects of substance use when it is very much a social problem, and getting someone to the point at which they are willing to engage in recovery is quite a long journey. Our main concern is that we did not feel that that was entirely reflected in the cycle of change. The bill does not entirely reflect the biopsychosocial approach that is needed, and what I suppose we would call the scaffolding that needs to go around it. It still feels very medically orientated.

Elena Whitham: That speaks to my second question. People with lived experience have emphasised to us that it is all about wraparound support, and that recovery goes well beyond any rehabilitation that might occur. Things such as mutual aid and recovery communities, as well as that wider look across to housing and so on, are all important. Does the bill, as drafted, adequately promote the collaborative working that there needs to be between health, addiction services and broader support services? I will start with Dr Williams.

Dr Williams: In relation to the bill is drafted, the RCGPS has concerns that those specific types of treatments are not linked in with wider harm reduction measures in the way that they need to be.

As you identify, other types of support are also crucial in relation to life changes and the other momentous changes that some people will go through when they address what are sometimes very long-standing problems. There are all sorts of other social supports that go beyond medical treatment, and we recognise the third sector's role in providing those.

I can see why some organisations would favour some aspects, such as the residential aspects, having some form of guarantee behind them. However, I worry that, if we promise too much in relation to those treatment options, which can be quite expensive at times, and they are not carefully matched to the other longer-term approaches and behaviour change elements, we might set up unnecessary clashes with patients and their families, who will have raised expectations that cannot then be met. Things may unravel for some of those people, so I can see difficulties in trying to provide a guarantee on a narrow spectrum of interventions.

Elena Whitham: I guess that it is about the fact that recovery is not an event but a journey, and it is not linear. Any bill that seeks to address that needs to recognise that recovery is not a single thing but may be a multitude of things, and that it may come in fits and starts. Does it need to be explicit that the journey can be restarted at any point and that different options will be available?

Dr Williams: Part of the difficulty in offering somebody a guarantee about a journey that might take all sorts of twists and turns is how we can plan carefully around that and continue the journey with a trusting bond between the clinical and wider multidisciplinary team, our social care colleagues, the patient and their family. I absolutely want people to have options and to be able to make choices that are suited to their circumstances, but I feel that a compact is involved. We need to offer our patients and their families a realistic understanding of what is available. We should absolutely bolster the treatment options and interventions that work, but we should also have a wide range of other things available for when we see people run into other challenges.

Elena Whitham: We are short of time, but do the other witnesses have anything brief to add?

Lyndsey Turfus: On the scaffolding and the things that are missing, one focus of our subgroup is about creating compassionate communities. I bring your attention to the fact that one of the really effective ways of getting someone into treatment more quickly and getting them to sustain that treatment is the community reinforcement and family training—CRAFT—approach. That is the sort of thing that we need support with, but there is an absence of that in the bill.

It is not about gatekeeping access to rehab; it is about making sure that the person and their family are prepared for that, because it is a really gruelling process for somebody to go through, and they need to be ready to go through it. My colleagues will know more about the stats on people coming out of rehab. However, if someone has an unsuccessful attempt at rehab, their overdose risk will be really high, so we need to be careful that that support is available.

Elena Whitham: That is very helpful. Thank you.

Gillian Mackay: Good morning.

In your professional opinion, how appropriate is it to set timescales for drug and alcohol-related treatment in legislation, and how might the provisions in the bill impact on waiting times for that treatment?

Lyndsey Turfus: May I go ahead and start on that one? At the moment, we use the drug and alcohol information system—DAISy—which is fraught with problems as it stands, and I think that staff are already working at capacity. On timescales, I do not think that there is anything in the bill that we do not already have. Our concern is that the bill will put additional pressures on staff who are already stretched.

If we go as far back as the Munro report, we can see that the more we legislate for these things, the more it can cause unintended consequences, including unintended harms. We want people to be treated within a timescale, but there are concerns about whether it is necessary to legislate for that.

Dr Rice: There is no question but that the setting of timescales and standards affects practice and priorities. We have seen that with the MAT standards, and we see it with the drug and alcohol treatment waiting time. When timescales are set, the behaviour of services and individuals certainly shapes up. We have tight timescales for certain things through the MAT standards.

However, the alcohol and drug treatment waiting time, for example—it is a three-week waiting time to enter treatment—has turned out to be a three-week wait to get an assessment. After that assessment, there can be considerable hidden waits for psychological treatment, family therapy or whatever.

The timescales are important because they influence behaviour. It would be great to have everyone in treatment of a good-quality standard within three weeks—that is a very good aspiration to have—but we are quite a way short of that in many areas of the sector at the moment.

Gillian Mackay: On that point, how realistic is it to have people in treatment within three weeks, given the different stages at which people come to seek help, relative to whether they are ready for some of the things that are covered by the bill? Is there a risk of pushing people into a specific set of treatments that may or may not be appropriate for them because that timescale is in the legislation?

Dr Rice: I will attempt to answer that. I think that it was Elena Whitham who made the point that, for most people, the "treatment determination"—to use the terminology of the bill—is a process, not an event.

In relation to any target, the important thing is that we are keen to have enough capacity to offer people good and effective treatment quickly. That treatment, or any other interventions, may change and evolve with time, in the light of people's progress and so on.

I am keen to have enough capacity to offer people reasonably rapid treatment but, in many circumstances, the treatment determination will change and evolve with time and with the patient's progress and their changing preferences.

Gillian Mackay: Does anyone else want to come in on that question before I move on?

Dr Williams: I will happily come in. It is lovely to see an ambition to get people rapid intervention and help. We know that people with alcohol and drug problems often struggle to find the help that they think should be there or the type of help that they feel comforted by.

Looking at the lists in the bill and thinking of the wide spectrum of different presentations and circumstances, I find it difficult, as a clinician, to see how that all ties together under a three-week target, especially if guarantees are being promised around that. I do not understand quite how those guarantees would be effective.

I see there being a wide range of different treatment types, each of which would have its own service pressures. Although I welcome the ambition, I cannot fully imagine how that would all pull together in a way that would retain the trust and confidence that exist between patients and clinical services.

11:30

Gillian Mackay: I asked our previous witnesses about the underlying trauma and co-existing mental health issues that people with experience of substance abuse often have. Does the three-week deadline in the bill risk sidelining other important work that could keep people in recovery for longer, because there will be a statutory obligation to have them in treatment for addiction?

Dr Williams: It is one thing to recognise that there are gaps in the services that we provide to people, but it is another to try to build up services that we know are in demand and are clinically effective, widely appreciated and successful. It is yet another thing entirely to promise access to something that is not available or would not be suitable for some people. On reading the bill, we can imagine conflict, or at least disappointment, arising through people thinking that they will have access to services that are not suitable for them in their individual circumstances, or which are still being developed or are under some form of strain.

Gillian Mackay: Thank you. I will leave it there, convener, in the interests of time.

The Convener: Brian Whittle has a brief supplementary.

Brian Whittle: Further to your point, Dr Williams, I asked our previous witnesses who should be responsible for holding rights. They suggested that that responsibility would sit with the NHS or the diagnosing clinician. If the service is already under strain, as you suggest, does that give you cause for concern?

Dr Williams: Many of our mental health services, including addiction services, are currently under strain. I would love to see parts of them being developed and more resource going to them.

On the wider harm-reduction approach, many different steps could be taken to benefit a wide range of patients outwith the measures that are listed in the bill. The crux might be who is responsible: is it the specialist service or the wider services? When I look at the drug and alcohol landscape, I see many services beyond NHS-employed clinicians. There is a wide range of people with various talents and knowledge who can offer various types of support. If we could bring all those together, we would not need to guarantee treatment within three weeks.

Lyndsey Turfus: I would like to comment on that, too.

Dr Williams touched on the really important issue of the wider group. Social Work Scotland has been involved in work with WEDG. I cannot remember what the acronym stands for, but the group is to do with substance use and recovery, and it is really important.

I have some concern about the way in which the conversation has been medically focused to date, because we—that is, social work and social care colleagues—are the ones who go out and visit a person in their home, or who try to track them down when they are homeless and get them into treatment. We do that in partnership with GPs, psychiatry colleagues and others. On the ground, we are all working very well as a team, but my concern is that that is not reflected in the bill.

It is wonderful to be here today and to be part of the discussion, but I still feel that it is very medically focused, particularly when it comes to the question of who decides on people's rights in these things. I understand the need for that if we are talking about international classification of diseases—or ICD—diagnoses, but as I have said, this is a social issue, too.

Emma Harper: I am interested in what the panel has said about there being lots of pathways for people, and Lyndsey Turfus has mentioned housing and all the other things for which people need referrals. I am thinking about the challenges that face people in rural areas, where everybody knows you. When you walk into a GP practice, it is as if people know, suspect or understand why you are there. Indeed, a person who lives in a rural area who has a substance use disorder might well not go to their GP or take a medical route. Would the bill impact on people who seek treatment through alternative approaches?

Lyndsey Turfus: I do not see anything in the bill that would strengthen what we have at the moment. With the MAT standards, people have a choice about where their care comes from, and some of our third sector colleagues are providing really good services, with online access to assessments and so on.

For example, something that we are doing in our local area and which Social Work Scotland has been promoting is the use of the NHS Near Me service. I think that you are right. For people in rural areas, the option of being supported through access to a Near Me appointment could break down a lot of barriers, not just when it comes to transport, but when people do not want to be seen to be accessing such services. That is where social work and social care can provide important support. Psychiatrists often work in clinics, and we can go out and facilitate a Near Me appointment with a person, because we see their social circumstances and how they present. We do not see those things if we are not face to face with the person, but we can bridge that gap. Perhaps there is a need for that to be reflected more in the bill.

Dr Rice: There is a section of the bill that might be easily overlooked, but which I thought was very thoughtful in describing existing processes that are not initiated by formal diagnosis but in which people are referred for treatment—for example, a social worker referring someone to a support service. At this point, I declare an interest as I am on the board of Tayside Council on Alcohol.

That sort of approach is actually the norm, and the bill says that the intention is not to interfere with processes that already exist. The worry, though, is that the bill might draw attention away from all that work and those other routes—for example, people in Dundee being able to phone a number and asked to an appointment the next Tuesday. An awful lot of such work happens. Again, I am thinking particularly of alcohol treatment, but that sort of thing is very frequent and is perhaps the most common route into treatment.

The bill is right to acknowledge the importance of such work, but I have to say that although the bill says that it will not affect it, I think that, in practice, it will—in particular, if it sets up a list of expectations with regard to governance around a particular activity. There is a real risk of that drawing attention away from other activity, such as is described in the bill.

Emma Harper: You talked about substances with regard to the bill not being intended to be about nicotine, but the previous panel talked about future proofing. We are now seeing evidence of young people vaping at levels such that nicotine is affecting their sleep, their attendance at school and their health. Should nicotine be included in the bill?

Dr Rice: That is an interesting question. You will probably know more about this than I do. Smoking cessation services did not, when they were developed in Scotland, sit within addiction services. I do not know quite what the mechanism was, but quite a big machinery has been established for smoking cessation services. The best that I can say is that, at that time, it was regarded as not being appropriate that smoking cessation services be included within existing drug and alcohol services.

You are right that there will be a need for such services, but there will be a need to think about which bit of machinery will be the most effective way to deliver that help, because it will not necessarily be within the services that are being suggested in the bill.

Lyndsey Turfus: Future proofing is important, because over the past couple of years we have seen patterns of drug use change immensely. New drugs, such as nitazines, are always popping up. One of the problems with young people using vapes is that it is not always nicotine that is in the vapes, and they often do not know what they are getting. We are seeing a shift towards a lot more stimulant-use behaviours.

Dr Williams: Emma Harper mentioned the rural dimension, so I will comment on that, as someone who lives and practises in a rural area.

To come back to the intoxication side of things, I note that access to transport is also limiting to people, if they have something on board that impairs their ability to drive or navigate. I wonder whether, in remote and rural areas, people have a limited selection of options, anyway.

Carol Mochan (South Scotland) (Lab): I will touch on training and continuous professional development.

Dr Williams, if the bill were to be passed, would there be training requirements to support people in respect of the right to a second opinion? Is there scope for that?

Dr Williams: I suggest that there are ways of training and upskilling clinical staff concurrently. For example, RCGP Scotland is proud of its certificate in problem drug use, the course on which we run at the moment over two half days. In November 2024, we took in close to 80 people—the course was fully subscribed. Through it, we get active clinicians thinking about the challenges of problem drug use.

It does not require legislation to get people interested and involved. I wonder whether, where there is legislation, it drives some forms of activity; however, as I said, I do not think that we need legislation, including the bill, in order to achieve upskilling across our workforce.

The change to outreach using nurses with an addiction specialty can be a way of getting expertise into community settings while avoiding the rural issue of everybody knowing everybody else, for example. It is possible to make people with expertise easily accessible and known about. There are models in the more rural parts of Lothian, for example, that demonstrate good value.

That change in practice tends to involve feedback, upskilling and changing how we train people; for example, by ensuring that people who are not prescribers are given training so that we have non-medical prescribers. Education plays a key role in protecting and assisting people who have drug and alcohol problems.

11:45

Carol Mochan: That is helpful. I am hearing that you feel that people across the professions engage with the process, which is good for us to hear.

Lyndsey, do you have a sense of whether the bill would build on people’s lived and living experience of how health professionals work on treatment determination for people with drug and alcohol misuse issues?

Lyndsey Turfus: I am not sure. We have recently had the “National Collaborative Charter of Rights For People Affected by Substance Use”, which I think is the main measure that provides a framework for people with lived and living experience. I would like to see more support being put towards that, rather than having something additional.

On inclusion and the skills that are needed, a framework has already been developed through WEDG—the workforce expert delivery group—so I wonder whether training could be built into that. We probably need to look to the charter of rights rather than include something in the bill.

Carol Mochan: Great. Thank you. Would anyone else like to comment on training?

Dr Rice: I will say only that there are considerable workforce pressures, including in psychiatry. As I was saying earlier, legislation and targets shape behaviour and set the direction of priorities, which means that other things are deprioritised. In the evaluation of the national mission, we saw comments about how it has affected prioritisation. That is relevant to workforces because this is a person business, and the hours of person time that must be devoted to a particular activity are what really matters.

The workforce issues are potentially substantial. That needs to be considered when people think about the bill.

Carol Mochan: Are you saying that the workforce is under pressure at the moment, so anything additional, including additional training, should be taken into consideration when we look at the financial memorandum, and so on?

Dr Rice: Yes.

Carol Mochan: That is helpful, thank you.

Paul Sweeney (Glasgow) (Lab): I thank the witnesses for their contributions so far.

You have mentioned in evidence issues with resourcing and some of the practical challenges that the bill's aspirations or intentions might present. Do you have any modelling or understanding of what increases in demand might be generated in terms of workforce numbers or man hours, and of which areas that might be particularly problematic or challenging in?

Dr Rice: I can start on that. One area—although it is not an aim of the bill, and the bill does not really consider it—is routes into treatment and support. We know that there is unmet need—more so in relation to some substances than to others. In Scotland, we are probably meeting about 10 per cent of the alcohol treatment need at the moment, which, in international terms, is not bad. Other places do worse.

When you are considering the scale, you need to think about the ambition, how much of the population in need we need to cover, and the routes into the treatment and support system. Any consideration of the sector needs to include consideration of routes into the specialist treatment system.

Dr Williams: I can comment. We are currently many years into primary care reform, in which we have attempted to widen the multidisciplinary team that is built around general practice. I mentioned the example of nursing outreach, with nurses being deployed from health centres. We do not have much space—even although we are digitising paper records to free up whatever available space we can free up, there is still a lot of competition to use the rooms in the primary care estate.

In some parts of our system, we can bring in extra workers and base new teams somewhere or try new combinations. However, without expanding the health centre footprint—without having extra consulting rooms, enabling people to be seen locally or even using the innovative Near Me videoconsulting service—there are currently constraints that might interfere with the ability to boost particular elements of the menu of options in the bill.

Lyndsey Turfus: We work with harder-to-reach people in the landscape of health and social care partnerships, which are, as things stand, very much constrained in their budgets. We do not currently have the financial capacity to expand, so we would obviously welcome any additional funding. However, it is not entirely clear where the funding would be allocated, so that is a concern.

Paul Sweeney: The picture that you paint seems to be quite complex with regard to patient flow, interaction and presentation, and whether you would then induce demand by creating an easier interface.

Lyndsey Turfus: The point about whether we are inducing demand is interesting. We go and look for people, and we find people, through adult protection services. That is important when we look across policies on early intervention and prevention—it affects everything from children to older people. An important point was made about the unseen aspects—our public health colleagues have referred to it as "missingness"—across that particular client group.

Paul Sweeney: That is all helpful context, but this is what I am trying to get at. There is currently a relatively known number of people in Scotland who use drugs and might benefit from rehabilitation if that service were available to them. If we assume a fairly high take-up rate, do we have an understanding of the capacity that would be required?

Obviously, everyone presenting at once would be unrealistic, but has there been any consideration on your part of the rough numbers that we would be looking at in terms of scale, staffing and facilities? It might be that all of that is perfectly fine—my question is about whether you have looked at the logistics in any detail.

Dr Rice: To answer your question directly I will say no—we have not done that modelling. We know that although some sectors are probably not bad at meeting need, others fall well short of doing so.

There is an invest-to-save case to be made. Dame Carol Black's report used the estimate—which originally came from the chief medical officer in England—that if we invest £1 we save £4.

However, I also recognise, from discussions with policy makers over the years, that the idea of simply finding a bag of money from the invest-to-save approach does not really work. It is part of the picture: there is an invest-to-save structure, and interventions can reduce costs in criminal justice, in unplanned healthcare and so on. As I said, I am under no illusion that those savings immediately pop up in the right budget and are then available to be spent. If you are doing proper modelling, that aspect ought to be part of consideration of the unplanned work that results from not meeting need.

Lyndsey Turfus: We need to be careful that the focus is not necessarily on residential rehab. I cannot recall the name of the organisation, but we have a framework of facilities that we are able to access for funded places in rehab and, as far as I know, the majority of those are used. If we had an understanding of what we could use the funding for, I am sure that we could get some modelling.

Paul Sweeney: It would be interesting to know, for example, whether requests for referral to residential rehab are not being fulfilled, and whether that illustrates unmet needs in a more critical sense—not necessarily assuming that X thousand people would theoretically benefit and that therefore we can convert that to capacity. As you said, myriad complexities and risks are associated with the subject. It would not be the case that everyone would turn up on the first day. I am just trying to get a rough idea of the scale of financial and other resource capacity that might be needed.

Also, what impact would the reporting requirements that are set out in the bill have on healthcare professionals?

Dr Williams: At the moment, some of our data is poor or absent. When somebody is admitted to a secondary care facility, they are coded—a diagnosis is made—so that we are able to articulate well about people who have a severe and enduring mental illness, for example, or who require very specialised care. To an extent, some of the most high-resource and high-intensity input will also describe people with drug and alcohol problems—again, at the more severe end of things.

However, we are lacking data on the lower level problems for which people receive input—as, I think, we all agreed earlier—even without a diagnostic label having been attached. A lot of wider very important work needs to inform our modelling and how we develop the different but interconnected services.

Dr Rice: I will comment about the requirement for healthcare professionals to report; I started to make the point earlier. Many of the healthcare professionals will not be working in specialist services. Particularly when it comes to alcohol, they will be general practitioners, staff who work in A and E or staff who work in acute medicine. Today, there will be, let us say, 70 admissions with a primary alcohol diagnosis to places such as Ninewells and Foresterhill hospitals and Glasgow royal infirmary. Those staff would also be required to fulfil the requirements that are in the bill as written, which would be a major undertaking.

I like the requirement to report to the Parliament: some sectors would benefit from that. There is a lot of reporting to do on the national mission at the moment. If we were able to broaden out reporting in the bill to other parts of the picture, that would be great. However, health professional reporting has captured a much wider part of the workforce than people might realise on first reading the bill.

The Convener: Two members wish to ask supplementary questions. We can get both in if they and the witnesses are brief.

Sandesh Gulhane: My question is simple. Do you think that the position that we face today with regard to the level of drug and alcohol deaths is acceptable?

Dr Williams: Goodness—no. It is a complex picture. We see much harm, and people's ability to seek help is hampered by stigma and fear. Some services are able to offer a wide spectrum of help, but it is clear from the number of deaths that we continue to see and the level of harm that is out there that we are not meeting current needs. Can we do that by increasing resource? Can we match the level of need by changing the ways in which we work? I think that we need to change how our systems are configured and to learn what strategies are effective and what frameworks are helpful. Things such as the charter will help us to make progress in reducing stigma and enabling people to put their hand up to step forward.

12:00

It is not a straightforward easy-to-solve problem. We will need to adapt and flex. We mentioned the ICD terminology. This is an example of an area in which the conceptual language is refined over a short period of years, and the consensus changes on what approaches to treatment work best for people with different substance use problems and for people who have other medical and mental health problems that interact with their substance use.

It is a complicated picture. I would say that we must do better as a country, but part of that will involve being able to flex and adapt, instead of simply stating a guarantee.

Brian Whittle: My question is probably for Lyndsey Turfus.

We have talked about the journey that is involved—it is not just an intervention, but a journey. Following initial intervention, support will be needed on an on-going basis. You talked about people who are hard to reach.

What role do you think that the third sector has to play in all this? How can we better integrate statutory and third sector organisations? I feel that third sector organisations have a big role to play when it comes to capacity and on-going treatment.

Lyndsey Turfus: We need to give consideration to the findings of the Feeley report in relation to the involvement of the third sector and to consider the financial position that local authorities find themselves in.

As well as representing Social Work Scotland, I work in Fife. We receive amazing support from third sector organisations, but they are reliant on short-term grants and bits of National Lottery Community Fund funding. We recently almost lost one of our services, which enables access to same-day treatment. The harm that losing that service would have caused to the community would have been indescribable.

The third sector needs to be treated as an equal. It really is as clear as that.

The third sector employs a lot of people with lived experience, which is very important. With some of our hardest-to-reach people, they might tell us to go away because we are social work, but if we send in someone with lived experience, they will open the door for us. It is as simple as that: there is a need for person-centred practice that is relationship based. Unfortunately, there is no magic bullet here.

The Convener: I thank the witnesses for their attendance and their helpful evidence. We will have a short suspension.

12:03

Meeting suspended.

12:05

On resuming—

Subordinate Legislation

National Health Service (Common Staffing Method) (Scotland) Amendment Regulations 2025

(SSI 2025/43)

The Convener: Our third agenda item is consideration of SSI 2025/43, the purpose of which is to amend the National Health Service (Common Staffing Method) (Scotland) Regulations 2024, which specify the staffing level and professional judgment tools that must be used as part of the common staffing method for specified kinds of health. No motion to annul has been received in relation to the instrument.

The committee first considered the instrument at its meeting on Tuesday 11 March, when members agreed to invite the cabinet secretary to attend today's meeting to give evidence on it. I welcome Neil Gray, the Cabinet Secretary for Health and Social Care, who is joined by, from the Scottish Government, Erin Murphy, who is a policy manager in the nursing and midwifery policy team, and Christopher Thompson, who is a team leader in national workforce planning, guidance and strategy.

I thank the cabinet secretary and his officials for agreeing to attend the meeting at such short notice, and I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Social Care (Neil Gray): Thank you for giving me the opportunity to speak to the committee. I will briefly set out the reasons for the amendments to the National Health Service (Common Staffing Method) (Scotland) Regulations.

The amendments, which are relatively technical in nature, largely take account of changes that are linked to the implementation of the reduced working week for agenda for change staff. The first half-hour reduction in the working week for those staff was implemented on 1 April last year. It is clearly important that the staffing tools that are provided for under the Health and Care (Staffing) (Scotland) Act 2019 are adjusted to reflect the new definition of whole-time equivalent working hours. Further amendments will be required at the point at which we deliver the 36-hour working week, on 1 April 2026.

I reiterate for the avoidance of any doubt that the Scottish Government is delivering on its commitment to implement the reduced working week by 1 April 2026. I look forward to staff feeling the full benefit of that change. A clear delivery plan is being set out to give confidence regarding its delivery.

As part of the Health and Care (Staffing) (Scotland) Act 2019, the common staffing method sets out a process, including the use of tools and the consideration of a range of other factors, to determine appropriate staffing levels. Those tools will need to be updated and supplemented periodically, and corresponding updates to secondary legislation will be required. The tools provide a useful source of information to support local decision making, and they form part of a wider set of systems and processes that were introduced by the 2019 act to support effective workforce planning.

To be clear, the intention is not to prescribe what staffing numbers are appropriate or to set recommended ratios at the national level. Such an approach would lack the flexibility to account for local circumstances and would fail to take account of the dynamic nature of healthcare services and the care that they are required to deliver. Instead, the approach is designed to support robust and transparent local decision making.

It is important to recognise that this is the first year following the commencement of the 2019 act and that, as more resources become available and learning takes place in the years to come, we will naturally see incremental improvements in the approach that is taken to compliance. That is not to say that some benefits are not already being felt. I am aware of work that is being done across the system to review staffing establishments as part of broader efforts to ensure that our services are fit for purpose and able to respond to the demands that we can reasonably anticipate. The act has added impetus to those efforts, and we will learn more about health boards’ experience of implementing the legislation when we receive their annual reports in the coming weeks.

I will re-engage with the Parliament later this year to give an update on the Scottish Government’s plans in the light of the evidence that continues to emerge. I will, of course, be happy to take questions from committee members.

The Convener: Thank you, cabinet secretary. Sandesh Gulhane has some questions.

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

Thank you for coming to the committee, cabinet secretary. I have a number of questions. First, have Healthcare Improvement Scotland and the Scottish Government accepted that there are flaws in the tools?

Neil Gray: No. I will bring in Christopher Thompson in a second. The tools are there to help to inform different parts of the system to ensure that staffing levels are appropriate. There is a duty on local boards to report to ministers on their staffing levels. Ministers must lay those reports and respond to them, which I will do later this year.

Christopher can correct me if I am wrong, but I do not believe that we have had any concerns expressed.

Christopher Thompson (Scottish Government): As the cabinet secretary said, it is important to point out that this is the first year of the Health and Care (Staffing) (Scotland) Act 2019. We will get the first board reports in April this year, when we will be able to get a full picture of how boards have got on with compliance with the act. HIS owns the tools and is working through a process of updating them where that is necessary. It is currently working on the maternity tool, some aspects of which could be improved on. HIS has a work plan that it will be working through to update the tools as necessary.

Sandesh Gulhane: Has the Scottish Government or HIS ever published the reliability and validity data behind the tools that are being used? Can you explain exactly how the tools were arrived at?

Neil Gray: The tools are there as guides for local decision makers in ensuring that there are safe staffing levels. As I said, they are intended to be dynamic and flexible to respond to local need and clinical demand. As Christopher Thompson set out, HIS is working on developing the tools to ensure that they are responsive—the tools are works in progress. As a result of the legislation and the work that the Government is doing with boards on supplementary staffing, significant work is on-going to ensure that establishment staffing levels are appropriate. A considerable benefit is coming through as a result of the legislation and the on-going work that is being done by HIS and by boards.

Sandesh Gulhane: Would you support publishing the data around the tools and information on how they were arrived at, even if that is on an on-going dynamic basis?

Neil Gray: Obviously, we will keep under review what we publish. We have to publish the board’s responses, which we will get at the end of next month. We will keep under review and consideration the data that is published alongside that.

Sandesh Gulhane: Do you remove time allocated for breaks from the calculations?

Neil Gray: I will need to defer to Christopher on that.

Christopher Thompson: I would have to check that with HIS, I am afraid. I can write to the committee to confirm that.

Sandesh Gulhane: The predicted absence allowance is 22.5 per cent, which the Royal College of Nursing says is the lowest in the UK and is too low. Do you accept that allowance or do you think that it needs to be looked at again?

Neil Gray: As we are setting out the tools and seeing the act being implemented in local areas, and as we see the response that comes back from boards on how they are reviewing and ensuring that they have safe staffing levels, of course we keep under review areas such as those that have been suggested by the Royal College of Nursing. The process is dynamic and flexible—it is not a one-size-fits-all approach—so that we can deal with potential elements that need to be worked on as the legislation is implemented. We keep under review concerns such as those from the Royal College of Nursing that Mr Gulhane has raised.

Sandesh Gulhane: Has the legislation provided safe staffing levels? I appreciate that a report will come out, but do you feel that the legislation has done what it set out to do?

Neil Gray: We will see what the reports from boards say. I have not had sight of those, and they are not due to arrive with us until 30 April. Challenges remain across the system in ensuring that we have sufficient staffing levels. I will not shy away from that, but I think that this, alongside some of our work with the nursing and midwifery task force, our work on GP attraction and retention and our work with the royal colleges and others on attracting and retaining staff in all disciplines, will help us to build towards ensuring that we continue to have the high-quality and safe clinical environments that people expect.

I am not going to pretend that, on every shift in every ward, staffing is at appropriate levels, because I know that we are sometimes short. However, this is about ensuring that we get to that point. Improvements in that respect will have been made over the past year, and I am looking forward to the reports demonstrating that.

Sandesh Gulhane: Thank you.

12:15

Paul Sweeney: I want to raise with the cabinet secretary correspondence that we have received from the Royal College of Nursing, which has expressed particular concern about the proposed reduction in the working week for the agenda for change staff. It claims that there had been mixed messages from the Scottish Government and health boards; indeed, it was aware of some boards proactively informing staff that further reductions would go ahead in April, and that people had made plans and arrangements accordingly. Therefore, the late announcement from the Government that a further reduction would not go ahead this year has resulted in a great loss of trust. Cabinet secretary, do you want to respond to those points from the RCN?

Neil Gray: I have engaged directly with the RCN, its leadership and its lay committee on many points since the decision was taken. With regard to the perceived delay, it was an issue on which I understood that there were very strong feelings from colleagues within the trade union movement, and I engaged with them to hear their perspective before I came to a decision. I took my time to come to that decision, because I recognised the strength of feeling on the matter, but also because of what I was being told and the advice that I was being given on ensuring that we safely implemented the commitment to reduce the working week.

There was no agreement in place about how we would arrive at the 36 hours. Given that the commitment in the pay deal was to get to 36 hours, I believe that I am implementing that deal by getting to 36 hours as of next April. I also believe that I am doing it in the responsible way, by having an implementation plan that takes place over the course of this year and that involves local area partnerships, the Scottish terms and conditions committee and the national trade union representative body. We will see draft plans coming through in May and confirmed plans from boards in October, and that will ensure that our approach to implementation guarantees that 36 hours will be arrived at in April of next year.

I absolutely understand what has been said, and I have engaged on the matter with almost all the relevant trade unions—I still have some to come—but, as I have said, this is Government delivering on the pay deal. We have not reneged. I understand the perception of the phasing of all of this and how people thought that it was going to be implemented, but there was no agreement as to how that would be done from Government. Therefore, I believe that we are delivering on the agreement that we set out in the pay deal two years ago.

Paul Sweeney: Thank you.

Emma Harper: Good morning, cabinet secretary. First, I declare an interest as a former employee of NHS Dumfries and Galloway who worked in the operating room department and perianaesthesia area. As such, I know that safe staffing is always considered in intensive care; whether there is one-to-one or one-to-two staffing depends on the number of people who have been ventilated and intubated. All of that is taken into consideration. It is my understanding, too, that in NHS Dumfries and Galloway, which is an example that I know, people meet three times a day to look at the staffing and the templates, which they use as guidance; to think about and assess patient acuity—that is, how sick the patients are; and then to make adjustments and decisions on that basis.

Just to be clear, as all of those templates across the NHS in Scotland are assessed and implemented, will we be able to look at the reports that are generated to see what is working well in one place versus what has not worked as well in another? Is that the plan with publishing the reports?

Neil Gray: I thank Emma Harper for that question, because she has illustrated what I was setting out in response to Sandesh Gulhane about the processes that are in play in all environments, in both health and social care, and what must be taken into consideration in order to understand what will be a safe staffing level for a particular shift.

Emma Harper rightly points to the fact that a number of factors will be dynamic and have to be flexible. In the example that she provided, the number of people who are intubated or in intensive care and requiring ventilation would change depending on the number of patients who are in that particular unit at that time. There is an understanding of that. The safe staffing legislation provides transparency around the tools that are used, the way in which the safe staffing level is determined, and ensuring that we comply with that across the NHS and social care estate. That is essentially what the legislation is designed to do.

Emma Harper: Is a risk assessment part of that whole process of planning?

Neil Gray: Of course. It has to be. That is why it is important that it is done at a local level, to respond to local need and the local environment, and to the various factors that Emma Harper will be familiar with, given her previous practice, in arriving at what will be required and what a risk assessment would arrive at as the best requirement for that particular shift, or for a longer period of time, depending on the environment that we are talking about. That is why it cannot be prescribed nationally. It has to be delivered locally, but we need the transparency that the legislation provides around how those decisions are taken, and when there has been challenge in the previous year, to arrive at a safe staffing level. The reports will come through in April to determine that, and the ministers will need to respond to those in the Parliament in due course.

Brian Whittle: I assume that there is a staff to patient ratio across specialisms that is fairly standard with regard to the minimum requirement. To go back to your answer to Sandesh Gulhane, I wonder whether the tools that will be used to report against that will show disparity in shortfalls and point to specific needs.

I have a very specific interest in that, because during the previous parliamentary session, under a bit of pressure, we got HIS to look at the neonatal unit in Kilmarnock, and we discovered that it was 24 staff short. There must be a better and quicker way of dealing with such a shortfall. I presume that the tools that you are implementing will be able to highlight that very quickly.

Neil Gray: They should be, yes, but to supplement that, I reiterate what Emma Harper has just put on the table and my response to Sandesh Gulhane—I cannot prejudge what will be in the reports. I will see the boards’ decisions and the risk assessments and other factors that they have used to determine what the staffing establishment should look like. When there have been issues, that needs to be clearly communicated in the reports that come through to ministers.

To add to Mr Whittle’s point, he will be aware that HIS now routinely inspects maternity and neonatal services. The first inspection is under way and we expect the reports on that in May.

In the light of what we are picking up through the boards’ reviews and other areas of learning, we will interact with boards that have a responsibility to make sure that they are honouring what they should be and providing safe staffing.

The Convener: Thank you, cabinet secretary. No one else has indicated that they wish to ask a question, so we will move on to the next item, which is to consider the negative instrument on which we have just taken evidence from the cabinet secretary.

As no member wishes to comment, I propose that the committee does not make any recommendations on the instrument. Are we agreed?

Members *indicated agreement.*

The Convener: At the committee’s next meeting, we will continue our stage 1 scrutiny of the Right to Addiction Recovery (Scotland) Bill, taking evidence from the representatives of health and social care partnerships, local government, NHS boards and alcohol and drug partnerships. That concludes the public part of our meeting today.

12:24

Meeting continued in private until 12:24.

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