HEALTH AND SPORT COMMITTEE

Wednesday 14 November 2007

Session 3

£5.00

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Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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HEALTH AND SPORT COMMITTEE
8th Meeting 2007, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Jamie McGrigor (Highlands and Islands) (Con)
Irene Oldfather (Cunninghame South) (Lab)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Chief Superintendent Simon Blake (Grampian Police)
Sandy Cameron (Stocktake of Alcohol and Drug Action Teams)
Patrick Layden (Scottish Government Legal Directorate)
Robert Peat (Angus Council)
Catriona Renfrew (NHS Greater Glasgow and Clyde)
Tom Wood (Scottish Association of Alcohol and Drug Action Teams)

CLERK TO THE COMMITTEE

Karen O'Hanlon
Simon Watkins

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Wednesday 14 November 2007

[THE CONVENER *opened the meeting at 10:02*]

Subordinate Legislation

Contaminants in Food (Scotland) Amendment Regulations 2007 (SSI 2007/470)

Materials and Articles in Contact with Food (Scotland) Regulations 2007 (SSI 2007/471)

The Convener (Christine Grahame): Good morning and welcome to the eighth meeting in session 3 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are turned off, please. Apologies have been received from Michael Matheson and Dr Richard Simpson, who is ill.

We have two instruments to consider under the negative procedure. Scottish statutory instrument 2007/470 will enforce a European Commission regulation that will revise the maximum level of fusarium toxins—I should have practised saying that—in maize and maize products. The Subordinate Legislation Committee has raised no issues in relation to the regulations.

SSI 2007/471 will enforce a European Commission regulation on good manufacturing practice in respect of materials and articles that are intended to come into contact with food, and will implement a directive on materials and articles that are made of regenerated cellulose film and are intended to come into contact with food. The Subordinate Legislation Committee drew our attention to the regulations on the ground that an explanation had been sought from, and provided by, the Scottish Government.

No comments have been received from members and no motions to annul have been lodged.

Do members agree that the committee does not wish to make any recommendations in relation to SSI 2007/470 and SSI 2007/471?

Members *indicated agreement*.

Natural Mineral Water, Spring Water and Bottled Drinking Water (Scotland) (No 2) Regulations 2007 (SSI 2007/483)

The Convener: Agenda item 2 is consideration of another instrument that is subject to the negative procedure. The purpose of SSI 2007/483 is to amend the Natural Mineral Water, Spring Water and Bottled Drinking Water (Scotland) Regulations 2007 (SSI 2007/435), which we considered on 31 October. The regulations contained a drafting error.

We had arranged to take evidence from a representative of the Food Standards Agency Scotland, but he has had an accident, unfortunately—I trust that it did not have anything to do with our calling him before us—and he has been taken into hospital. Therefore, I welcome Patrick Layden QC TD from the Scottish Government's legal directorate, who has been given the task of speaking to us. I ask him to speak to the regulations and to then take questions from members.

Patrick Layden (Scottish Government Legal Directorate): I regret the absence of Sandy McDougall of the Food Standards Agency Scotland. However, the interests of the FSAS and the Scottish Government Legal Directorate in the matter are the same, so I am grateful to the committee for allowing me to represent both organisations.

First, I apologise unreservedly on behalf of the FSAS and the Scottish Government Legal Directorate for the typographical error that caused us to have to replace SSI 2007/435. I will explain how the error was made. The process of drafting this Scottish statutory instrument—which is, in essence, a revocation and re-enactment of previous SSIs—began some time ago, but was delayed last year because the regulations had to be referred to the European Commission under the technical standards and regulations directive. Work resumed this summer. The process involves the FSA in London preparing a draft which is then passed on to FSA Scotland and to my office. We look at such things critically, because everyone is concerned to get such things right. We do not draft our own regulations in Scotland because doing so would not be very user friendly: the people who use the regulations prefer to have the same regime north and south of the border. Therefore, even in cases in which we could do things differently, we try to do things the same. However, we take account of drafting and other alterations that have been made in London and we ask why things are being done in particular ways.

In this case, the draftsperson in England was replaced after the summer, and the new person rearranged some of the material. We took account

of that in our next draft, but that was when the typographical error came in—regulation 12 is where the error occurred. I have copies of the regulation with me if committee members would like to see it. A look will make it clear what happened: the word "not" was missed out in regulation 12(1)(b). In spite of the fact that lots of people looked at the regulation here, in Aberdeen and in London, the error was not picked up.

I do not know whether committee members have noticed, as I have, that once you imagine that a word is there, your eye runs over it and you seem to see that it really is there. The point was not noticed before the instrument was laid on 20 September, and it was not noticed in either of the committees of this Parliament that considered the regulations. The point was finally noticed by a stakeholder who looked at a copy of the regulations and said, "What's all this?" As soon as we found out about it, we sent a submission to the minister and presented a new statutory instrument.

The end result was that the new instrument came into force before the old instrument had come into force, so there was never a time when the law was wrong. However, we deeply regret having made the mistake, we deeply regret not having noticed it, and we deeply regret having wasted the committee's time with a replacement instrument. I apologise for that.

The Convener: There are no questions from committee members, so I thank Patrick Layden. We are all somewhat culpable—certain committees here should perhaps have noticed the mistake along the way. What has happened just shows that it is often the person who has to implement a statutory instrument who notices problems and asks, "How on earth do I do this?"

I thank Mr Layden for coming to explain what happened. We will all, including the Subordinate Legislation Committee, have to pay more attention in the future.

Patrick Layden: We all will. Thank you very much indeed.

The Convener: Are committee members agreed that the committee does not wish to make any recommendation in relation to SSI 2007/483?

Members *indicated agreement*.

Budget Process 2008-09

10:08

The Convener: For agenda item 3, I welcome Tom Wood, who is the chair of the Scottish Association of Alcohol and Drug Action Teams. I wonder whether Mr Wood would like to make some opening remarks before we move to questions.

Tom Wood (Scottish Association of Alcohol and Drug Action Teams): Good morning, and thank you very much for inviting me. I am sure that I speak on behalf of all of us who will take part in the panel later on when I say that I am pleased to be here and am pleased to have the opportunity to take part in a candid discussion.

I am not here to lay blame or to describe how people have failed and/or have not done things in the past—the debate in this country has been polarised and held back because it has been turned into a blame game, which is very unfortunate. We should not forget the progress that has been made or the enormously good work that has been done by the previous and present Governments and their civil servants. Nothing that I say today will detract from that good work.

Alcohol and drugs is a complicated and extremely wide area; I will restrict myself to a few remarks about budgets and spends, which I know will be the committee's core business today. When considering budgets and spends in this area, the first problem that we come across is that we do not know how much we spend. We know how much we spend through dedicated health and social services budgets, but that is only some of the money that we spend on dealing with alcohol and drugs across the board. In local authorities, the health service, the justice system and other areas, we do not actually know what we spend. Therefore, it is very difficult to judge whether we spend the money wisely or well.

Bold attempts have been made as recently as 2000 to calculate total spend. As far as I know, however, we do not have an accurate figure for the total commitment. Some countries have made good attempts to find out. For instance, work on that has recently been done in Australia: I have details from that study with me if any members would be interested to read them later.

The other difficulty concerns how funding has been managed and directed. In the recent past, funding for alcohol and drug action has been piecemeal and has been routed through a number of different channels. In Edinburgh, for instance, there are six distinct funding streams in respect of drugs. They operate through various statutory and non-statutory agencies, each of which has

different terms and conditions and service-level agreements and each of which works over different periods. That complex tangle of funding militates against planning for the future and having a secure platform for service delivery.

In addition, special initiative funding has very much increased lately. That means funding for new things, new initiatives and quick wins, which has sometimes been at the expense of core funding. I have described it to people as being like the icing on a cake. Over the past few years, there has been more icing, while the cake has been nibbled away. The people whom I represent frequently despair over the fact that, although funding has been released for new things, especially in relation to drugs, the old routine things—the core services that we know work—have slowly been eroded. They have been proved to be successful, but they are not sexy and they are not a quick win. That is an unfortunate trend in the application of funding.

I will say a word or two about the context of the situation in Scotland. Let us make no mistake about it: the prevalence rates for alcohol and drugs are very high—they are perhaps the highest in Europe. In previous evidence to the committee, it was commented that nobody has found the magic bullet. That is right, but a lot of countries in Europe are making a better job of managing the situation than we are. Most countries in Europe have, with a co-ordinated and long-term vision, turned the trend around and are controlling the situation better than we are, so there are lessons to be learned from other countries, although I am not saying that we can cut and paste or superimpose the Dutch or Scandinavian models here. Sometimes, we in Scotland think that we are unique. That is a strength, but it can also be a weakness. It is a weakness to think that we cannot learn from others. I think that we can learn a lot from others.

Having spoken about prevalence rates, I urge the committee to remember that the majority of people, including young people, do not take drugs and do not use alcohol harmfully. Sometimes, we get ourselves into the mindset that the problem is too big or that the issue is enormous, that it encompasses all of us and that we will never get out of this situation of despair. That is not the case. About 27 per cent of the population, according to the statistics that I have read most recently, had used alcohol harmfully—and the debate is about what is harmful and what is not. Only 1 per cent of the population use drugs to the extent that they are seriously addicted and require service. They are a minority, albeit a very difficult one to deal with.

10:15

I will not go on speaking all day, but I will mention differences between how we handle the problem and how it is handled in more successful models. How we regard the problem is a big issue. We have traditionally regarded drugs as a justice issue—almost a moral issue—and we have talked about a drug war. However, we regard alcohol in a completely different way. Over the years, we have allowed alcohol to creep up on us until it has almost become part of our national character. As members will have heard a dozen times—the papers have been full of this during the past week—alcohol is a far bigger and more deeply rooted problem in society than are drugs.

However, that is not reflected in spend and funding. During the past 20 years we have given an awful lot more money to drugs, in particular at the justice end of the issue, than to alcohol services. Alcohol services have traditionally been poorly funded and it will take a long time to put in place adequate funding across the board for alcohol services. It is interesting that national figures for the United Kingdom support the assertion that about half the money that we have spent in the past 20 years has been spent on justice interventions. About half of that has gone on treatments, much of which were to do with medical responses to the problem, such as methadone.

Recovery and prevention services have been the poor relations. If I can leave the committee with one message, it is that we need to concentrate on recovery and prevention. We must try much harder and we must apply many more resources if we can, or we must adjust the resources that we have to tackle those areas. I am not an economist, but from my economics classes at university I remember the balanced efficiency model, which shows that we must invest equally in different areas of our business if we are to have an efficient organisation, structure or machine. We have not been doing that. There has been far more investment in justice, some investment in treatment and very poor investment in recovery and prevention.

I make a plea to the committee: the people whom I represent require cool-headed leadership, pragmatism and long-term upstream thinking. If we are ever to get ahead of the problem, we need to invest our money where it can do the most good. We need to invest in young people and families. We need to invest in the unborn and young children who are in an environment in which there are alcohol or drug-dependent people, instead of pouring lots of money into lost causes.

The people whom I represent have no fear of the toughest performance outcomes that Parliament wants to give us: give us the toughest

outcomes on finance and performance, but give us the tools to do the job. If Parliament does that, I am confident that the hundreds of people I represent will do a first-class job. We can turn the problem around. We are already making progress.

The Convener: Thank you for your impassioned presentation. Parliament has tried to deal with the issue. I remember our first debate on alcohol, in 2000, when I said that alcohol is often a gateway drug. Many members have served on committees that have dealt with the issue.

On 28 November the Health and Sport Committee will take evidence from three cabinet secretaries: the Cabinet Secretary for Justice, the Cabinet Secretary for Finance and Sustainable Growth, and the Deputy First Minister and Cabinet Secretary for Health and Wellbeing, in an endeavour to pull together and ascertain whether we can apply funding more strategically, as you ask. I was convener of the Justice 1 Committee during the first session of Parliament and it saddens me that long-term funding is still an issue. Perhaps now that we have a mature Parliament we will make progress.

Ross Finnie (West of Scotland) (LD): Thank you, Mr Wood. That was very helpful. I think we know the answer, but it would be good to hear it from you. We talk in terms of resource and finance, but I presume that what you are really talking about is the level of resource to people within the specific areas that are your province. That is not to say, as you rightly pointed out, that the drug and alcohol problem does not stretch across a number of portfolios.

I presume that you are talking about people. It is slightly worrying to hear that the icing is covering a cake that is getting smaller. If you are talking about people, that would imply that if a Government allocates to a body or to a local authority money that includes an inflationary settlement, then it ought by definition to cover the wages of everybody currently employed by that body. If that has not happened, does that imply that the alcohol and drugs element of those budgets has been slightly lower in the pecking order?

Tom Wood: There have been no inflationary rises in core budgets in the past two or three years. Let us be clear: additional moneys have been given in both alcohol and drugs—nothing like enough in alcohol, but substantial sums nonetheless. However, those moneys have been given for special projects, which has been a way of achieving some kinds of performance outcomes. I can understand the thinking behind that, but the fact that the money has been given for specific projects, over specific times, with specific target outcomes, has resulted in a considerable lack of leeway in how the money is used. At the same time, there have been no inflationary increases for core services, which has meant that the cake has shrunk by inflation. Over the past three years in my city, it has shrunk by about 4 per cent or 5 per cent, but the icing has been enhanced. The balance ought to be considered.

Mary Scanlon (Highlands and Islands) (Con): I think that we are all in favour of cool-headed leadership. Across parties, there is total commitment and determination to do something. One of my party's commitments was to provide £100 million for drug detox and rehab. However, what I really want to ask is where we should put the money so that it is effective, so that we get the results that we hope for, and so that we get value for taxpayers' money.

I know that you wanted a candid discussion, and I hope that you will understand that I am not looking to lay blame, but I need to understand whether that money should go into the alcohol and drug action teams. Is that the best place?

I looked up Sandy Cameron's "Report of the Stocktake of Alcohol and Drug Action Teams". What he says when he talks about your organisation is quite incredible. He says that some partners

"appeared marginalised, disengaged and, sometimes, resentful and this undermined effective co-operation."

He went on to say that they found "serious shortcomings" in several, including

"poor leadership, lack of commitment and an insufficient understanding of the strategic aims of the ADAT."

He also said that

"In a number of ADATs the members had no shared vision"

and that some operate

"with overstretched support teams even when financial resources were available."

I am not looking to lay blame but, as a member of the committee, I need to understand what went wrong and whether it has been put right. Are the ADATs the proper channel for the investment that we all want? I would be grateful if you would explain what has been done since Sandy Cameron's report to address its criticisms.

Tom Wood: Mary Scanlon asked a number of questions. Let me take them from the top. First, you talked about "cool-headed leadership". I am very encouraged by the commitment of ministers—currently and in the recent past—to this issue. I agree that robust leadership and determination to get something done are being shown, which is illustrated by the fact that we are here today.

Alcohol and drug action teams were set up in 1994, with a lot of responsibility but not much

power. Very little funding is routed through the alcohol and drug action teams—they are partnership organisations that are as strong or as weak as their components. If additional moneys have flowed through the alcohol and drug action teams, it would only have been en route to the other major funding partners within the teams. The four big partners are local authorities, health boards, the voluntary sector and the police, although there are others.

Professor Cameron is here today, and he will speak later about what is happening with ADATs. I will attend a meeting this afternoon with ministers and senior civil servants to discuss what we will do about the stocktake. I cannot argue with much of what Sandy Cameron's report says—he is absolutely right to say that the ADATs are a mixed bag. However, they were set up like that, and they were never empowered to do the job that they should be doing. The choices are clear—we either empower them to do the job, or we give the job to some other organisation or structure.

The most important part of Mary Scanlon's question is on where the money should go. I am clear that it should go on recovery services, with particular emphasis on young people and on children who are being brought up in drug and alcohol-dependent households. We must also try an awful lot harder at prevention. We have, to be frank, been unsuccessful over the past 20 years at preventing many of our young people from getting themselves into difficulties with alcohol and drugs. We all accept that it is very hard to do: it is difficult throughout the world, but some countries are doing a much better job than we are. We have to try harder, and we need to work harder at getting those areas right. Upstream investment is the way to go.

Mary Scanlon: We are all agreed on prevention, recovery and treatment. I made a point on that earlier. However, your teams were overstretched even when you had enough money—when financial resources were available. You did not answer on whether those criticisms of the ADATs have been addressed, whether you recommend that additional money should go through the alcohol and drug action teams, whether those teams are more robust than they were when the criticisms were made, and whether you can guarantee value for money and an effective approach to drugs and alcohol. In case I do not get in again—

The Convener: Heaven forfend—I am very relaxed.

Mary Scanlon: Just in case. You said that you do not want money for "lost causes". How do you identify a lost cause?

Tom Wood: I will address that question first. We have to make tough decisions. We all want there to be enough money to do everything, but there is not, so we have to make hard decisions about what to invest in. We have to be robust and pragmatic enough to invest our scarce resources where we will get most back and where we will have a better chance of success. That is the real world. I say again that we need to invest in recovery services. That means proper recovery services—I am not talking about counselling alone. Housing support and family support are just as important as counselling and medical interventions, but they are peripheral and are out on the verges of alcohol and drug treatments.

Mary Scanlon: I understand that. Will you give me an example of a lost cause?

Tom Wood: There are people who are so far down the road of addiction that all we can do is maintain them and keep them alive. The chances of recovery for some people in such circumstances are, to be candid, very small. Those are tough decisions, but we cannot keep spending all our money where there is very little chance of recovery.

Mary Scanlon: Do you mean people who are on the methadone programme—sometimes for decades?

10:30

Tom Wood: Some people have been addicted for many years and the chances of their ever making a complete recovery are very slim. Of course we have to do our best to keep them alive and in the best possible way, but the chances of their making a full recovery, becoming drug free or holding down a job are very slim. That is the truth of the matter. We have to make tough decisions.

The work to put the ADATs right is being done right now—that is what this afternoon's meeting is about. Professor Cameron's report is relatively recent, but when he made the point that some ADATs had a lot of money and still had problems, he was referring to one or two, not all of them. As I said, the ADATs are a mixed bag—some are big, some are small; some are good, some are bad; some are efficient, some are not so efficient; and some are well resourced, while others are not so well resourced. Whether the teams are good or bad depends on the partnership—on who is round the table taking part. However, there is not a systematic approach, which is not a sustainable business model. You will soon see major reforms to the way in which alcohol and drug action teams do business. All of us who are in the action teams and who want to do a good job look forward to the reforms.

The Convener: I see that Mary Scanlon has another question, but I want to let other members in just now.

Helen Eadie (Dunfermline East) (Lab): The witness's evidence has been impressive. I am particularly interested in the paper that he mentioned when he said that Australia has endeavoured to identify how it spends its money. I and perhaps other members would be interested in having a copy of that paper, because it sounds relevant to our work. He went on to say that there is no magic bullet, but that lots of countries in Europe are doing better than we are—he mentioned the Dutch and Scandinavian approaches. We would be particularly interested to hear about how those countries have tackled the issues and to have the best practice in those countries highlighted.

I sympathise with the convener, because she does not have an easy job but, just in case I, too, do not get to ask another question, I ask Mr Wood to identify areas of pragmatic upstream thinking. I know that the British Medical Association and the royal colleges say that it is possible to get people off methadone—that is the relatively easy part—but that the hardest part is changing habits and getting people into a social environment that enables them to continue to thrive and survive. Will you comment on that medical opinion?

The Convener: I assure members that they do not need to ask all their questions in one big bite—I will let them back in for supplementaries if a point occurs when somebody else has asked a question. I say that just to put members at ease.

Tom Wood: The BMA is absolutely right. It is possible to get people off methadone or substitute prescription; the trouble is keeping them off. That requires the kind of wraparound and recovery services that I have talked about, including employability services and housing support. It is hugely frustrating for people whom I represent who run recovery services to see someone come out of a recovery service and go right back into the environment that they came from, sometimes living with or next door to their drug dealer. Drug addiction is a chronic relapsing condition. Relapse is to be expected and a lot more information is coming out about how addiction works in the brain and what it means. You and the BMA are absolutely right that we need to provide more such services.

That is the secret of the success in some of the continental countries that I spoke about. They have a greater range of services and can apply services from that range to individuals on a case-by-case basis. For instance, the Dutch have a huge variety of services, with everything from compulsory hard-ended stuff in prisons to soft early interventions out of prison. They have heroin prescription on one side and cognitive behavioural therapy on the other. They have a vast menu of services from which to choose; we do not. We have services in certain parts of the country but not in others and the range of services here is not as comprehensive as it is in many other successful countries. It has to be said that other countries—including England and Wales—spend substantially more per head on the client than we do.

I am determined not to say, "Gimme, gimme, gimme—we need more money," which is always the easy thing to do. We cannot escape from the fact, however, that funding levels in Scotland—particularly for alcohol services and particularly when compared with the successful models—are low compared with those in other countries. Because they concentrate on the work and have a range of services, their client base shrinks. For example, Holland has about twice the population that we have but half the number of people in drug services because it has worked hard and been successful at whittling the number down. Of course, the fewer people you end up with, the more resources you can concentrate on them.

The Convener: You mentioned drug services, but what about alcohol services, or is alcohol not such an issue in Holland? Alcohol is a gateway into drugs. I note your figures: 27 per cent use alcohol harmfully but only 1 per cent use drugs. Those figures are for the UK, I think. Does Holland not have the same issue with alcohol?

Tom Wood: Alcohol is just as big a problem, but most other European countries consider alcohol and drugs together. In fact, they consider alcohol, drugs and tobacco together, with the three being regarded as gateways to each other, and they deal with them in the same way. Interestingly, only one other country in Europe—Spain—has a justice lead for drugs. Every other country in Europe regards the issue not as a justice issue or a moral war but as a health or community issue. In Scandinavian countries, for instance, powerful communities departments within the Government structure deal with many issues including addiction to alcohol, drugs and tobacco.

Helen Eadie: Sweden has stringent alcohol laws—we need to bear that in mind when we think about the Scandinavian model. I am not sure about Denmark or Norway, but it is difficult to access alcohol in Sweden. I am persuaded by what the convener said. She suggested that, because 27 per cent of people in the UK use alcohol harmfully, that should be a bigger focus for our attention. Will you comment on the fact that Scotland is regarded as having one of the worst alcohol problems in Europe? In that context, it might not be apposite to compare Scotland with Holland.

Tom Wood: All those countries have worked hard to attack their alcohol problems. We have a lot to learn from them. It is interesting that drinking is increasing in the UK, whereas in all other European countries it is reducing. We are now number 3 in the world in terms of what we drink. Finland and Ireland beat us, but the UK comes third. The increase is a worrying trend and a huge concern.

There is another big concern. When I speak to my European colleagues about future threats, they talk not about heroin and cocaine but about young people drinking alcohol and taking strong cannabis in combination. That has long-term consequences for people's health—there are huge implications in that. If we are thinking about upstream priorities, the big issue for 10 years down the road is not heroin, cocaine or any of the other hard drugs that we hear about, but alcohol and cannabis in combination, which have a ratcheting effect with one another, the results of which we are already starting to see.

Ian McKee (Lothians) (SNP): Alcohol is a huge problem in Scotland, and it seems to me that the alcohol services that your teams provide might be losing out by being linked with drug services. Drugs are a major problem, but although there are similarities in patterns of addiction and points of entry from one kind of addiction to another, the fact remains that alcohol is a legal commodity and drugs are illegal. The drug treatment service in Edinburgh began with infectious diseases money, in an attempt to prevent the spread of HIV, and I assure you that in the early years of that service no one was at all concerned about how many drugs were prescribed or whether the amount of drugs being prescribed to an individual was increasing, so long as there was evidence to show that that person was less likely to spread HIV as a result. The two problems have different treatment backgrounds and challenges, and are of different magnitudes, so why do we lump them together and allow one to lose out by concentrating on the other, which is a bit more glamorous? Perhaps glamorous is the wrong word.

Can you comment on the balance between maintenance treatment for people on drugs and attempts to get them off drugs? The latter, although we would all like it, is an enormously complex problem. If someone who has been taken off drugs is sent back to the home or the estate where they lived before, they will face the same problems and the same people who enabled their addiction in the first place. You say that you will not deal with lost causes, but your definition of a lost cause will involve someone being kept on methadone, which is an expensive medication; supervised consumption at a pharmacy; and regular visits to the doctor. When you said that you would not pay attention to lost causes, I thought that you were going to deny people all sorts of treatment altogether, but you are still talking about pretty expensive lost causes.

Finally, how do ordinary people who have problems link up with the outflow of drug action teams? You mentioned your customer organisations—if that is the phrase. How do you monitor whether the mechanisms that health boards put in place for people who need help are adequate to provide that help expeditiously? There is a lot of evidence that people are not getting that help at all at the moment. Do your organisations monitor that, and how do you decide what you are going to do about it? In particular, when people are transferred from the Scottish Prison Service to the community, there is a huge gap in continuity of care, and someone coming out of prison is immediately back on high levels of drugs.

Tom Wood: That is a multistranded question. Let us start with the important point about alcohol. I am well aware of the fact that a huge number of people who work in alcohol services are deeply concerned about linking them with drug services, because they fear that all the resources will go to drugs. Alcohol services have been very much neglected over the past 20 years, but that is no longer the case. We try to prioritise alcohol services as much as we can. As I say to all public bodies, the alcohol problem is a far, far bigger, more deep-rooted and deep-seated problem than drug use is, and it affects a lot more people.

I know your background, Dr McKee, and I have no doubt that you will have come across these problems throughout your professional career. Alcohol is by far the bigger problem, and you are right to say that it needs a separate plan of attack. In some ways, it is quite simple. The World Health Organization has laid out clearly how to deal with alcohol addiction; it is about price, availability and the co-ordination of services to deal with the consequences of the availability of alcohol. It is also about enforcement of the law, good recovery services, education and so on, but price and availability are key. Of course, that idea is not popular with people in the licensed trade and the alcohol industry, but I am sorry to say that we cannot get past it, and this country will have to bite that bullet.

10:45

On maintenance, it is unfortunate that methadone in particular has been given such a bad name, because it has done a good job. What Ian McKee said is right; I was a young policeman when heroin first hit the streets and the huge threat of HIV and AIDS was incredibly real. An enormously good job was done through needle exchanges, for example, and courageous decisions were made—about the methadone

programme, for instance. An HIV and AIDS epidemic in Scotland was successfully prevented.

However, the world has moved on. Whereas we have had and still have an effective methadone programme, the recovery bit has been missing. I agree that that is complicated, expensive and time-consuming, but it is essential. If we want people to function fully again by standing on their own feet, holding down a job and a house tenancy, and looking after their families, we need to do the recovery bit. Other successful models prioritise the recovery element and intervention with young people.

On how we monitor health boards, we must be honest that alcohol and drug services are not priorities for most health boards or local authorities. I know of only one or two health boards or local authorities in Scotland that give more money to dealing with addictions, whether alcohol or drugs, than they are required to, or than is ring-fenced for that purpose. We have to work very hard to ensure that the money that is allocated by the Government to that cause is used for that cause. At the moment, that is done through the corporate action plan. Every drug action team in Scotland has a corporate action plan in which the health board and local authority sign up to delivering a specific service over a specific time. The plan is not as streamlined as it could be—the document is pretty cumbersome—but the Scottish Government is reviewing it as we speak.

I hope that I have answered all the strands of the question.

Ross Finnie: I am sorry to press you, Mr Wood. Ian McKee asked a relevant question when he identified quite crisply the different histories and backgrounds of alcohol and drug services. With respect, I do not think that you expressed why alcohol and drug services are best joined. Your opening remarks made it clear that you would address that, but your answer did not.

You also introduced generally the complex issue of supply and price. However, in a country that has one of the highest levels of taxation on alcohol products, the question of price is not a simple one, and, again with respect, I do not find loose generalisations on that point helpful.

Ian McKee also specifically asked you about lost causes. The latter part of your answer made it clear that you think that it is essential to have programmes to assist people to get off methadone. However, your earlier answers said that those people were lost causes, and so, by definition, no resources were going to be applied to helping that cohort to get off drugs. I hope that I am not putting words into my colleague's mouth, but those were pertinent questions and I ask you to narrow down from the general to the more specific in your answers. Your opening gambit was very helpful, but the committee is looking for more specifics so that we can address the question.

Tom Wood: No one has ever accused me of being slack with my answers before, Mr Finnie, so let me be specific.

On the price of alcohol, our taxation rates might be high, but so is discounting. The reality is that alcohol sells at half the relative price that it did in 1980. Whether we attack that by increasing taxation or preventing discounting is really a matter for you, but I—and the people with whom I work who provide front-line services—believe that alcohol is too cheap at the moment. We tend to concentrate very much on pubs and clubs. However, the real issue for the young drinker is promotions in off-licences and supermarkets. I hope that I am making myself clear when I say that sooner or later we will have to tackle that issue.

Let me also clarify what I meant by lost causes. I am not suggesting that we withdraw services or deny them to people. That is morally objectionable and, under the law, it would be impossible to do so. I simply said that we should invest more in areas where we will achieve better results, which might mean having to make a judgment about people who have been addicted for many years and who, frankly, will not make a full recovery. In such cases we are obliged to maintain life and limb, but we should not deceive ourselves about the chances of those people making a full recovery; it is just not going to happen. Resources are fixed, so we have to make hard decisions about where we invest our money, and I repeat my belief that it should be invested upstream, in young people, in recovery services and in trying to prevent people from getting into trouble in the first place.

Have I missed anything?

Ross Finnie: Yes—the combining of alcohol and drug services.

Tom Wood: Everyone accepts that a great deal of alcohol abuse is not connected with drugs. However, there are also an enormous number of clients for whom there is a connection between alcohol and drugs. Most drug users also abuse alcohol. In my neck of the woods, there is almost no such thing as a drug death. I realise that that is what such deaths are called, but the fact is that they have been caused by a combination of drugs and alcohol. As I made clear in my comments about future threat, we have to treat alcohol and drugs together because the current trend among younger people is to take such substances recreationally. We have already heard warnings

from Europe about the threat of alcohol combined with strong cannabis.

I do not want to do anything to jeopardise alcohol services—indeed, quite the reverse. However, the reality is that over the past 20 or 30 years alcohol services have been pretty poorly supported. We simply have to be aware that, although a huge number of people drink but do not take drugs, a good number of people take both substances. Keeping both things absolutely separate makes no sense.

Rhoda Grant (Highlands and Islands) (Lab): Will you expand on your comments about the need to invest in prevention and in protecting children—including unborn children—in households where there is alcohol or drug dependency? What kind of services would be required in that respect and what benefits would such an approach have?

Tom Wood: One of our most successful interventions in recent years has been with women in the early stages of pregnancy who are using drugs and/or alcohol harmfully. After all, becoming pregnant is a natural turning point in a woman's life, and we have found that people at that point are much more willing to make the change, step forward and embrace services. Such intervention is also hugely important because, if we are successful, we will not have to intervene when the child is five or six years old and much damage has already been done. At that point, we can be faced with some very stark options, such as removing the child from the home or providing some very intensive treatment. Although such an approach is pragmatic, it plays on the fact that at that time families—and, indeed, women—are much more liable to recognise the dangerous path that they are following and to make changes. We must have services ready to intervene, there and then, to help them to do that; we must not put them on a long waiting list.

Rhoda Grant: What happens to children who are brought up in homes where there are drug problems?

Tom Wood: It is a huge problem. About 40 to 50 per cent of people who come through the door of drug agencies in Scotland have family protection issues. That puts enormous workload pressure on all areas of social service. There is a difficult balance to strike. The simplistic solution is to take the child away, as we see in the papers, but we all know that the outcomes of taking children into local authority care are not always good. This will be a huge growth area and responsibility for us for the next decade. At the moment, we are dealing with the young children of the drug-using population of the late 1990s and the turn of the century. However, we know that over the past four or five years drug use has increased, so there is a backfill still to come. That will be a huge problem for us, and there is no easy answer to it. Right now it is vexing and taxing all areas in local authorities, especially social work children's services. Robert Peat will speak more authoritatively than I can on that area. It is difficult to get the issue right.

Rhoda Grant: I have a supplementary to my earlier question. You talked about the icing getting bigger and the cake getting smaller. What is the cake? What services do you think are being squeezed by initiatives? Was that spending decision made at Government level or at partnership level? Why is the squeeze happening, and where is it happening?

Tom Wood: Services in the localities are being squeezed. I refer to the clinics—many of which are in the voluntary sector—that provide drop-in and counselling services on housing estates. The squeeze is an unintended consequence. Rightly, Government is trying to get a better handle on performance and outcomes. No one can blame it for that—I would do the same. Government is allocating money for specific initiatives, such as mandatory drug testing and drug treatment and testing orders; there are many other examples. However, the money is strictly confined to specific purposes, over a specific time, with specific outcomes. That is what I describe as icing. At the same time, because for the past two or three years there have been no-growth budgets, services in the localities are getting slimmer and slimmer. They are getting 2 or 2.5 per cent less funding per year.

It is for Government to decide how to allocate funding. It may decide that it wants to fund initiatives, rather than the other services that I have described. I am merely pointing out that the unintended consequence of that decision is that the cake is getting a wee bit slimmer and the icing is getting bigger. I am not sure whether that is the most effective balance for us.

Rhoda Grant: Is the problem caused by health boards and local authorities giving drug and alcohol services ring-fenced money—as you mentioned earlier—but no more than that? Is the money that could have been used flexibly to provide the services that you have described not allocated in the same proportion because ring-fenced money, which cannot be used flexibly, is available? Health boards and local authorities may be investing the same amount of money, but they are not taking account of the fact that some of it is ring fenced and are failing to compensate services for money that was previously provided.

Tom Wood: I understand that health boards and local authorities are receiving no-growth budgets from the Scottish Government.

Rhoda Grant: Some of that money is also ring fenced.

Tom Wood: Yes. Less money is coming from the Scottish Government for those core services and local authorities find themselves unable to contribute more funds. There are some notable exceptions, such as Glasgow, which has nailed its colours to the mast and come up with substantial additional funding. However, most local authorities and health boards have simply passed on the money that they are required to and have not augmented it in any way because they have other priorities, which is understandable. That has brought about this narrowing.

11:00

The Convener: Earlier, you seemed to suggest that ring fencing was not a good idea because it applied only to sexy projects that could deliver measurable results and that the balance of money had to come out of the core funding. However, later, you said that a lack of ring-fenced funding for alcohol and drug services was a problem.

Is it your argument that alcohol and drugs should be perceived as a single issue for society, rather than one being perceived as a social issue and the other as a justice issue? Do you think, therefore, that ADATs should also receive funding from the Government, while the ADAT funding that comes from NHS boards should be ring fenced for various projects' core funding, or whatever? ADATs could be responsible for reporting back to ministers on the outcomes of that funding.

Tom Wood: I am sorry if I have confused the issue. I know that ring fencing is no longer seen as the way to go, but money should be reserved either by ring fencing or by outcome agreements, which do the same thing. Further, the fewer discrete subdivisions that are enforced within that pocket of money, the better, because that means that there will be more room for leeway and discretion, which will benefit the ADATs and their partners.

The Convener: Earlier, you said that, when your organisation was set up, you were not given the power to do what you were supposed to do. When you talk about power, are you talking about funding coming to the ADATs, which would then control it?

Tom Wood: That is one way of doing what I am talking about. However, the important thing is that someone—ADATs or some other organisation—has to have both the power and the responsibility. There is no use having one without the other.

The Convener: Three cabinet secretaries are coming before the committee on this issue. Would you argue that one Government directorate should be responsible for drugs and alcohol rather than the four—if we include the education and lifelong learning portfolio—that are involved at the moment?

Tom Wood: Certainly, European countries that have more successful models than ours have one lead department. Usually, that is a health department; sometimes it is a community services department; and sometimes it is a recreation and healthy living department, if such a thing exists.

The Convener: We are dealing with the budget today, so we had better leave the discussion at this point. However, some interesting issues have been raised, such as that of the European models, and members might wish to revisit the committee's work programme in order that we can explore those at a later date.

I thank Mr Wood for his evidence.

11:04

Meeting suspended.

11:10

On resuming—

The Convener: I reconvene the meeting and welcome the second panel, which comprises representatives of a health board, a police authority and a local authority—we felt that the subject crosses all the boundaries. Catriona Renfrew is the director of corporate planning and policy in NHS Greater Glasgow and Clyde; Mr Robert Peat is the director of social work and health in Angus Council; and Chief Superintendent Simon Blake is from Grampian Police.

Thank you for your forbearance. I hope that you found the previous evidence session interesting. I ask you to make short opening statements if you wish—it is not compulsory to do so—after which the committee will ask questions. In answering questions, you should be self-selecting unless a member directs their question at a specific panellist.

Catriona Renfrew (NHS Greater Glasgow and Clyde): It is important to make clear the basis on which I am speaking to the committee. As well as being a director of NHS Greater Glasgow and Clyde, which is responsible for delivering health care services to 1.2 million Scottish people, I am the chair of the alcohol action team for our board area. In Glasgow, we separate alcohol and drugs in our strategic planning, and I speak on alcohol on behalf of the health board, eight local authorities and Strathclyde Police, which all fall within our board area.

I will begin by saying a bit about the budget context. The committee will have been confused

by the earlier discussion because, essentially, there are two different sources of funding, in budget terms. In our board's case, the AAT and the drug action team get £10 million of funding. The health board spends a further £23 million of its mainstream allocation—which has been increasing—on drug and alcohol services. Our local authority partners also spend similar sums of money, so the total pot for drug and alcohol services is much more substantial than AAT and DAT allocations. I suggest that the biggest issue is the total value of the pot rather than the routes via which it comes—that is a difference between my view and that of Tom Wood.

The Convener: Can you give us the figure for local authority spending?

Catriona Renfrew: I am sorry but I do not have that figure, and I do not want to speak for local authorities. It is important to keep a clear line between what I can and cannot speak on.

Ian McKee: Is the amount about the same?

Catriona Renfrew: I think so—but I could get that information from the local authorities in our area without great difficulty.

The Convener: That would be very useful, thank you.

Catriona Renfrew: What we cannot do is separate out drug and alcohol spending by health board and local authority because, as Tom Wood said, a lot of the services are integrated.

A lot of people present with drug and alcohol problems. Only 10 per cent of our serious alcohol misusers and only half of our serious drug misusers are in treatment services, yet we have probably the highest proportion of people—

The Convener: Sorry, I missed that. Did you say 10 per cent?

Catriona Renfrew: Ten per cent of serious alcohol misusers—not people who occasionally binge drink or who regularly drink slightly more than the recommended unit limit—and 50 per cent of serious drug misusers are in treatment. Our spending on services at the moment is approaching £50 million, yet we are reaching only 10 per cent of alcohol misusers and only half the drug misusers. That gives you a sense of the scale of the treatment issue and the multimillion pound gap that exists.

We estimate that, in greater Glasgow and Clyde, around 20,000 children live with either a serious alcohol misuser or a serious drug misuser. However, only half of them get any kind of social care or additional family support service. Again, that gives you a sense of the scale of the issue. The truth is that the 10,000 children in those circumstances who receive no support will be the next generation of drug and alcohol misusers. That takes us back to one of the initial points that was made in the previous discussion, which was about the spending on the consequences of drug and alcohol misuse and the failure to tackle the entry routes.

I have two more points to make if you will allow me, convener.

A policy has been pursued in the UK and in Scotland over the past 20 years that has allowed increasing access to alcohol at increasingly lower prices. Prices are now significantly lower, and we have almost unlimited access to cheap alcohol in Scotland. In every part of Scotland, every night of the week, we see the consequences of that for the police, for social services and for health services, and the price is increasing every day. It is the biggest public health issue in Scotland, notwithstanding our concerns about and focus on drugs.

In 2002, the estimated cost of that policy of unlimited access to cheap alcohol was about £1 billion of public money, which was spent on social services, criminal justice, the police and the national health service. That information was published in the "Plan for Action on Alcohol Problems", which the Scottish Executive put together at the time. On one level, there is no shortage of money going into alcohol services and tackling the issues of alcohol, but it is going to the wrong places. It is being spent on picking up the pieces following increasing drinking, increasing disorder and the increasing social damage that is caused by unlimited access to cheap drink.

The Convener: Thank you. We move on to Mr Peat.

11:15

Robert Peat (Angus Council): I am the director of social work and health at Angus Council and I chair the combined drug and alcohol action team in Angus. I am also the lead person on alcohol and drug issues for the Association of Directors of Social Work.

The issue of alcohol and drugs has an impact on a wide range of local authority services, including social work services, criminal justice services and the other services and support that we provide in the community to people in and returning from prisons. I wish to focus on children's services, particularly those that we provide for children who live with substance-misusing parents. Those services place significant pressure on local authority social work budgets. Over the past few years, funding to local authorities has increased for work in children's services—mainly for preventive work with young parents and children in their early years. It is right that we focus on that

area. I hope that we will see the benefits in future years.

The difficulty now is that, while we are trying to do that work, we continue to deal with crisis situations. Over the past five to seven years, the number of child protection referrals has been increasing and more children are being looked after, either at home or in accommodation. More young people are being accommodated with foster carers or kinship carers, with a reduced dependence on residential settings. We want to maintain children with relatives or, if need be, with foster carers. However, those services are being placed under significant pressure.

Angus is a relatively small local authority area, with alcohol and drugs issues that are similar to those anywhere else in Scotland. You might think that we would not have the same problems in a nice rural area such as ours, but we do. In the period from April to June this year, for example, 22 children were added to the child protection register. In 90 per cent of those cases, they were placed on the register because of parental alcohol or drug use. We face a significant problem.

There is a real difficulty in social work departments and among our partners around how we ensure that children get back home. At the moment, we find that children are not being reintegrated back into their families in all instances. That is difficult to address. We need to get more children back home and families need to move forward, caring for their own children. For that to happen, we need to focus much more on parenting issues—working with parents on how they care for their children and on family relationships. That is difficult when people are using alcohol and drugs, but we need to do that work.

Generally, we have been focusing more on drugs. We have responded to drugs issues where they are present in families, but we have responded less in relation to alcohol issues. We should be thinking less about the alcohol and drugs, and more about the behaviour. Workers need to identify problematic behaviour and then consider how to improve the situation.

I agree with what Catriona Renfrew said. I do not have the statistics to hand, but we use the ring-fenced money that is allocated to alcohol and drug services. The key issue, however, is that local authority services, including mainstream services, are affected by alcohol and drugs. Significant resources are dedicated to addressing those issues. The money will not be labelled as alcohol or drugs funding, but the demands that are placed on our services mean that we are devoting significant resources to addressing those matters.

The Convener: Thank you. I invite Chief Superintendent Blake to introduce himself.

Chief Superintendent Simon Blake (Grampian Police): Good morning. I have a largely operational and generalist policing background.

I echo many of the comments that have been made. Identifying the budget spend for the police on tackling drugs and alcohol issues is a problem, because although we have specialist units that target drugs problems—such as drug squads—I think that almost every police officer would say that drugs and alcohol issues are insidious and affect a huge percentage of our work in our core policing and specialist roles. My lay experience of partner agencies is that it is the same for them. It is quite difficult to chunk off the budget for tackling drugs and alcohol issues.

My main message is that the approaches should be balanced. The Association of Chief Police Officers in Scotland's drugs strategy is to reduce supply, demand and harm. That results in good headlines, but the issues are complex. Plainly, the police are the leaders on enforcement issues, but we are also active on the softer side—in education and triggering other agencies. That is the right approach, but my point is that no one agency has the answer and that no one approach provides the answer. Our experience plainly indicates that it would be wrong to focus on one element. A balance must be struck in respect of the competing demands for the budget.

Operational officers see the chaos that results from alcohol misuse and drug abuse for individuals, society and families. I echo the concern for the children who are associated with that chaos.

Alcohol never went away. For a while, much of the public discussion focused on drugs issues, which are hugely important. Our continuing enforcement activity has shown benefits in disrupting the national and international supply of drugs—there are indicators of that, which we can discuss if the committee wants to do so. Discrete local enforcement action can impact on local markets, the availability of drugs and the harm that is caused. However, alcohol is also a significant issue for the country. I suspect that the average operational officer will say that alcohol creates more work, because it creates more social and individual chaos. Therefore, the focus on alcohol must be maintained.

I will give some simple local statistics. In the two months since 1 September, 75 per cent of serious assaults in Aberdeen are believed to have been carried out by people who were either drunk or under the influence of alcohol, and alcohol has been involved in 70 per cent of recent breaches of

the peace. That is a snapshot, but the figures are stark.

I could continue, but I will cease and await questions.

The Convener: From the police's point of view, is there a divide? Is it fair to say that, in general, crimes of violence result from people taking alcohol, and acquisitive crimes result from people taking other drugs, although, obviously, chaos also results from that?

Chief Superintendent Blake: A lot of acquisitive crime is definitely driven by drugs in the traditional sense. Tom Wood spoke about when he was a young police officer. When I was a young police officer, before drugs came along—

The Convener: We are picturing that.

Chief Superintendent Blake: I will not go there.

Before drugs came along, a huge percentage of our work related to dealing with disorder, violence and acquisitive crime that were driven by alcohol. An element of that work has continued. Drugs have added to it.

The Convener: I intend to invite members to ask questions in an order that reverses the order for our questioning of Tom Wood. I will work my way round the table.

Rhoda Grant: I want to pursue the line of questioning that I pursued previously, on the services that are required for children and young people who are growing up in homes in which people are dependent on alcohol and drugs. What services and statistics are needed? Catriona Renfrew mentioned that most children who do not get access to services will end up abusing drugs or alcohol. Has that situation been monitored? Is the statistic real? What do we need to do to support those children and young people?

Catriona Renfrew: The children in greater Glasgow and Clyde who do not receive a service need basic services to support their family and to support them to stay in and get some value from education. None of that is rocket science—that is the basic infrastructure that is required to ensure those children have the quality of life that children who do not live in substance-misusing families have. As my colleague Robert Peat said, that also involves working with a family to address the issues and trying to get parents into drug or alcohol misuse services. That is more of the same of what we do with children and families through health services and social care services for all sorts of situations, but the quantification presents us with a challenge.

Staging is an issue. We are very concerned that children from zero to five who are in chaotic families are sometimes invisible because they have not yet entered the formal education system. If they have a disrupted childhood, by the time they enter that system they are miles off the pace and the attainment that a five-year-old normally has on entering school. We in greater Glasgow and Clyde are exercised by those lost children.

Robert Peat: As Catriona Renfrew says, it is important for services to work closely together, particularly in the early years. Health services should link with the local authority social work service, particularly if child protection matters are involved. Each area has child protection procedures in place and it is important that they work effectively.

It is essential to work with parents on their alcohol and drug issues, as Catriona Renfrew says. Work with families is resource intensive. The problem is that we are dealing with crisis situations, and local authorities do not have the resources to do that intensive family support work.

Chief Superintendent Blake: When a crisis occurs and the police are involved, fairly good mechanisms pick up almost all incidents in which children are involved on the periphery. We try to identify and report those situations. However, we are concerned that some of our colleagues have resourcing issues with meeting the need that we identify at the front end.

Rhoda Grant: In the area that I represent—the Highlands and Islands—two groups deal with children and young people who are young carers. The huge majority of the children that they deal with are in families where there are drug and alcohol misuse problems. Those children take the lead in running the house and caring for an adult. The organisations in my area tell me that that work is hugely expensive but that those young people find it easier to deal with a group that is not attached to the social work service, so they need not worry about being taken into care. They can access in their own right services that are designed for the child rather than the family. I am interested in your comments on such services, which provide advocates to help young people with education and access to health services and benefits.

Robert Peat: Young carer services are fundamentally important. In Angus, the Princess Royal Trust for Carers provides those services. Our drug and alcohol action team provides a small amount of money for a worker to support young carers.

Local voluntary organisations play an important part. Barnardo's and Tayside Council on Alcohol work with young people who may have alcohol or drug issues or who are affected by parental substance misuse. The voluntary sector plays a significant part in supporting those young people,

for the reasons that you gave. Sometimes, people do not want to have a relationship with their local authority.

However, it is fundamentally important that the voluntary organisation—be it the carers centre or another body—links with the local authority when appropriate. Under the hidden harm agenda, protocols are in place to ensure that all agencies make appropriate referrals if there are significant concerns about protection of those children.

Catriona Renfrew: It is really important not to lose sight of the intergenerational link. Most of us learn our drug and alcohol behaviour from the circumstances in which we live, so there is a strong correlation between the drug and alcohol behaviour that children observe and the behaviour that they go on to pattern. A compounding effect comes from the loss of opportunity, the lack of attainment and the loss of educational connection.

In discussing dealing with the current problem, as opposed to prevention and trying to work more upstream, we cannot emphasise enough the need to focus on those vulnerable children. If 20,000 children in Glasgow are in those circumstances, we can probably assume that that figure is 70,000 or 80,000 throughout Scotland.

11:30

The Convener: The figures are appalling. For me, the focus will now be on the children in those families. We might try to get someone from the voluntary sector to come to the committee. The timescales are short for our budget considerations, but it would be interesting to hear about voluntary sector funding. We have all met young carers, and we know that they often hide what is happening in the house because they do not want to be taken away from mummy—or from the passing daddy who happens to be there at the time.

Ian McKee: I was very interested when Catriona Renfrew said that the amount of money coming in from the health board and the local authority was a lot when compared with the amount of money coming in from the drug and alcohol teams. Is the funding structure an efficient way of spending money on the treatment of alcohol and drug problems? Also, I ask all three witnesses whether they feel that alcohol and drugs should be treated as separate issues.

Have you noticed a link between alcohol and/or drugs and areas of deprivation? I know that alcohol and drugs affect all areas of society but certain research suggests that the problems are much greater in areas of deprivation. Is it possible that the countries that deal with these problems much more successfully than we do have societies that are less stratified? Having a more equal society could make these problems easier to tackle.

Catriona Renfrew: On the funding issue, I part company with Tom Wood. We have not found it a problem in our AAT and DAT arrangements to pool the resources from our mainstream budgets and from specific allocations, and to agree how to use them in a comprehensive and strategic way. However, although we have not had a problem, Sandy Cameron's report, which committee members have seen and will discuss later, illustrates that that might not be the case around the country. Our primary problem relates to the total pot of resources and to the fact that so many of the resources for drugs and alcohol are spent on picking up the pieces and not on preventing the breakage in the first place.

The funding problem that has been raised is not an issue in NHS Greater Glasgow and Clyde. Our funding is transparent and we have an agreed formula for the distribution of resources through the DAT and the AAT and through local authority planning groups, which then decide on local priorities. The system works effectively for us. It is not without tension when money is short, but it works within the strategic framework.

The delivery of services for drugs and alcohol problems should not be separate. A number of people use both services and a number of the service responses have to be the same, whether the person is misusing alcohol, drugs or both. We therefore have integrated drug and alcohol services as our primary entry point to services in community addiction teams. There is sometimes a differentiation between specialist drug and alcohol services. However, we want a single entry point where need is assessed.

We part company with some others in relation to our view that, in strategic planning, the focus of alcohol and drug services is different—for the reasons that have been outlined, such as legal and cultural reasons. Many people in this room will drink too much. Most of us probably do not take illegal drugs—although that would perhaps not be a good question to ask.

The Convener: Do not look at me when you are saying these things.

Catriona Renfrew: I do not want to catch anyone's eye.

The Convener: I have a reputation to defend every day.

Catriona Renfrew: We have separate alcohol and drug planning structures but we bring them together at local authority level. The AAT and DAT meet jointly. Where there is overlap, we do joint planning. We are a big board area; obviously,

other areas will face challenges on a different scale.

Ian McKee asked about deprivation. If one of my public health colleagues was here, they would give you endless illustrations of the relationship between deprivation and drug misuse, which is very strong. There is also a strong—but not as strong—relationship between deprivation and alcohol misuse. Among the population who are not deprived, many more people drink too much and misuse alcohol than misuse drugs.

My public health colleagues would argue that inequalities in income and opportunity are a primary driver of drug and alcohol misuse in this country. They would tell you that if we want to tackle alcohol misuse at the upstream point, we must start by tackling child poverty, particularly as partners, because health boards need to influence other players, as well as delivering treatment and prevention services. NHS Greater Glasgow and Clyde has set out its stall and works with local authorities and other partners to tackle child poverty, as a primary approach to dealing with social problems that are manifested in drug and alcohol misuse. We have agreed a joint alcohol policy with Glasgow City Council and the police that includes a range of actions, from delivering services to lobbying the Government and local licensing boards. We are trying to make a difference by acting across a range of alcohol-related issues.

Robert Peat: Catriona Renfrew gave a comprehensive answer. As happens in Glasgow, we deal with alcohol and drugs differently at the strategic level, although there is one drug and alcohol action team, because there are different issues at the strategic level. For example, our focus on alcohol Angus project was developed so that we could engage with wider community planning partners. It is fundamentally important that the DAAT is linked to community planning arrangements in the area.

The Convener: Which wider community planning partners do you mean?

Robert Peat: Community planning partners include local colleges—in our case, the universities in Dundee—and people who deal with environmental issues and the economy. Alcohol impacts on the services that are delivered by a much wider group of partners, so there are opportunities to work with such partners to address the impact of alcohol. For example, the Angus environment forum deals with issues to do with taxi licensing, whether toilets are open when the pubs close, whether taxi ranks are in the right places, noise levels and so on. Wider partners who are not necessarily in the DAAT have a part to play.

There is a clear link between alcohol and drugs and deprivation. However, Kirriemuir—I do not know whether members know the town—has a significant drug issue, although it is a small town in a rural area and would not be regarded as an area of deprivation. There are complex issues—

The Convener: You can take it as read that members of the committee are fairly experienced and are well aware that we are not talking about just an urban problem. We know that in places such as Eyemouth and in parts of the Highlands there are problems—there are particular problems with drugs in fishing ports, for example.

Ross Finnie: The panel's evidence highlights the difficulty for the committee, in that it is impossible to separate policy issues from finance allocations. It is slightly absurd that we are concentrating on a budget paper and trying to decide on which monetary figures we should focus our attention, given that all three witnesses have given evidence on how policy and finance are inextricably linked. Catriona Renfrew's more evidence-based account of supply hit on a serious policy issue, which is that alcohol is not a prescribed or controlled substance. The Licensing (Scotland) Act 2005 contains mechanisms whereby we can try to deflect offers, but competition law applies in such matters and the 2005 act does not control alcohol per se.

I want to ask Catriona Renfrew about resource. If health boards get more resources, I suspect that the constabulary will be left with a bigger resource issue. You provided statistics on total spend, which was helpful, and—even more helpful—you were more specific on the part of the population that you can cover. We could all spend a billion pounds more. None of us would have great difficulty in doing that, even at home—

The Convener: You always look at me when you make such comments.

Ross Finnie: I just like to defer to you, convener.

If there were to be an incremental resource increase, what improvement in outcome could be achieved? Can Catriona Renfrew help the committee by saying whether the percentages need to be increased if we are to achieve better outcomes, or whether we must contemplate much wider cover, to address the needs of serious drug or alcohol abusers and the children in their families? Is better allocation the issue? The witnesses from social work and the police might also have a view on that.

Catriona Renfrew: On the direct allocation of resources, a significant expansion of drugs and alcohol treatment services is a priority. Our view is that the priorities for that expansion should be people with children and the services that support

those children. If we had £20 million or whatever, that would be the priority.

There are questions about efficient service delivery. We have been able to expand year on year the number of clients that we get through services by focusing on assessment, efficiently processing people and reducing duplication between health and social care. However, I do not mean to imply that there is no room for generating growth in treatment through efficiency and different ways of running services.

The other key point is that we are wasting money on alcohol services if we do not also act to reduce alcohol consumption, because as fast as you give us more money to treat people, there are more people to treat. The trends on the graphs increase day on day, month on month and year on year.

There has to be a focus on what we do as employers. We are the biggest employer in our area, so we have a raft of work to do with the 50,000 people who work for us. There is a stream of people who misuse alcohol, and we must focus on inequalities of income and opportunity, as well as on enforcement, pricing and advertising, to prevent that misuse. The Scottish cup is sponsored by Tennents and Glasgow's Commonwealth games bid was sponsored by Diageo. We are giving incredibly mixed messages about our attitude to alcohol and its place in a healthy society, which presents everybody with challenges.

On enforcement, we are lobbying Strathclyde Police. I do not know what Simon Blake will say about that. It is illegal to serve people who are drunk, yet every day in Scotland millions of people who are clearly intoxicated are served alcohol. One of the steps that we need to take, using the existing law, is to give people the message that that is not acceptable any more. The culture is changing in Scotland, just as it changed in relation to drink-driving. Once, it was thought to be okay to drink-drive, even though it was illegal. We are in dialogue with the police about using the existing law and existing process to give the public a different message about alcohol. Fundamentally, the issue is about changing people's attitudes across generations.

Helen Eadie: That is a powerful message. I agree that attitudes to drink-driving have changed significantly in the past 15 to 20 years. People now recognise that drink-driving is unacceptable. The committee can work on that.

I can almost guess what each of you will say in response to my next question. How can we identify the money in the budget heads? You said that drugs and alcohol issues are insidious. If we cannot identify the money in the budget heads, how can we shift resources around? How can cabinet secretaries and ministers see where allocations should be shifted to reflect priorities? At your level, with all due respect, you are stuck with finite sums of money. Have the ways in which resources have been shifted around in recent years been beneficial?

Also, to what extent are you aware of the work that is going on in Australia? Apparently, some progress is being made there with attempts to home in on budget allocations.

I have another question, convener, in case I do not get in again, on the issue of work at a European—

The Convener: We will take those questions first. I will let you in again—I give you an assurance.

Helen Eadie: Thank you.

11:45

Chief Superintendent Blake: I echo the comments about the preponderance of alcohol and drugs in society. Especially in the case of younger people, we would be unwise to be complacent and to assume that more affluent parts of society are immune. Our experience is that alcohol abuse in particular is evident among young people with disposable incomes, and we have some fairly startling examples of parents supporting that behaviour.

It would be sensible for the separate alcohol and drugs budgets to be managed together, because there is crossover in treatment and service provision. However, although we travel down the same route, we often veer off for separate actions for alcohol and drugs.

I support the comments about the availability of alcohol in Scotland. I know that ACPOS has made comments about forthcoming legislation. We are seeing young people going out and becoming extremely drunk. They often frontload—as we call it—by buying heavily subsidised and discounted alcohol from supermarkets and shops and drinking it in their own homes, the homes of friends or in public places. They then go to licensed premises.

The Convener: MSPs are well aware of that problem.

I would like you to address the issue of moving resources. We are trying to focus on where the money should go.

Chief Superintendent Blake: I picked up the earlier comment about constabulary. Of course, I argue that the front-end role of the police in enforcement is vital. We react to many of the debris-on-the-streets situations. On people who are in distress and chaos, we also have a key role

in triggering service provision by other agencies, because providing such services is not a police role.

It is a complex situation, but there is a good and well-established example in Aberdeen. Alcohol Support in Albyn House was set up 23 years ago, and we as operational officers have taken drunk and incapables there instead of locking them up and introducing them into the criminal justice system. The place has been resourced for a number of years, although I think that it is currently under a degree of threat. If it were shut, the budget would, in effect, be transferred. The workload would go to the rest of the public sector, creating work for the police, the criminal justice system and the Crown Office and Procurator Fiscal Service.

Closing Albyn House would affect health provision. I can think of a concrete example, which I will keep suitably anonymous. Two alcoholic brothers followed fairly criminal behaviour patterns: one was quite violent. Police officers in Grampian knew them well, and they were extremely problematic and a heavy drain on housing, social work, health, police and criminal justice system resources. When they went to places such as Albyn House and were introduced as drunk and incapable, they accessed support services immediately—which is key—and disappeared off the radar for months. That meant something in terms of service provision and capacity for the police and the other organisations that are represented here, and it was an intelligent use of money. Budgets shifted in real terms.

The Convener: Is Albyn House a charitable organisation?

Chief Superintendent Blake: It is, but it receives funding from the local authority and the health board.

Mary Scanlon: And help from the Church of Scotland.

Catriona Renfrew: May I amplify that response? An economic analyst could spend an enormous amount of time at national level deriving programme budgets for alcohol and drugs and trying to identify every bit of spending on them, because it is difficult, not least because of some of the fuzzy lines around criminality and alcohol and drugs. What is just criminality and what is criminality caused by alcohol, for example?

At a local level, we need to improve how we shift money between agencies and how flexible we are in using cash. It is enormously difficult to do that when we are all short of money to deal with the alcohol and drug problem. We are not in a position to have an academic debate about where the next £1 million goes, because there is pressure at every point.

It would be perfectly legitimate to try to develop a policy framework that says that the police, the NHS and local authorities as the three primary funders—the voluntary sector is important, but it does not bring cash to the table—should examine how they pool resources and move them between budget heads. However, it would be difficult to do that at a national level.

Robert Peat: To an extent, it is fair to say that we have not done that on the basis of good evidence to date, but we need to do it.

The Convener: Mary Scanlon has the next question.

Helen Eadie: You said that you would let me back in, convener.

The Convener: After others, Helen. I will let Mary Scanlon in first—she may address the issue that you want to raise.

Mary Scanlon: My first question is for Simon Blake. Inverness has an equivalent to Albyn House—Beechwood house—which is absolutely first class and means that people who are picked up off the street do not take up a police cell. However, there is a problem with longer-term funding. Mr Blake said that he recognises the resource needs of local government. To be helpful, I ask whether that was diplomatic shorthand to express his frustration that there are many people like the brothers that he mentioned about whom he feels, "Oh, for goodness' sake—you again." Was that diplomatic shorthand for the frustration that you and police officers feel about the fact that many people who could be helped are not helped, through no fault of local government, but through a shortage of resources?

Chief Superintendent Blake: I am grateful for the way in which you phrased that question—thank you.

Mary Scanlon: I tried my best.

Chief Superintendent Blake: In short, my answer is yes. A recent snapshot showed that between 27 and 34 per cent of the custodies in Grampian Police either were drug users or had an alcohol dependency and that, of the drug users, about 50 per cent were on methadone. That is in no shape or form critical of the methadone programme, but we see repeated entry into the criminal justice system because of the chaotic lifestyles and behaviours of people with substance misuse issues.

We are responding to incidents and families in crisis. Some of the pick-up from measures such as mandatory drug testing and, in particular, arrest referral is good, but there is frustration—that should be just the start of the process. When people are arrested during a period of crisis, they might be open to intervention. We have evidence

that they are open to that, although I understand the debate about whether people stick with programmes. However, capacity is definitely an issue, and it frustrates our partners, too.

Mary Scanlon: I turn to my fuller question. People talk about detox and rehab. My understanding is that a person's detoxification is paid for by the NHS and lasts about six weeks, whereas rehab is paid for by local government—that is certainly the case in the Highland Council area. After six weeks of detox, people often have to barter for funding, depending on their progress. I had a recent example of that. Would it help to have a single budget, so that people who go through detox are not left halfway through their recovery if the council does not have money for rehab?

I am trying to put the process into sections. The ideal process would be to have detox, rehab and then the long road or transition back to employment. After detox and rehab, who is responsible for taking people and their families back to the world of work, to help them and society? As far as I am aware, support just falls away after rehab.

Catriona Renfrew: We need to be careful about that, because the arrangements differ throughout Scotland. In Glasgow, the addiction service is a single integrated service with a single budget. People make decisions about what will happen to clients and the money follows. We do not have a debate about whether the money is a health pound or a local authority pound, or whether it is for detox or rehab. That is why we created an integrated service.

To return to the policy issue, one problem is that we have no clear national statement about the services that local authorities and the NHS are expected to provide for drug and alcohol problems, so it is left to local discretion. There is no statement about the expectations of service provision, nor about the responsibility for that provision. A point was made earlier about people who come out of prison and require treatment. Breaks in treatment arise because in Scotland there is no consistent approach to dealing with people who come out of prison. We could have a national policy statement that the NHS and local authorities are required to provide treatment and care to drug users who come out of prison on a programme, but no such statement exists. Therefore, at present, if people come out of Barlinnie and go to Glasgow they get a service, but if they go to Ayrshire and Arran they have less possibility of getting a service because of the long waiting times. There is no consistent policy and there are different models of providing services. Debates about health pounds and social care pounds happen in some places in Scotland but not in others.

Mary Scanlon: The whole system has simply evolved rather than there being a strategic policy with responsibilities or remits.

Catriona Renfrew: That is right. Tom Wood kindly said that we put our hands in our pockets to tackle drugs and alcohol. We do that because they are the biggest health problems that we face and it is important that we spend health money on them. Other health boards have taken different positions on relative priority. I suppose that because the problems are so extreme in Glasgow, it is difficult to pretend that they are not health problems and therefore not allocate resources to them.

Mary Scanlon: Before Mr Peat answers, will you take the following into account? Given that, as we speak, the Cabinet Secretary for Finance and Sustainable Growth is talking to local government, and given what Catriona Renfrew has just said about roles and responsibilities, are the drugs and alcohol budgets vulnerable? We are all aware that the budget will be tight this year. In addition, Rhoda Grant mentioned the voluntary sector. Is its budget also vulnerable, given the squeeze?

The Convener: I do not think that the panel is able to answer those questions at the moment. We will see what has happened to those budgets only when we have the budget in front of us—unless the witnesses feel that they can answer the questions.

Robert Peat: I do not think that local authorities will say that they will not dedicate resources to address alcohol and drugs issues, because those problems have such a significant impact.

Mary Scanlon: I was just wondering about the potential for increases and decreases in those budgets.

Robert Peat: We need to look at the range of funding and how it is integrated. We have community safety moneys and youth justice moneys, and we need to consider them together to decide how best to use them. The problems that alcohol and drugs cause are so significant that local authorities must address them with the commitment of their partners at local level—they are not problems for just one agency to tackle.

Integration works better in some areas than in others, particularly in health services and local authority social work departments. There is a genuine opportunity for DAATs to ensure that the wide range of services that are needed are in place, but also to work with community justice authorities to ensure that there is a good link between the alcohol and drugs agenda and the offending agenda, particularly with those offenders who have alcohol and drugs issues. We also need

to consider how community justice authorities can support the work of DAATs and vice versa. CJAs offer an opportunity to go forward more effectively.

Catriona Renfrew: I offer a comment about the squeeze on budgets. The total level of NHS and local government funding is a political decision that is made in this place. A budget and a set of policy imperatives are then passed down to us. The critical issue for us will be how we marry those two aspects.

When we as the chairs of AATs and DATs met Shona Robison and Fergus Ewing, I made the point that if money is tight and the imperatives for the NHS are about waiting times for acute services, savings will have to be found elsewhere to fund those imperatives. There is interplay between overall funding levels and how they are passed down, and the priorities that are set by the Government and Parliament. Drugs and alcohol services have not been set as a priority for NHS and local authority resourcing to date; they have been set as a political priority, and we are told, "You must do something about this," but that is not the same thing.

The Convener: Ross Finnie raised an interesting point when he said that you cannot separate policy from funding when you receive your priorities. If the priorities are alcohol and drugs, that is a policy. I found it interesting when you said that there is no national policy statement about drugs and alcohol, and that nobody is being told who is responsible for what, why and so on at strategic level. Am I correct?

Catriona Renfrew: I will amplify what I said: there is no requirement on local authorities and the NHS to assess needs in their areas or to demonstrate how they are meeting needs for drugs and alcohol services, how they apply funds for those services and how they ensure that anyone who needs those services can get them. For example, if someone needs a hip replaced, we have to replace it within a fixed time. We cannot say that we are short of money or that we do not prioritise that patient; there is a bottom-line limit. If someone needs a primary care appointment, they have to get it within 48 hours. Neither we nor local authorities have such obligations in respect of drugs and alcohol services, which are inevitably deprioritised, because they are not imperatives on which we and local authorities are measured.

12:00

The Convener: We can raise that issue with the cabinet secretaries.

You talked about integration, which is working in your area, but you said that it must be done at local level and cannot be done at national level by integrating the various cabinet secretaries' policy and funding obligations. I asked the previous witness, Tom Wood, whether someone should be entirely responsible at Cabinet level for drugs and alcohol policy and funding, and I think that his answer was yes. However, you are saying that integration is not possible at national level and that it must take place at local level.

Chief Superintendent Blake: I go back to my first comment—the issue is insidious, therefore it cuts across all that we do. It is difficult for one person to have the knowledge and support to address it. If the issue is a strategic imperative across all departments, that will filter down to professionals, officers and volunteers at local level.

The Convener: I promised that I would let Helen Eadie back in, but before I do so I will ask a final question. We must make hard choices. You and Tom Wood prioritised early intervention and recovery. You have identified 70,000 vulnerable children in Scotland. Dealing with them would be the intervention part; dealing with their families would be the recovery part. If cabinet secretaries are to make a hard choice, should those be the areas in which they invest money? Are you saying that we should expect a big hit not in two or three years but eight years down the road, because we will have broken the cycle?

Catriona Renfrew: I return to my previous point: if any other NHS service is needed, we must deliver it, but if someone has a drugs and alcohol problem, service provision is optional. That must be challenged, because drugs and alcohol problems patently are real health and social care needs, just like the needs of disabled people and people who require hospital treatment. There must be a public policy debate about why we treat the health service's and local government's provision for those illnesses differently.

The Convener: I will not dwell on lost causes or the recycled alcoholics who are costing a lot of money. As you argue, the health service and local authorities should have an obligation to deliver drugs and alcohol services—at the moment, there are no such obligations, as the services have been deprioritised. However, if we have to make a hard choice on funding, should the committee tell cabinet secretaries that we expect them to spend their money on the specific category of children and families? Would that be appropriate?

Robert Peat: I will probably disagree with Catriona Renfrew. Local authorities have a statutory responsibility to assess need for community care services, regardless of whether someone has an alcohol or drugs issue, is an older person or is someone with a disability—no such distinction is made. However, if resources are identified for one area, it should be for

investment in children and in supporting families in which children have substance-misusing parents.

Catriona Renfrew: We assess people, but the issue is whether they get services to meet their assessment. The phrase "lost causes" is extraordinarily unfortunate. Anyone who has a drugs or alcohol problem should be treated. Some people may not make a full recovery or any recovery, but they should all be treated and they should all attract the attention of the services for which we are responsible.

Helen Eadie: We all know that political priorities are set at different levels of government. Today we have seen that there are priorities that are set at Scottish Government level and programmes of work that are set at local government level. Programmes of relevant work are also set at European level, with the other member states of the European Union. How and to what extent does each of you engage with that work? The work programme for the European Union for health and related matters, for which we have a limited competence, includes issues that are related to drug and alcohol policy. Funding streams are available for some of the priorities. How do you interact at a European level in working groups, task groups or work to share best practice and experience?

Robert Peat: I am a member of the Scottish Advisory Committee on Drug Misuse, which is meeting shortly and which is looking at connections with particular European countries. That is an opportunity to examine further evidence from other countries. At a local level, we use the data that are available. We in Angus have no formal links with other European countries, but we look at research data and literature about work that has been carried out not only in Europe but in other parts of the world, and we take that into consideration.

Helen Eadie: You are not a member of any work groups or task groups that are sharing experience and knowledge.

Robert Peat: Personally, no.

Catriona Renfrew: Our primary links at a European level are through our public health director, who connects with all sorts of public health policy networks at that level.

Robert Peat: We also link with European colleagues through professional bodies such as the Association of Directors of Social Work.

The Convener: I want to keep the focus on the funding. We are marrying policy with funding.

Helen Eadie: It is related to funding, because there are funding streams from Europe in the context of special programmes of action. That is why I am asking how far the panel members have gone out of their way to make themselves aware of that and how they interact at that level. It is clear from what they say that someone at another level is interacting, but none of them knows how.

Robert Peat: We have a local authority funding officer—it is a corporate post—who highlights any funding opportunities that arise.

Helen Eadie: So the Association of Directors of Social Work does not do anything in that area.

Robert Peat: We link with European colleagues, but at the moment we do not have any formal links in relation to alcohol and drugs or funding opportunities. We have not accessed any of those.

Helen Eadie: So you are not aware of the programmes of action.

The Convener: I am going to move on because, although that is funding, it would not be part of the budget itself.

Helen Eadie: Can we hear what Simon Blake has to say? He wanted to make a comment.

The Convener: Bear in mind that we are focusing on the ministerial budget that is coming before us. Can I suggest—

Helen Eadie: This is relevant.

The Convener: No, Ms Eadie.

Helen Eadie: There are funding opportunities from Europe. If the Scottish Parliament and the Scottish Government do not have as one of their priorities the need to access that European funding and knowledge, we need to know that. The witnesses who are here this morning can tell us. Mr Blake was about to tell us what they know in Grampian.

The Convener: With respect, I appreciate all that—we have drifted a bit on other issues as well. That funding would be additional to the budget, as I understand it. It would not be part of the ministerial budget.

Chief Superintendent Blake: All I was going to say is that, unfortunately, I have no knowledge of our being active in Grampian at the European level. Nationally, there is a great deal of co-operation with Europe through activity such as international drugs enforcement. There is, doubtless, a sharing of resources there, but I do not have the detail.

Rhoda Grant: Moving funding in a policing budget from one head to another was mentioned earlier. It is illegal for licensees to serve people who are already drunk. The police pick up those drunk people off the streets as they come out. Would it be a better investment to fund the policing of licensed premises to ensure that the licensees are fulfilling their legal obligations not to serve

drunk people, so that you do not have to pick those people up off the streets when they come out?

Chief Superintendent Blake: Without a doubt, effort in that regard would be useful. Some of the realities have to strike home—we are a large organisation, but members will know that our resources are finite and have many calls on them. Although we make an effort in licensed premises, it is difficult to get the saturation policing that would need to be put in place to pick up every drunk in Scotland who is served alcohol. It is quite difficult, legally, to establish that someone was drunk and that they were then being served alcohol—it is quite a technical process. It is not done on a commonsense basis—we have to prove that it was alcohol that they were served, prove that they were drunk and so on.

Rhoda Grant: So, it is the persecution that might make it difficult to change that—prosecution, I should say.

Chief Superintendent Blake: Yes, prosecution not persecution.

Rhoda Grant: Persecution might be a good thing!

Chief Superintendent Blake: I could not possibly comment.

We put additional resources into the city centres and town centres at weekends, at the peak times when alcohol is an issue. The figures are 70,000 people in the centre of Glasgow and 20,000 on an averagely busy weekend in Aberdeen. That is an awful lot of individuals to monitor and take specific individual action for. We make efforts, but I concede that an awful lot of drunk people in Scotland are served alcohol. This is a good example of where a partnership approach is required between the police, as part of the enforcement agency, the alcohol licensing officers, local authorities and, importantly, licensing boards.

Catriona Renfrew: We are not suggesting that there should be 10 policemen in every bar in Glasgow who would arrest everyone who is served when they are drunk, but high-profile cases can send a different message to licensees. I imagine that licensees would change their behaviour fairly rapidly if they were prosecuted and lost their licences.

The Convener: Would it therefore be more appropriate for trading standards officers to take over responsibility for ensuring that licence agreements are not breached or that shops are not selling alcohol to underage people? I understand that that is a police responsibility at the moment. Would using trading standards officers be a way of saving money?

Chief Superintendent Blake: They could do it, but dealing with a drunk person might pose particular challenges for trading standards officers. However, the sale of alcohol to underage people in off-licence premises might be a different issue.

The Convener: I thank you all for your interesting evidence, and I thank the committee for its forbearance. This has been a lengthy evidence session, but it has also been very worth while.

I am not going to allow the committee a break. A very patient Mr Sandy Cameron is now going to take the witness chair. The former Scottish Executive asked Mr Cameron to chair a stocktake of alcohol and drug action teams. Mr Cameron, would you like to make a short opening statement or to comment on what you have heard so far, which would be quite interesting for the committee? We will then ask questions.

Sandy Cameron (Stocktake of Alcohol and Drug Action Teams): As the committee knows, Scottish ministers appointed me to lead the stocktake, and to look at the current performance of alcohol and drug action teams across Scotland. I think that I was appointed because I was chair of an alcohol and drug action team for 10 years in Lanarkshire and, before that, I chaired the alcohol misuse co-ordinating committee in Borders region. I therefore came to the stocktake with some knowledge. I was supported by a team of officers seconded from a variety of backgrounds. That team visited every ADAT in Scotland, conducting in excess of 300 interviews. The information that we gathered therefore forms a comprehensive overview of ADATs.

In summary, we found that, in many cases, ADATs were doing very valuable work, but that there were significant structural weaknesses in the current arrangements and there was fragmentation in the way in which problems were dealt with across Scotland. The issue that the committee is particularly concerned with—how resources are applied and used to best effect—was one of the vexed issues. It was interesting and notable that, over several years, in all areas of Scotland other than Glasgow the separate alcohol committees and drug action teams had come together and decided that it would be best if they had joint teams. Indeed, some of them have expanded their remit to include tobacco. Glasgow had two separate teams; Catriona Renfrew has explained that position. That was also a reflection of the size of the area and the number of people who would be involved.

We were concerned that, from the vision in the ministerial task force's initial report in 1994, which led to the drug action teams being set up, there was a diminution in the level of involvement and seniority of the people who were engaged round the table. That ministerial task force report

envisaged DATs as comprising the most senior strategic officers from the relevant services, who would be able to co-ordinate their activity, share information and agree on how resources were being deployed. They had to be at a senior level if they were to be the people in command of the resources and able to take those decisions. It is clear that in different parts of Scotland the level of representation has become diluted over the years. There were some significant gaps in the membership of many ADATs, not least in education and housing. Given the breadth of the issue, that was a particular concern.

12:15

There is engagement in what is now a complex landscape of public services throughout Scotland. ADATs sit alongside community planning partnerships, community justice authorities, community health partnerships and community safety partnerships. That is a complex landscape, which often involves the same people sitting around different tables. An issue for further reflection is whether we are getting that right and making best use of the resource. In relation to the committee's discussions this morning, one of the gaps that were of concern was that few of those teams had effective linkages to licensing authorities. Considering the approaches that need to be taken, that is a significant gap.

On the other hand, the teams were well linked into child protection committees and child protection procedures. That may well be a reflection of the lead that has been taken over recent years to get it right for every child and to get our priorities right. That has led to the recognition by very senior officers across the services that they carry a responsibility and that they need to be engaged in the protection of children. The committee has been talking a lot this morning about the crucial issue of protecting children for the future.

When we considered what the alternatives might be, there was no doubt in our minds that partnership was crucial; that agencies needed to work together; and that there needed to be a coherent structure that tied those partnerships in at the local level, at a wider, regional, strategic level, and, crucially, at national level. A vexed issue over many years has been the accountability of the ADATs, which is not at all clear. The accountability really only lies in the very different accountabilities of the people who sit round the tables. When I was chairing an ADAT, I was very clear that, as director of social work in South Lanarkshire, my accountability was to the council. It could not lie elsewhere. My accountability was very different from that of the chief executive of the health service, and the accountability of the chief constable was very different again. We reached a view that there should be a direct accountability to ministers, and that we should have a structure that would ensure that national policy was derived from discussion, and informed by the experience at a local level. We also felt that the important expert committees should be drawn together to feed into that. This is an area in which expertise is particularly important; it is not simply policy.

Tucked in the report of the previous review of the drugs policy is a sentence that, at the time, Professor Neil McKeganey and I pushed hard to be included, which said that, in future, all policy would be based on sound research. Although that is something of a challenge, it is still the important issue. What we have often been doing about these problems is not necessarily what the best evidence suggests we might do.

We found that although good things were happening, it was not consistent throughout the country. There is a need for consistency; for engagement at appropriate levels; for transparency in how resources are used; and, if we are to have a successful intervention in the serious problems that our communities face, for proper linkage at every level—national, regional and local.

Ross Finnie: We are talking about budgets and resource allocation. From the evidence that the committee has heard—not just today—it appears that there is an overwhelming need for co-ordinated action across the piece. We take that as a given.

Quite a striking difference emerged in the evidence this morning between ADATs acting as co-ordinating bodies, using and basing their approach on the evidence assembled by their constituent bodies, and ADATs having a separate view. In the evidence from the ADATs, we heard that they have a view on a variety of things. I am not suggesting that they are not entitled to a view, but I was slightly concerned that the three witnesses who followed contradicted in almost every case the evidential base on which some of the earlier statements had been made. I am not talking about personalities; I am talking about the organisations as corporate bodies. Having led such a body, are you of the opinion that ADATs should have more of a co-ordinating role? Is there a danger of their floating off into areas of policy and determination of resources, so that they do not reflect a proper co-ordination of their constituent bodies?

Sandy Cameron: The best route is probably somewhere in the middle of that. ADATs need to co-ordinate the resources, but they also need to take a view about what the local priorities should be. Those should be linked into the national priorities that have been set, but they will vary

throughout Scotland because our communities are different and the issues are different. That is why we believe that there is a need for a strategic level at a more local level and then an implementation level locally, to ensure that the best use is made of the resources that are available and that that is co-ordinated. We do not want differences shooting off from what our national perspectives should be; it should be a proper reflection of local needs and priorities to address the problems.

Ross Finnie: Where should the evidence base come from? In the earlier evidence, we were led to believe that all aspects of ADATs were substantially underresourced, but that was not supported by the subsequent witnesses.

Sandy Cameron: The stocktake shows that there are pressures on budgets. The issue that needs to be addressed is whether the best use is being made of budgets and whether there is sufficient flexibility in the budgets. We identified that one of the products of ring fencing or the way in which the funding streams come is that, at local level, there is not sufficient flexibility to ensure that local needs are properly addressed. Some areas have managed to find ways round that, but that does not happen consistently. There is a danger in locking things into particular streams. The fact that the bulk of the money that ADATs saw themselves as having any great influence over came through health and was, therefore, located in treatment often meant that the critical areas of prevention and education were much more difficult for them to tackle.

The point was made earlier that it is difficult to be clear about how much money is spent on these issues. Tom Wood referred to the work that was done for the Scottish Advisory Committee on Drug Misuse in 2000 by health economists, which identified that it was difficult to draw out all the elements of funding. More attention needs to be paid to that. The funds that are being committed and that people can identify need to be transparent. There was a sense that, in some ADATs, the funds were not always put on the table, that they were not always transparent and that there was not always a mechanism for agreeing how the funds would be directed and used. That issue needs to be tackled.

Mary Scanlon: I have here the executive summary of your report, in which you are not as diplomatic as one of our previous witnesses. I will not go through it all, but you use the words "marginalised", "disengaged" and "resentful" and the phrases "this undermined … co-operation", "serious shortcomings", "poor leadership", "lack of commitment" and

"insufficient understanding of the strategic aims".

You made 32 recommendations. I appreciate that that was only five months ago, but have you had any response on whether the measures that you recommended are being implemented? Do you feel that the implementation of those measures would lead to the view that ADATs should continue, or are your criticisms so severe that you think that ADATs are not the mechanism that we should use to prevent and treat drug and alcohol problems?

Sandy Cameron: I regret that I cannot help you with what has happened since the report was submitted. The report was made to ministers. It is now with ministers and it sounds as if discussions are still on-going. When the cabinet secretaries appear before the committee, the question how they intend to take the matter forward would therefore be relevant.

Our view was that we will continue to need bodies such as the ADATs. However, we found too much variation in effectiveness across Scotland. Often, that is a reflection of the individuals involved and the level at which they operate. Our view is that this provision needs to be reviewed. The ADATs need to be strengthened. We need to reaffirm the requirement for the membership and working relationships of those bodies to be at the most senior level—the level at which it is possible to take resource decisions—and for them to be open.

As things stand, the ADATs are not statutory bodies. One of the issues is that they cannot hold budgets, and there is also the issue of their status and standing in terms of accountability. No body has the requirement to be an ADAT member as part of its statutory duties—participation in ADATs probably does not even form part of people's job descriptions. There is therefore a degree to which people do, or do not, commit themselves to doing that. That needs to be strengthened. We need to ensure that the key strategic partners are round the table.

In the stocktake report, we suggested that the mechanism for accountability could, short of statutory change, be addressed by the holding of an annual meeting—certainly one that involved ADAT chairs—at which an accountability review could be made, perhaps involving the appropriate minister. That is not dissimilar to what happens in the health service. At that time, a report on how the partnership is progressing could be made. Our recommendation was for an annual delivery plan based on a three-year strategic plan. In that way, those involved could say, "This is what we have done this year. These are the resources that we have committed." Such a clear focus on accountability to Scottish ministers would help to sharpen the focus of the partner agencies. They

need to ensure that they put the appropriate resources on the table for open discussion.

Mary Scanlon: That is helpful. Obviously, there has to be accountability, responsibility, and a strategy. To get that, a clear policy is required.

You mentioned Neil McKeganey, and the need for policies to be based on sound research. We all are looking for a bullet—any bullet, magic or not. Can you point us towards research on inputs that would maximise value for money and effective outcomes?

Sandy Cameron: It is clear that there is no magic bullet. The problem is serious. If there were simple solutions, I am sure that we would have found them.

As we have heard a number of times this morning, some of the most influential recent research—the research that has helped to shift thinking—has been Neil McKeganey and Marina Barnard's work on children who are living with drug misuse. If I may, I will take a couple of minutes to explore the issue, which is important in terms of resourcing.

The "Hidden Harm" report was produced by the Advisory Council on the Misuse of Drugs, which is the UK statutory body, as a result of pressure from its Scottish members, of whom I was one. The work was led by Dr Laurence Gruer, who is a leading figure in the field and based in Scotland. The report clearly focused attention on the impact of drug misuse on children. I agree that there is the wider issue of drug and alcohol misuse, but "Hidden Harm" was on the particular issue of drug misuse.

Marina Barnard's research shows the impact of drug misuse on children—it looked at more than 50,000 children who live with chaotic drug misuse. From my experience over many years, my view is that this is one of the most serious challenges that faces us in Scotland: I fear that, if we do not tackle it, our successors will be sitting around this table in 20 years' time, wondering how on earth they will find the resources to deal with the mounting problem.

12:30

There has been talk of young police officers. I was once a young assistant director of social work—in the late 1970s and early 1980s—when, through guidance rather than law, we had misuse of drugs co-ordinating committees. At that time, in central Scotland, we were discussing people sniffing felt-tip pens and even nutmeg. The view was that although there was some cannabis around, we did not really have a drug problem. I look back with regret—and some culpability—that we did not grasp the issue in a serious enough way. If we do not grasp the issue of children being born into drug-misusing families and deal with the associated resourcing issues now, we will have an even bigger problem in future decades.

I am the chairman of the Parole Board for Scotland, which routinely deals with second and third-generation drug misusers from chaotic, drug-misusing families. They are the children and grandchildren of drug misusers.

The evidence from American research suggests that children who lack nurture in the early years of their lives can recover if stability is introduced and they are given nurture, but that if nurturing is not introduced before the age of three, they cannot recover. We need to be alert to the long-term damage that can be done to children who grow up in chaotic, drug-misusing households. This issue is different from the one concerning the children who are carers. We need to look to the future with regard to how we intervene in this area.

In discussions with the previous Government, I said that we need a clear statement that says that chaotic drug misuse and parenting are not compatible. We should not be deflected from that position. That is not to say that we should not be providing every bit of assistance possible to drug misusers to enable them to be good parents, but we need to be clear that they cannot be a good parent and a chaotic drug misuser at the same time.

The resource implications of what I am talking about are substantial. We need to provide the children who are carers with significant support. We also need to be thinking about how we allocate resources for the children who are not yet born, to ensure that they get off to the best possible start and that they and their parents are supported. We also need to be prepared to take difficult decisions if the change in a family does not happen. Over the years, there have been cases in which we have intervened and removed the children, then the parents have begun to do a bit better, so the children have been returned, then problems have re-emerged and the children have been removed again, which has meant that the children have yo-yoed backwards and forwards. The evidence suggests that cumulative damage builds up throughout that process.

These are difficult areas. I do not suggest that there are easy solutions, but they are the challenges that alcohol and drug action teams need to be considering. The issues have to be considered in terms of national policy and national resourcing, because if we do not tackle them our communities will have to deal with more severe problems when they end up facing the fourth and fifth generations of people who have had no nurture, have led a chaotic lifestyle and are involved in criminality.

The Convener: You have made the role of ADATs clear and you have talked about the policy imperatives. Both issues will impact on what this committee should be thinking of in terms of the priorities for funding. The issues seem to be crystallising around intervention and recovery programmes in relation to children and families.

Sandy Cameron: If we had to choose—and I do not suggest that our efforts should be all or nothing—I would say, with an eye to the future, that that is where we need to invest, while doing what we can to maintain services in the meantime.

Helen Eadie: You have spoken several times about the need for transparency in the use of resources. How would you make transparency happen? Will you comment on, or amplify, what the other witnesses have said this morning about there having been no clear policy statements in the past? Is that the case?

Sandy Cameron: Transparency is important if agencies have a shared commitment to tackle the problem in their area and are prepared to put their resources on the table. It is important to consider how resources can best be used in a policy context, and that agencies are flexible about where money will go. One point that we have made is that it should not be presumed that money will simply be spent in the statutory services. In particular, there must be a level playing field with the voluntary sector, which can bring expertise.

If an annual accountability review process is as challenging and robust as it should be, it should flush out whether all the money is on the table, whether agencies are being up front about what they are doing and whether they are using money to best effect. Annual delivery plans should be clear about the outcomes to be achieved and people should therefore be able to measure whether the apportionment of resources is achieving what it was intended to achieve. There should also be a capacity to shift resources if things are not working.

In the field in question, money often gets locked into services that people have ownership of over a long time, but they may not be delivering effectively and it is often difficult to shift resources. There must be a commitment to be prepared to tackle that difficulty.

Helen Eadie: Do you want to comment on strategic policy statements?

Sandy Cameron: Yes. Local action or delivery plans must be founded on the strategic imperatives—the objectives that have been set—and people must consider how, having identified the strategic issues in the national policy, resources will be used at the local level to achieve strategic objectives so that there is not the continued fragmentation that results from money being spent in historical ways or on local whims. Local plans must be tied into the strategy.

Helen Eadie: That is helpful, but will you amplify your point about historical ways in which money has been used and the suggestion that a lot of the cake has disappeared and we have been left with only the icing? What particular strengths have been lost that we need to have regard to?

Sandy Cameron: Perhaps the cake is sometimes eroded because there are other demands and pressures. Catriona Renfrew was clear about the pressures and demands in health. Tackling alcohol and drugs issues is not always seen as one of those pressures or demands. Local authorities face many pressures, and local decisions are taken about things that are seen to be the priorities. One dilemma that arises as a result of moving away from ring fencing money, which seems to be happening, is that people are given greater flexibility, but funds may not go to causes that are not seen to be popular. That was one concern that ADATs reflected to us. They were conscious of the tension between people lacking flexibility and people worrying about getting money. Such issues can generate moral panic, but they are not necessarily always the most attractive issues at the local political level for people to make resources available to tackle or for them to sustain making resources available. The preparedness to sustain investment is a critical issue in tackling many of the problems.

Ian McKee: I have heard all the evidence that has been given this morning, and think that the exact role of ADATs is very unclear. I will have to think about it much more.

We have talked all morning about top-down structures, and we have discussed co-ordination among health boards, local authorities, justice departments, housing departments and so on. My experience before coming into Parliament was as a general practitioner. I know that an awful lot of people with alcohol and drug problems present first in the primary care context. The vast majority of general practitioners, and therefore their teams, are more self-employed than employees of the health board, and the link between the health board and primary care is sometimes slightly tenuous.

There have been various carrots to motivate GPs to tackle certain subjects: one is declaring something an enhanced service. There is an enhanced service for drug problems. Many GPs have taken that up and now provide at primary care level a service for people with drug problems. There is also an enhanced service for a route out of alcohol problems, but it is only one of nine that have been offered this year, and general practices have to take up only three. In Lothian, the three

that have been taken up by primary care have not included alcohol services.

Do you have any comments about how we should integrate services at the grass roots? At the moment, if someone comes to the doctor with an alcohol problem, they are told, "I've got you an appointment in three months' time; please don't go there drunk or they won't see you." That is a totally inappropriate response. We can have wonderful edifices higher up, but unless we ensure the link-up with the person who needs help at the time they need it, they will be almost useless.

Sandy Cameron: You are absolutely right. The whole point of national policy and strategy must be to ensure that those critical services are put in place and work together. In the report we make the point that we see little value in policy being set only at the highest level. It needs to be informed from the grass roots up, and a view should be taken on that basis. The structure that we have suggested looks to create those linkages.

You are right: there is no point in a medical practitioner telling someone, "I think you've got an alcohol problem. I'll refer you to this service and you might be seen in three or six months' time." What we should have—as I have tried to provide in other existences—is a system in which the doctor can say, "If you just wait there, someone will see you now." That is particularly important for hospital clinics, because many people present not with alcohol as their problem but because they have a liver condition, heart disease or something else, and an assessment indicates that alcohol consumption is a factor. Just giving them a leaflet, referring them on and telling them that they will be seen at some point often means that they do not turn up.

What is needed is rapid, immediate intervention from someone with the short-term intervention skills to grasp the problem. If resources can be directed in that way, they will provide better support for the medical practitioner and engage the person with the emerging alcohol problem much more rapidly. All of that has resource implications, but they must be weighed against the opportunity costs.

One complexity of the economics is that it is a question not simply of what we spend directly on dealing with the problem but of what we spend as a result of the problem. That is a large amount of money, particularly in the health service, social work and the police. If we are to tackle those opportunity costs, we need to put more direct services in place.

Ian McKee: I accept what you are saying, but it is a definition of the ideal rather than a mechanism to bring it about. I am certain that, given the necessary stimulus, a lot of services could be provided locally, but that stimulus does not exist at the moment. Do you have any views on that?

Sandy Cameron: In the report, we recommend a structure to try to ensure that that stimulus exists and that resources are put into direct action to ensure that the problems are tackled.

I do not for one moment underestimate the difficulties, but people need to get their heads together, sort out some of the problems and cut their way through the blockages that have existed. If they do not do that, they may be culpable of spending money in less-than-effective ways.

12:45

The Convener: Tom Wood said that ADATs do not having the power to deliver what they are supposed to deliver. Would putting them on a statutory footing and sending much more of the funding straight to them be of assistance? You mentioned that education and housing services are not always part of ADATs. If they were statutory bodies, they would have a framework and they would comprise the same bodies throughout Scotland. Although that framework would be flexible on delivery, we would be able to see what funding went in and it would be accountable. Robert Peat said that he sat on the DAAT with his director of social work hat on—that was his primary responsibility—which shows that there are divided loyalties. Would it be useless to make ADATs statutory bodies, or would it assist in directing the funding, placing it strategically and ensuring that they are accountable?

Sandy Cameron: It would certainly not be useless and it is one of the options to consider. However, legislating is not necessarily straightforward—I do not need to tell the committee that—and there are costs involved in setting up new statutory bodies. That would need to be weighed against other ways of delivering the services, at least in the interim, such as the structure that we suggest in the report.

The other issue about establishing ADATs as statutory bodies is that a complex landscape is emerging in Scotland. The work of community justice authorities clearly has significant overlap with the work in which ADATs are engaged, but there are eight CJAs whose boundaries do not tie in with other boundaries for anything. Although the CJAs will have budgets, they face difficulties in shifting resources between some of their partners.

The statutory route is certainly an option that is worth exploring, but it is not without potential problems. One of the issues that needs to be reflected on at some point is the complexity of the landscape. Are we making the best use of resources by having people sit round different tables on different days of the week to discuss

overlapping issues, or do we need to think about how to bring more of those discussions together?

The Convener: I concluded that.

Thank you very much, Mr Cameron. It has been a long evidence-taking session, but it has been extremely worth while. We would have liked more time to deal with the issue and may come back to drug and alcohol action teams and drugs and alcohol policy at a later date.

Meeting closed at 12:48.

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