HEALTH AND SPORT COMMITTEE

Wednesday 21 November 2007

Session 3

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HEALTH AND SPORT COMMITTEE
9th 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:

Julia Bracewell (sportscotland)
Stewart Harris (sportscotland)
Roger Howard (UK Drug Policy Commission)
Jack Law (Alcohol Focus Scotland)
David Liddell (Scottish Drugs Forum)

CLERKS TO THE COMMITTEE

Simon Watkins
Tracey White

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Wednesday 21 November 2007

[THE CONVENER *opened the meeting at 10:03*]

Subordinate Legislation

Feed (Specified Undesirable Substances) (Scotland) Regulations 2007 (SSI 2007/492)

National Health Service (General Medical Services Contracts) (Scotland) Amendment (No 3) Regulations 2007 (SSI 2007/501)

National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Amendment (No 3) Regulations 2007 (SSI 2007/502)

The Convener (Christine Grahame): Good morning, and welcome to the ninth meeting of the Health and Sport Committee in session 3. I remind all members to ensure that their mobile phones are switched off. We have received apologies from Rhoda Grant.

Item 1 is subordinate legislation. We will consider three instruments that are subject to the negative procedure. Scottish statutory instrument 2007/492 will transpose a European directive that revises the maximum permitted levels of certain compounds that are classified as undesirable substances in animal feed.

SSI 2007/501 and SSI 2007/502 will amend previous regulations on general medical services contracts and on primary medical services section 17C agreements. They will both insert references to "civil partner" into the definition of an "immediate family member" and insert a definition of "pharmacist independent prescriber".

No comments have been received from members, and no motions to annul have been lodged. Are we agreed that the committee does not wish to make any recommendations in relation to the three instruments?

Members *indicated agreement.*

Budget Process 2008-09

10:05

The Convener: Item 2 is the budget process. As members will know, we are looking in particular at the line on drugs and alcohol. I welcome Jack Law, who is chief executive of Alcohol Focus Scotland, David Liddell, who is director of the Scottish Drugs Forum and Roger Howard, who is chief executive of the UK Drug Policy Commission.

I invite each of you, in no particular order of merit, to make a few opening remarks—I ask Mr Law to begin.

Jack Law (Alcohol Focus Scotland): Thank you for the opportunity to present to the committee. I do not propose to say an awful lot at this point—I am more interested in the discussion that I hope will ensue. I remind the committee that alcohol use is different from illicit drugs use—although that is not to diminish the importance of illicit drugs use. There are several major differences: alcohol is legal, it is ubiquitous, and it has positive as well as negative lifestyle associations. That makes its use an extremely difficult issue to address, in the context of alcohol-related harm. Its misuse and use are embodied in our culture, and its use is underpinned by policy and legislation. The most effective legislation that is currently in place appears to be the licensing legislation, which will—and should—have an impact on culture. I am pleased to be able to talk to committee members about alcohol misuse and its cost.

David Liddell (Scottish Drugs Forum): I thought that it would be useful to make a couple of comments that pick up on what the committee discussed at its previous meeting. For my sins, I was a member of the strategy committee that recommended the creation of alcohol and drug action teams in 1994 and was involved in an earlier review of their function and performance. The Scottish Drugs Forum has been a member of the majority of such committees since their inception, so we have a valuable and informed view of what should happen to them in the future.

Drug action teams were established with the clear intention that senior officials within the key agencies would bring their resources to the DAT table. Those resources would be dispersed according to need and other evidence regarding the areas in which they would make the biggest impact. In reality, that has not happened in any significant way as many of the key players were reluctant to give up control of their resources to a partnership. The result is a very muddled situation, in which DATs—and now ADATs—have direct

control over some resources, influence over other resources and no control over another section of resources. The teams have been tasked with taking a strategic approach, but they have not been given the means with which to be strategic—they do not control their budgets. Without control over budgets, nothing will change—I am afraid that in five or 10 years we will be back discussing similar things.

We would like a pooled or unified budget from a range of Government directorates: health and wellbeing; justice; education; enterprise and lifelong learning; development, in particular housing and regeneration; and, ideally, from the Department for Work and Pensions. That would provide ADATs with the necessary resources, but without that step change, we will continue just to muddle along. We currently have at Government level funding silos that are mirrored at strategic local level, which result in service silos on the ground. However, it is not just the root of the funding that is important—it is the level of resources and the evidence on which investment is based.

Roger Howard (UK Drug Policy Commission): The UK Drug Policy Commission is a three-year specialist think tank, and it is funded by a leading philanthropic foundation—the Esmée Fairbairn Foundation—that has a long history of stimulating public and policy discussion about controversial issues.

We all recognise that drug policy is a highly political and highly charged area. The commission's starting point is that we do not know enough about what works, how it works and where it works well. There are good things about drug strategy in the countries of the United Kingdom, but we have not researched and learned enough. In such a climate, good pragmatic policy innovation and analysis are often stifled. We were set up to consider drug policy and interventions objectively and to try to use our findings to influence people such as Parliament, the media and the public.

We are independent of Government and special interests. We are not in any way a lobby group, a campaigning group or a pressure group. We are trying to bring objective analysis to drug policy; we do not come from a particular standpoint except the desire to find out what is effective—"effective" is the big E for us.

Three critical questions seemed to emerge from the committee's meeting last week. What difference do current interventions make in reducing the drug problem? Do they represent value for money? Where can the Scottish Government get the biggest bangs for its scarce bucks? We can give some answers to those questions, particularly if we draw on evidence from other countries.

I make this comment so that it does not get lost: I am afraid that the UK, including Scotland, fares badly in trying to develop its knowledge base. The United States federal Government spends 20 per cent of its prevention and treatment budget on research. In this country, according to the best figures that we can find, we spend less than 1 per cent of the whole UK drugs interventions budget on research. Canada, Australia and other countries put us to shame in what they spend on trying to understand the problem and what works.

The Convener: Thank you. Members have a summary of the research that you commissioned, so we know what issues you raised.

Ian McKee (Lothians) (SNP): I thank the witnesses for their helpful presentations. Mr Law mentioned the many differences between alcohol and drugs misuse, although they are both addictions, as is gambling, for example. As you said, alcohol is legal and ubiquitous. It has positive and negative features and its use and misuse are embedded in our culture. In our meeting last week we heard that about 24 per cent of the Scottish population are affected by misuse of alcohol, compared with 1 per cent who are affected by drugs. Both issues are important.

At our previous meeting, I got the impression that alcohol services had suffered by being included with drugs services when ADATs were formed. Alcohol services are the poor relation, although alcohol does much harm, perhaps because drugs are a more interesting topic for the media. Would benefits be gained from separating drugs services from alcohol services in the future, so that we give both issues the consideration that they deserve, instead of lumping them together because we think that because they are addictions they are vaguely similar?

Jack Law: We tend to forget that alcohol is also a drug and to think of it as just a drink that many of us in Scotland consume. That said, separating alcohol from drugs when deciding how to spend money would bring considerable benefits. The reality is that little has been spent on alcohol services in the past 10 to 15 years—dealing with illicit drugs has predominated in budgets. There are good reasons for that, but we are suffering as a consequence. As our knowledge of the extent of the alcohol problem grows, we see that it is huge—it is significantly different from and larger than the drugs-related problem.

10:15

We also suffer from the fact that, as long as we pool money for dealing with drugs and alcohol problems, we lose the opportunity to consider

different initiatives for alcohol and drugs. Cultural understanding is important in respect of acceptance that the two things should be treated separately. Because people think that drinking is not necessarily problematic—many people's drinking is not problematic, but could lead to problems—the consciousness and understanding of what needs to be done about drinking are significantly diminished. One of our arguments is that separating the resources—money, people and services—for dealing with drugs and alcohol would offer a better chance of tackling the problem at its source.

David Liddell: We should deal with drugs and alcohol together, particularly because of the many crossovers. For example, people might relapse on methadone and develop a drink problem, and cocaine use and alcohol are often closely linked.

As I said in my introduction, I argue for a pooled budget. That must take a strategic approach to effective needs assessment of the extent and nature of problems and to the evidence about what has an impact. We should join up the issues. The committee has previously discussed joining up drug, alcohol and tobacco policies in the Scottish Government.

The Convener: Does the question fall within the UK Drug Policy Commission's remit?

Roger Howard: We observe in our submission to the consultation by the English Government—Whitehall—on the drugs strategy that the issue should be considered. Scotland has recently reviewed ADATs, but we in England have not had such a review. A review was held of crime and disorder reduction partnerships, which raised many issues about the links between drug and alcohol action teams in England.

Sometimes, the issue is not so much structures as willpower, commitment, vision and the ability to work in partnership. In all the research, including Sandy Cameron's work, consistent arguments are made. Throughout partnership working in public services, there are common problems about leadership, responsibility, accountability and having a form of budget on which to work. Those are general principles, but I have no observation on whether drugs and alcohol services should be separated.

The Convener: Does Ian McKee want to pursue the issue?

Ian McKee: No. I am interested in the contrasting views that have been expressed.

Mary Scanlon (Highlands and Islands) (Con): I found Mr Howard's paper depressing—I came along looking for a magic solution and we have found it difficult to identify where drugs expenditure should be made. David Liddell's point about a single budget was helpful.

I address my question to Mr Howard, but I am happy for others to answer, too. You say that we have

"the second-highest rate of drug-related death in Europe";

that

"it is unlikely that the benefits of treatment to individuals and families will have translated into a substantial and measurable impact on … levels of … drug use and crime";

and that

"school-based prevention efforts do little to reduce initiation"

into drugs and

"have very little impact on future drug use."

Where do we start from and where do we go? You said in your introduction that 1 per cent of funding goes towards research. I appreciate, as you and Mr Law said, that the culture in this country is different and that something will not work here just because it works in another country. Where should money go to help individuals and families effectively, to get people back into work and to provide value for money—what you called the "biggest bangs for … bucks"?

Roger Howard: That is the $64,000 question. To give a helicopter view—although I would not want you to go away with a pessimistic view, because really great strides have been made throughout the UK, including in Scotland—

Mary Scanlon: Your paper is not exactly cheerful on that front. I do not want you to think that I am misinterpreting it.

Roger Howard: It's the way we tell them. [*Laughter.*]

Mary Scanlon: I approached the paper with optimism.

Roger Howard: I will unpick what we are trying to say. Most of the available evidence is international. Evidence from the UK and Scotland is limited, so the first point is that we rely on transferable lessons. We all accept that important differences exist, but let us assume for the moment that the lessons can be transferred.

On education and prevention, an effectiveness review of drugs education in Scotland has been carried out, which I looked at again on my way to the meeting. It says that the programme has been effective, but that begs the question of what "effective" means. If we ask whether the education programme is effective in delaying the onset of drugs use, it probably is—slightly. If we ask whether the programme gives youngsters and school children good information and knowledge

and allows them to develop their skills, the answer is yes. If we ask whether the programme ever prevents use, the international evidence is that it does not. If we ask whether it makes youngsters who are experimenting with using drugs desist from that, the international evidence is that it does not. The evidence on that is pretty consistent across the globe. Cochrane-type evaluations have been done of that evidence.

That is a difficult message to leave with politicians and the public—although we have an intrinsic faith that education can solve every problem, it can do only so much. However, let me make it clear that that is not an argument for not carrying out education programmes. A value-for-money or economic analysis would show that school-based education is pretty cheap per unit cost, so there is a strong argument for doing it. However, we must realise that in the long term it will not influence the prevalence of, or uptake and consumption of, illegal drugs. I will leave alcohol issues aside for Jack Law—I am not operating in that domain at present.

On prevention more generally there is, as I think Tom Wood said last week, strong evidence internationally to suggest that we should intervene and target preventive efforts at vulnerable young people who have a package of problems, by using broad-based interventions that are focused not only on drugs or alcohol, but which are preventive programmes to help improve their functioning and their family functioning. The strong evidence internationally and from the UK is that such programmes are good.

Mary Scanlon: Your report states:

"Even those programmes that are delivered effectively seem to have very little impact on future drug use."

Are you saying that our programmes are not targeting the right people and are not holistic enough in that they do not approach the whole package?

Roger Howard: I will distinguish between education and prevention, although I know that that is a slightly angels-on-a-pinhead argument. On prevention, the message that comes across consistently from the international evidence is that we get the best value for money when we target the most vulnerable people: if we do that and put in place early broad-based programmes that cover a range of issues—such as teenage pregnancy, mental health, drugs and addiction—we are more likely to have a long-term impact on those vulnerable people's lives.

On treatment—leaving aside, for the moment, the question of the type of treatment—there is a strong evidence base internationally for its effectiveness and cost effectiveness. In England and Scotland, research programmes and evaluation programmes consistently show that the crime reduction benefits, the health improvement benefits and the wider benefits to victims, communities and so on are extremely great. The English study is more mature than the one in Scotland and it shows that, for every £1 that is spent on treatment, there is a £3 return to the taxpayer due to a reduction in crime. I am sure that the Government will be able to provide the committee with that information.

The important thing is that, even within the addicted population, particular treatments are slightly more effective than others. I am sure that I will be asked, in a follow-up question, whether abstinence is better than methadone: at the moment, I will say that—broadly—abstinence-based programmes, methadone-based programmes and substitute prescribing are all extremely effective.

Another point—which is a difficult political point—is that spending on the justice system and prison provides much less value for money than spending on treatment. A consultancy that does a lot of work for the Home Office recently produced a report on the value for money of prisons and what would be saved by focusing on community-based programmes or by increasing treatment in prisons. However, we are flying blind in relation to enforcement and supply reduction. We do not have robust effectiveness studies in those areas. That is not to say that enforcement is not effective—on the contrary, it does a lot to reduce harm in communities.

Jack Law: In the alcohol field, there is a similar mantra, which is supported by evidence from the World Health Organisation and others. The view is that, on its own, education is relatively ineffective in terms of changing behaviour. Education improves knowledge but does not necessarily change behaviour. However, we argue that education in context is important. That context involves prevention work, early years work, community-based initiatives, working with families and peer-support initiatives. Prevention involves finding ways of enabling communities—within schools, families and more broadly—to change their culture. That can be done by working with local licensing forums, which have been established across Scotland as a consequence of the new licensing legislation. They were set up to analyse and assess the impact of licensing decisions—such as the granting of a large number of licences—on the quality of life of their communities. That gets a debate going about alcohol issues and helps to inform people about them.

It is also important to look at how alcohol is drunk in the home in normal everyday life. We know that the balance of alcohol consumption is

increasingly being driven towards private consumption in the home rather than public consumption in bars and so on. Evidence suggests that there is a lot that can be done in that area.

10:30

There is considerable evidence to suggest that, the earlier we start working with children—not necessarily on alcohol issues but on issues such as developing empathy and understanding—the more we will reduce the problems that they might experience in later life. Evidence from the United States and Canada suggests that, if we work with children as young as one or two years old on developing empathetic approaches to life, that will reduce the problems that they create in later life.

We argue that working with families is extremely important. It can be done in a variety of ways through community-based initiatives and resources, such as local councils on alcohol and other agencies that work directly with families on alcohol-related issues. It can also be done through counselling and individual support therapies. That work is important because it educates families about drinking behaviour and its impact on family life and communities.

The Convener: You mentioned early intervention. For clarification, at what age would you start to discuss alcohol and drugs?

Jack Law: The evidence from the States is not on talking about alcohol and drugs. That is the point. It is about teaching children how to deal with the learned behaviour that they get through their families. It focuses on anger management, dealing sympathetically with people, and finding other ways of understanding people's behaviour. That can happen at pre-school level.

The Convener: I understand that. I was wondering about broaching other topics and threading them into conversations with children. They might introduce the topics themselves, of course, because of what is happening at home. At what age should that happen?

Jack Law: Three to four upwards. Some of the research suggests even earlier intervention, but I would not argue for that.

Peer support initiatives are also important. They engage young people who are interested in alcohol issues in working with people who are affected by those issues. Such initiatives in Scotland and elsewhere in the UK are effective in helping young people to deal with alcohol issues.

There is an absence of interventions in the criminal justice sector. We argue that that needs to be addressed here in Scotland. I disagree with my colleague Roger Howard about work on alcohol issues in prisons. Little is done on the issues and interventions in prisons, yet the vast majority of people who end up in prison are there because of alcohol-related offences.

We could develop other initiatives that appear to be effective in relation to, for example, drink driving. Rather than simply giving someone a legal outcome, we could insist that they go into a programme that examines their alcohol consumption relative to the offence that they committed. Such alternatives to the formal system for dealing with alcohol-related offending would be useful.

The Convener: Is that work done anywhere?

Jack Law: There is little evidence that it is done in Scotland. There is some evidence that it happens in England, but more work happens in the United States.

Ian McKee: I think that it was done in Dundee at one stage. Dr Dunbar—

The Convener: I asked for questions rather than evidence, but I do not mind.

So it was done somewhere. You made an interesting point about losing your licence but then doing something else other than that.

Jack Law: There is a UK-wide initiative that could be considered, although it does not go much further than the Borders and perhaps a few other spots in Scotland.

David Liddell: I reiterate the point about early and sustained intervention with vulnerable families, which is a theme that interests the committee. I stress that the support must be sustained. It has to be given to families in the long term. We are talking about a range of interventions with those families. What tends to happen with parents who have a drug problem is that support comes in only at the point of crisis, as is clear from talking to parents who have had their children removed, or to those who have managed to keep their children; in most cases the parents then try to shake that support off, for fear of losing their children. Providing early support to vulnerable families is therefore a huge issue.

My second point is about hepatitis C prevention, and more generally about how we can encourage people to access services as quickly as possible. There is a need for outreach provision across Scotland, particularly for needle exchange to prevent hepatitis C. There is a lot of evidence to support the fact that we need to do that. On treatment itself, one of the big debates in recent years has been about moving from a narrow model of medical care to wraparound provision, including family support, education and training, housing support and housing. That is why, to return to my original point, we have been arguing

for pooled budgets, because the problem is how that wraparound care is delivered. That is a fundamental issue if we are to improve treatment and care. I support what Roger Howard said about the outcomes of treatment and care, because we can do better than we are doing just now.

Someone mentioned "lost causes" at the committee's previous meeting; that is a particularly unhelpful notion. As a humane society, we must try to make support available to all who need help. It is also important to point out that we can make a bigger impact with wraparound care. I do not know whether any members of the committee saw "The Politics Show" recently, when it visited a ship in Arnhem that is funded by the local council to provide care for 120 individuals who might be perceived by some people as lost causes. That wraparound care, including accommodation and other facilities, has resulted in 75 of the original 120 care recipients moving on to more structured programmes of treatment and care.

Given the right environment, people can progress and move on but, for far too many people, provision of treatment is narrow and increasingly bureaucratised, with numerous assessments, and takes a less person-centred approach. That is a big issue that we must address.

My final point is about the need to examine wider issues of poverty reduction and regeneration. Just before the meeting, I looked out some information about the prevalence of problematic drug use in other countries. Austria, Denmark, Finland, the Netherlands and Sweden all have substantially fewer problematic drug users than we do, so we must examine the wider social factors that have led Scotland to have one of the biggest problems in Europe. That also leads us to the conclusion that we have to see drug problems fundamentally as social problems with legal and medical consequences.

The Convener: That point is made in the UK Drug Policy Commission's paper, on policy implications. We cannot simply lift a policy from one country and transpose it to another, because there are cultural differences.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I must start by declaring that I am still working on an area of drugs policy at the moment, developing a single shared assessment for the Lothian DAAT.

Having been the minister in charge of drugs policy in 2001 and 2002, and having subsequently worked for four years as a consultant psychiatrist in charge of a drug and alcohol addiction service, I find it depressing that we are still talking about integration now—five years on from when I was a minister. I would like the witnesses to expand a little on the inefficiency of having silo services. Five years after the effective interventions unit produced a policy document and held seminars throughout Scotland on the integration of services, why are we still talking about silo services?

If people are simply shifted from service to service, without receiving comprehensive services through a key worker, we will never achieve the changes that we all desire. I would therefore like some further comment on silo services—relating to the budget if possible. How do we deliver from a central budget, which now supports the overwhelming majority of the funding through health, local government and voluntary organisations? How can the Government ensure, without ring fencing, that the integration process takes place?

I have two further questions, the first of which is for Jack Law. Noting the welcome and specific budgetary expenditure of £20 million, £30 million and £35 million over the next three years, I wonder what he thinks the priorities are for the expenditure of the £20 million. How should it be bid for and spent? In the past, the bidding process has been extremely difficult.

My final question is more for Mr Howard. It is vital that we all understand the difference between education and prevention. Education is about the provision of general knowledge, which is vital to every young person as they grow up. Primary, secondary and tertiary prevention are different, however. My question has already been alluded to. At what stage do we begin to identify those to whom primary prevention applies, as opposed to pure education? In other words, at what stage—judging from international evidence and from the UK Drug Policy Commission's work—should we identify and target young people and their families for sustained, wraparound support to ensure that all aspects of their lives and their future behaviour are modified? That way, we reduce the numbers of people going on to drugs, developing alcohol problems and getting involved in crime and going into prison.

David Liddell: As I have mentioned, wraparound care and integration are crucial. Speaking as someone who was on the original integrated care groups five years ago and who is now on another set of working groups within government, I would say that the big focus has been on integrating things. I would take a different view from Richard Simpson regarding single shared assessments. I think that we need to consider more fundamentally how we are delivering services. I would argue that, over time, we should be providing a range of services in the one agency. I am referring to the wider issues of housing support, family support and employability. As someone who has been more than an observer

in the field over the past 20 years, I have come to the conclusion that smaller, commissioned units, which also deliver the prescribing elements and other things that are required, will provide the best way of delivering integrated care. We will not deliver that outcome through single shared assessments.

I am sad to say that we have considerably bureaucratised the response. It is becoming increasingly difficult to have effective relationships with individuals. We are hearing from workers and service users about mechanistic provision and demoralised workers. The whole issue needs to be revisited to establish how we can effectively deliver services.

10:45

It is pretty impossible to envisage how we can do that without ring-fenced funding, given that treatment agencies are currently struggling to get housing support, early family support and access to education and training for their clients. We are talking about an excluded group, which is not a desirable care group for other mainstream providers. That is the fundamental problem and we need some form of positive discrimination if we are to help people out of the situation that they are in. That is why I argue for pooled budgets and the commissioning of holistic services, without which we will always struggle to deliver a wider range of care for people.

Dr Simpson: I am not saying that the SSA is in any way a solution, but it addresses the problem of clients undergoing multiple assessments, in which they repeat material and become fed up because the problems that they—not the provider—identified are not being addressed, because they are being dealt with by silo services.

We have not mentioned the sharing of information on children, which is vital if we are to prevent a fourth generation of drug and alcohol users from growing up in Scotland.

David Liddell: An effective relationship with a drug worker is a big issue, as many users tell us. We continually hear reports of people attending a service five or six times and being seen by a different person every time. The evidence of the importance of an effective relationship with a key worker is clear, particularly from the American drug abuse treatment outcome study—DATOS. When we consider that many of our 50,000 problem drug users have been in care or have had few or no decent relationships with people, we appreciate the crucial importance of treatment services that provide a relationship that is sustained over the long term. Relationships and the wraparound approach that I mentioned are key to improving provision.

Jack Law: I strongly argue that in discussions such as this we need clarity about what is spent on alcohol relative to what is spent on drugs. Very little has been spent on alcohol to date. If we are to spend more money—I am glad that we will do—it is important that we understand where and how to spend it most effectively.

We also need to know what is currently being done. What is being spent on alcohol services? Where is it being spent, and how effectively? All budgets have areas in which money is not being spent in the right way. Money that is not being spent on alcohol-related services as effectively and efficiently as possible could be redirected.

The Convener: Can you answer the questions that you posed?

Jack Law: No. We constantly ask those questions, because we do not know the answers. A few years ago, I asked how much is spent on alcohol services in Scotland, but it was difficult to get a clear answer across the board. I suspect that we still do not know how much is spent on alcohol services, partly because some funding streams have been shifted around and because there will be a long tradition of spending on services that have not been examined effectively.

I agree with other witnesses that services should meet people's needs—not the other way round. I worked in social services for more than 30 years and my experience was often frustrating, because there have traditionally been silos. However, things have changed and people are beginning to consider how to make services fit the person, instead of taking a bureaucratic approach in which they say, "We do this little bit and someone else does that." That is to be welcomed, but there is still a long way to go to enable service providers to provide an holistic service to individuals. People who have alcohol problems often have other problems, such as housing, employment and child care problems, and they simply want those problems to be fixed; they do not really care who fixes them as long as they are fixed. It is important that their problems are solved in one place. I am arguing for budgets to be expressed separately, but ultimately things need to be different at the point of service delivery.

Priorities are the most important issue. There are at least four priorities, one of which is the use of brief interventions. Much of the international evidence on alcohol clearly suggests that brief interventions can be effective. The duration of their effectiveness is still in question, but they can be seen to make a difference over a relatively short period. Brief interventions occur at the time when someone experiences a problem or when they become aware of an issue that they can address, and they can be delivered in various ways, such as in general practitioners' surgeries. Efforts have

been made to spend money on that front, but they can be delivered in other places. For example, studies in Glasgow have shown that they can be delivered by pharmacists. If someone with a sleeping problem goes into a pharmacy, the pharmacist will ask them a little about the problem. The person's alcohol consumption may need to be considered. Even that approach can be effective in changing a person's behaviour and enabling them to think about what they are doing. Brief interventions can also be delivered in dental surgeries. All the evidence suggests that they are extremely cost effective.

As I said in my introductory remarks, the problem with alcohol is that our understanding of it is culturally fixed. How we behave is fixed by how our culture looks on alcohol, which is different from how it looks on illicit drugs. Another priority must therefore be considering how community interventions can be used most effectively. A number of opportunities can be taken. As I have said, we now have local licensing forums. If we empowered those forums a little bit more, we could enable them to begin to talk to local businesses, stores and bars, which are part of our culture, about how they sell and promote alcohol, whether they sell it to young people and whether they allow proxy selling. That is an important field. It is important to work on alcohol-related issues in the community and to work with families and community organisations on community safety issues and alcohol-related noise and violence. Such work can be very effective at changing people's behaviour and influencing the behaviour of communities.

The third priority is the development of counselling and individual support therapies. It is demonstrable that the efforts of the local councils on alcohol that exist throughout Scotland to counsel individuals and families about their individual and family-related problems have been effective over the past 25 years in dealing with such problems in communities. However, their services have been significantly underfunded—in fact, funding for a service in Caithness was withdrawn only last year, which seemed bizarre to us, given the nature of the alcohol problem in that area. Over the years, councils on alcohol have struggled to gain sufficient funding to enable them to deliver services that meet the needs that they have identified.

The Convener: What is the source of their funding? Do local authorities provide it?

Jack Law: Either the local authority or the health service can provide funding, or they could both do so.

The final area that we need to explore is hidden harm—children who are affected by alcohol misuse by someone in their family. It is estimated that around 100,000 children in Scotland are affected in some way or another by that hidden harm, which is not receiving much exposure relative to the issue of alcohol misuse in our country. It is a large and difficult area in which to work, but if we really want to change the culture, and the life expectancies and expectations of those children, we have to address the issue.

The Convener: I will just pick you up on that figure, because last week we were given the figure of 70,000—heaven forfend that it is 100,000 or more. Where do those figures come from?

Jack Law: They are estimates. I cannot, off the top of my head, recollect the exact source of that estimate, but I can provide it for you.

The Convener: Please do that—it would be useful.

Jack Law: I think that that figure comes from an Aberlour Child Care Trust study that was carried out about a year or a year and a half ago, but I will confirm the source for you.

The Convener: Thank you.

Roger Howard: Dr Simpson made a point about services still being in silos five years on. I am struck by how we keep repeating that problem. Silo services do not occur in just drugs and alcohol—they are an endemic problem in a lot of public services. We have robust performance management systems that are very much top down, but we have not incentivised organisations to cooperate and to break out of their silos. Drug and alcohol services are a good example. A number of mechanisms can be used to provide incentives, rather than simply relying on strong performance management and diktats from the centre. That needs exploration.

Ring-fenced and pooled budgets have been mentioned. In England, there are pooled treatment budgets—the national spend is around £450 million, and it is estimated that the leverage in from local sources is about £200 million. There is, however, a lively debate in England—there is support for the pooled budget, but having a ring-fenced budget decided from the centre is controversial. There are arguments for and against—Bill Howat's report argues that there might be times when a ring-fenced budget is necessary. In areas such as justice expenditure, in which much of the budget is decided centrally, there might be an argument for saying that some form of protection is needed in order to get the local and the national funding dovetailed. In England, however, a lot of people are arguing against ring-fenced budgets because it takes away responsibility, and—as David Liddell said—the involvement of all the other agencies. That is a sort of counter-argument.

Regarding the different stages of education and prevention, we should not look at that in terms of chronological ages. We need to think more subtly about the needs that people have. Drug markets are discrete rather than homogeneous. One respected American policy analyst argues that drugs, drug addiction and varieties of drugs go through epidemic-type behaviours—at certain points, there are very sharp uptakes in certain drugs. A good example of that, if we look to the past, is ecstasy—there was a rapid explosion and then, as with an epidemic, there was a tail-off and some form of natural decay.

The early intervention and prevention efforts work best when they are front loaded. In order for that to happen, a strong information and intelligence system is needed that will tell us that the use of drug X is beginning to go up. Intervention is useful at that point, and the cost-effectiveness argument is that it then becomes much less useful. One argument is that we should not bother to intervene when the use of a particular drug is entrenched. We have to face the reality that Scotland and England have entrenched and mature heroin and cannabis markets.

11:00

On enforcement, the argument is made that, if we take out even a few low and middle-level dealers, others will come in to backfill. That is the nature of a mature market. However, that is not an argument for not taking that action. On the contrary, we have to keep doing that because it protects the community.

I return to the point about where you get bangs for your buck. You are politicians and you have constituents breathing down your necks all the time. There is an idea that things that are done at the individual level will not have a big impact. However, if you want some quick hits, quick wins and value for money, you should invest in the treatment of addicts because that brings fairly immediate returns—decreased crime, improved health, and so on. Your constituents are concerned about crime reduction. The international evidence shows that there are some pretty quick wins in the first year and that they stabilise after that. Some people will relapse and reoffend, but in many cases, with other treatments, offending will reduce even more. That also has an impact on the families and the health of the children. If you want some quick wins in relation to what your constituents see, the evidence is that treatment is the way forward.

To back that up, you should seriously consider introducing a mechanism to switch resources from incarceration to community-based treatment. A number of years ago, I worked in social services in England. This might not be the best example because of what happened, but I was responsible for the local authority side in providing for the closure of two large psychiatric hospitals. The budget for the mental health hospitals was transferred from the health service budget to the local authority social services budget. One went down and the other went up. Community care and mental health is probably not the most illustrious example to use, but there is a principle about how we begin to incentivise and transfer resources. How do we find headroom over a period of time? I am sure that there are other policy examples from other domains where there has been a fundamental shift.

That is a political decision. As politicians, you have the red tops and others breathing down your necks, but I argue that the decision is about leadership and the ability to grapple with the issue. By any stretch of the imagination, incarceration is not a cost-effective or value-for-money way of dealing with people who have drug problems and are prolific offenders. There are alternatives, and you would get some swift benefits from those.

If you are looking for a longer term solution—I pick up what Jack Law, David Liddell and others said—it will involve investing in targeted intervention in a holistic way. We have the evidence for that. Research by the organisation Big Brothers Big Sisters of America shows that the offspring of people—it is usually men—who go into prison are six times more likely to end up in prison. Tom Wood mentioned pregnant drug users last week. The trajectory of social disadvantage shows that most people's offending behaviour predates their tobacco, alcohol and drug use. Earlier misbehaviours, such as truanting from school, are missed opportunities for intervention. When we see things in silos and there is ghettoisation and a focus on individual responsibilities, we do not get a holistic response to the behaviour of the young person and their family. We must consider ways to incentivise people to participate in programmes, as well as wielding the stick. We all instinctively reach for the stick, but I suggest that we have not adequately considered how to incentivise people.

I have one final comment on incentivisation. The history of drug policy has a series of what I might call counterintuitive interventions that, on the surface, look intellectually and politically challenging, such as needle exchanges. Some countries have heroin-assisted treatment for people who have failed on other courses of treatment and some contingency-management programmes in the United States of America give vouchers to people who successfully go through a treatment programme. I am sure that many of you, your constituents and the media would be aghast at some of those interventions, but there is evidence that they keep those people in treatment. Sometimes, if you can step sideways and look at

the evidence about what works, that will help guide you when you have the political milieu breathing down your neck.

The Convener: Many of us will be sympathetic to the idea that one should not always reach for the populist solution and that, sometimes, politicians should lead.

Ross Finnie (West of Scotland) (LD): We all knew that the subject was complicated and, although you have been helpful, it has not got any easier.

I have considerable interest in this field but, unlike Richard Simpson or Ian McKee, I have no relevant expertise. To me, it seems that you are sending quite a mixed message. You talk of wraparound care and pooled budgets, but Mr Liddell illustrates that by describing what he would do for a drugs problem. Likewise, Mr Law talks about alcohol issues. If those are the distinctions that your narrative seeks to draw, what precisely would be the benefit of integration, beyond the obvious superficial benefit? Further, in relation to what Mr Howard said, if you look at intervening in people's economic and social background but rule out doing so in a chronological order because there are specific drug problems that you want to address, that will not be easily accommodated within an integrated system.

I hear what is being said about the direction in which you wish to travel but, to be blunt—speaking as one who is an outsider in this matter—the situation is confusing. I am slightly prejudiced by the fact that, in my area, people who deal with long-term alcohol problems and those who deal with drug problems are absolutely clear that, at that stage, they are not necessarily dealing with different clients. It might be that the arguments need to be broken out a bit. However, this conversation has not quite persuaded me. I appreciate that giving brief answers to a committee is not easy, but, in your articulations, you have illustrated constantly—from an early point—the differences between alcohol treatment and drug treatment. Therefore, I cannot quite understand the issues relating to the broader area, which involves an examination of the environmental background of people who have a propensity to turn to alcohol or drugs.

David Liddell: If I understand the question correctly, I would say that the first thing that we agree on relates to interventions with vulnerable families, which would not be specific to any substance. In terms of the holistic care that I was describing, there has been a move to integrate drug and alcohol services because, as I said, there is a lot of crossover between the two groups, as people who relapse on methadone might go on to alcohol. Jack Law might have a slightly different view.

Within that, the issue is about person-centred approaches. If a service is dominated by people with drug problems, some people who have primary alcohol problems might be reluctant to attend because of the stigma of problematic drug use. Issues arise about how we deliver those services, but the general thrust should be to deliver drug and alcohol services together, because of the crossover. Obviously, all the points about holistic care apply to people with alcohol problems, but they perhaps apply more to people with drug problems, who tend to come from very deprived backgrounds and have a range of social problems. To generalise, people with alcohol problems tend to come from a wider range of backgrounds. There are complicated issues about how we mix up the two client groups but, fundamentally, the services should be planned and delivered together.

Jack Law: I agree with most of what David Liddell said. We need to define what the problem is and acknowledge that, with alcohol, we are talking not only about treatment, but about dealing with a population. I will explain how I differentiate the problems. There are two types of problem, which in a sense are related to degree and visibility. The first problem is the people who evidently have problem alcohol use that leads them into extreme financial, family and employment difficulties and who come to the attention of a service in one way or another. That could be through their GP as a consequence of health issues, or it could be through social services or the education system, perhaps because their child is not attending school. That cohort of people needs specific attention.

There is also a population-related issue about our culture of drinking, which is not necessarily the case with drugs. We need to consider what influences our culture and the way in which we drink and how that influence contributes ultimately to the problem with alcohol in society. To reinforce what David Liddell said, there is little differentiation throughout the classes or income groups when it comes to drinking riskily. There is a different kind of differentiation from that with drugs. Many people who drink problematically do not ever become a social problem. They drink excessively and exceed the limits significantly, but that is not evidenced. The other side is that people from disadvantaged backgrounds are more likely to have their health adversely affected by alcohol-related problems than those who live in reasonably advantaged economic circumstances.

Alcohol issues are complex and extremely difficult. I share Ross Finnie's difficulty with trying to understand where everything fits and therefore how we can make the interventions that are required. People who have alcohol problems in their domestic situation and who come to the

attention of services often have a range of problems, such as mental health and financial problems. As I said, all that they want is support. The difficulty is tackling the bigger issue—the population and culture issue. How do we stop or slow down the problem drinking that is evident in our society? To use a broad measure, I am talking about people who drink in excess of the weekly limit of 21 units for men and 14 units for women. That issue is the other side of the alcohol equation and spend.

How do we teach and enable people, particularly adults, to shift and change their drinking behaviour so that they will influence their children? We know that, in most instances, children learn how to drink alcohol from their parents in a domestic situation. If we can convince and change people's behaviour in that situation, the likelihood is that we will change their children's behaviour. Allied to that is the issue of how alcohol is sold. That is where things get even more complicated. Alcohol is significantly cheaper than it was 20 or 30 years ago. It is possible to get alcohol at very low prices now.

11:15

The Convener: Time is pressing, so we will simply accept that point. We know about the big debate on, for instance, buying one crate and getting another crate free. We are also aware of the endeavours of the Cabinet Secretary for Justice and the supermarket issues that are being discussed at Westminster.

David Liddell: My final point was that how alcohol is sold also influences how people view alcohol. We need to spend money on that through the budget.

Roger Howard: Much has been said about that. I wish to go back now to the economic analysis, thinking about the markets for substances. I do not know whether you are aware of this but, a couple of years ago, the then Government office of science and technology completed a major project on brain science, addictions and drugs as part of the foresight programme. That included various research evidence overviews. Taking alcohol and illegal substances together, the OST was particularly interested to examine the impacts of, to use the economic jargon, cross-price elasticity.

The Convener: I feel like saying "Jings!"

Roger Howard: It is important that we try to understand the markets for the various substances. They are goods, and drugs behave like any other commodity in a market. I will read to you from a review that was commissioned for the project on brain science, addictions and drugs, which said of studies on alcohol and marijuana:

> "The majority of these studies found complementarity between these two drugs, suggesting that restrictions or higher prices for alcohol will reduce both drinking and marijuana consumption."

It is interesting how we might link things together. If we take action in one area, it will bring a benefit or gain in another area. There is a lively debate around that, but you should realise nevertheless that what you do might have a ripple effect or benefit elsewhere.

The Convener: Perhaps some unintended positive consequence.

Roger Howard: Absolutely.

Michael Matheson (Falkirk West) (SNP): I am conscious that we are discussing the budget process—there is a danger that we might drift into an inquiry into drugs and alcohol misuse. I am a little confused about the evidence that I have heard from you about budgeting. You have spoken about your concerns over organisations or funding operating in silos. You have mentioned the potential benefits of ring-fenced budgets, but also the benefits of pooled budgets. I am not entirely clear whether you favour pooled budgets to help integrated services and the important wraparound services, or whether you think that those services can easily be delivered through a system of ring-fenced budgets.

Can you help me to understand whether you are in favour of trying to get out of funding silos—I am referring to ring-fenced budgets—by having pooled budgets instead? Will pooled budgets deliver integrated services without the accompanying structural reform to ensure that you can deliver wraparound services? Any of youse, please.

The Convener: "Any of youse, please"—there is a cry from a Scotsman. Who would like to start on that?

Roger Howard: To give you a straight answer to that, I do not think that we have robust enough evidence to say that one way is better than the other. It depends on where people sit. Someone who sits in the centre will want control over a lot of things; someone in a local area probably wants as much discretion as possible. It depends, in other words, on who we ask.

On the stage of development—David Liddell was speaking about so-called wraparound and social reintegration services—there might now be a strong argument for some form of pooled budget, such as in England, but with a ring-fenced budget—you might also need to ring fence the budget in some way. They are not mutually exclusive. There is an argument—

The Convener: I want to follow your argument, as I followed what you said about cross-something

elasticity. [*Laughter.*] Are you talking about pooled, ring-fenced money?

Roger Howard: Yes. It comes from the Home Office and the Department of Health—

The Convener: I am still with you.

Roger Howard: The approach might be at a certain stage of development.

Michael Matheson: How much detail should there be in ring-fenced budgets? Should they identify specific elements, such as treatment, or should there be a ring-fenced, pooled budget for drugs and alcohol in generic, holistic terms, which does not go further and specify, for example, that 40 per cent of the budget is for treatment and 20 per cent is for research?

Roger Howard: Perhaps David Liddell wants to talk about the Scottish context.

David Liddell: As I said, drug action teams are held to account, but do not have the levers at their disposal. I suggest an overall, pooled, ring-fenced budget—those terms can be defined in different ways. Government could then say, "Of the £10 million in the budget, we suggest that a certain amount be spent on this and a certain amount on that." However, decisions would be made locally on the basis of local circumstances. Needs assessments, which took account of the social circumstances of and differences between local alcohol and drug-using populations, would inform how the money would be invested. Currently, the difficulty is that our strategic planning structures are not strategic planning structures, because they cannot control funds.

It is not easy to devise a way of delivering such an approach in practice. I suppose that my vision is for a budget that is top-sliced from the budgets of different departments and delivered through a single funding route, which could be health, if other departments were willing. It is a question of how flexible Government can be. An entirely new funding stream could be set up, but it would be sensible to use existing mechanisms. I would be wary of adding to the considerable bureaucracy in the area by introducing new planning structures. We can make the current structures work better.

Jack Law: I agree. The issue comes down to three or four points. It is about thinking nationally but operating locally. The national formulation might propose a particular formulation around alcohol and drugs spend, but ultimately a service must be delivered to the person who needs it or to the community that needs support. Such matters must be determined locally.

Specificity of outcomes is key. What are we trying to achieve with the spend? What accountability mechanisms will enable us to demonstrate that what we want is happening? If what we want is not happening, why is that and what needs to change? Such issues need to be considered nationally, so that we create a national framework—or get the best out of what is already there—and enable it to be clearly interpreted locally.

There also needs to be a local commissioning framework that clearly identifies the services that people want to purchase, not just from the third sector—the voluntary sector—but from across the board, in and outwith the statutory sector. We need clear indications of what needs to be spent and why, who is delivering services and how the money will be accounted for.

Roger Howard: With any budget, what matters is what goes into it. In England, a special pooled treatment budget draws money from the Home Office and from the Department of Health, but the prisons budget, for example, lies outwith that. A value-for-money exercise would include the cost of a prison place, which has been estimated at £50,000 a year. If that were left outside the thinking, the ability to shift money around would be constrained.

The Convener: Next week, the committee will take evidence from the Cabinet Secretaries for Justice, for Finance and Sustainable Growth and for Health and Wellbeing, because we are aware of those issues. Members of other committees will attend that meeting, for the exact reason that you have given.

Before I call Helen Eadie, I have a quick question that relates to something that David Liddell mentioned. We are running out of time, so I ask for a quick answer. I have asked about ADATs before. As part of tightening the system—including the funding, accountability and operation of ADATs—should ADATs be made statutory bodies?

David Liddell: I have referred to that issue. I would go not for that model, but for funding through one route, such as health services. However, that money would have to be signed off by alcohol and drug action teams before it was disbursed and all the issues, such as having appropriate commissioning structures, would have to be taken into account.

Helen Eadie (Dunfermline East) (Lab): We have heard comments about American and international comparisons. The committee is interested in international comparators. Will you highlight examples of best practice in European countries? Spending on research in the United States has been contrasted with that in this country. I would like more information on lessons for the committee to learn from other countries in Europe or from the States.

David Liddell: As I have said, it is evident that the size of a country's drug problem is strongly linked to the extent of social problems there. Recently, Sweden and the Netherlands have been compared. They have different drug policies—one is pretty hardline and the other is fairly liberal—yet both have relatively small drug problems in comparison with ours. Drawing specific lessons is not always easy.

I mentioned the project in Arnhem. The Dutch approach is to provide the full range of services for the most vulnerable. I could pick other examples, but the Dutch one is interesting, because of the amount of resources that have been invested. The evidence is that that population is ageing and that there are few recruits to it.

Jack Law: There are several examples. The first one that strikes me is server training for sellers of alcohol, which happens in the USA, Australia and New Zealand. We deliver that in Scotland and such training will be compulsory under the Licensing (Scotland) Act 2005. You might think that the example is a bit oblique, but we in Alcohol Focus Scotland have found that about 20 per cent of the people who undertake that training change their drinking behaviour as a consequence—we have asked about that in our research. That is 20 per cent of a fairly large section of our population. If such training were introduced in secondary schools as part of service sector training for young people, it could have an equal benefit.

Secondly, brief interventions have been proven throughout the world to make a difference to people's drinking behaviour and to the consequential problems that arise. Thirdly, it has been demonstrated that within student populations, particularly in the United States, positive social norming changes students' drinking behaviour. That involves dealing with alcohol-related issues not by saying, for example, that 35 per cent of young people have an alcohol problem, but the other way round—by saying that the majority do not have an alcohol issue. Finally, working with young people who are affected by someone else's alcohol misuse has been found to be effective throughout the world.

11:30

The Convener: That is the second time that you have mentioned those four priorities. Have you costed them?

Jack Law: No.

The Convener: We need a cost for those if we are going to tackle the cabinet secretaries on the issue.

Roger Howard: Part of the problem is that you do not have the research and the knowledge base on which to do some of that work. You are struggling to find the answers—as are we—because there has not been investment in research and what we call knowledge development. I urge the committee to provide that leadership—and shame England, if I may say so.

The Convener: You make it sound so tempting to us—certainly to a Scottish nationalist.

Roger Howard: I will be on your side on that one.

I will give you a couple of examples. Australia has invested in three national research centres that are contracted to support and evaluate their drugs strategy. In Canada, there is a statutory body called the Canadian Centre on Substance Misuse that is enshrined in legislation and independently provides a lot of the evaluation, knowledge development, and knowledge transfer. The United States Department of Health and Human Services has just funded 15 centres for what they call addiction technology transfer—lovely jargon—which is how to spread good practice. I am sure that you will say that there is not the money and things like that, but if you do not do it, you will be asking the same questions five or ten years down the line.

Regarding wraparound services and the integration with employment, countries such as Germany and Italy do that much better than we do. There are new developments and innovations such as heroin-assisted treatment, which is counter-intuitive, but it happens in Switzerland, and there are trials going on in the UK that are promising—there are significant and sustained reductions for a small cohort of people. One can draw on things such as that. Some of the measures, such as drug consumption rooms, are contentious, but there is international evidence to support them.

The Convener: I will ask Mr Liddell a final question. You suggested that there would be funding from the Department for Work and Pensions for ADATs. How?

David Liddell: I would leave that to you.

The Convener: I thought that you were going to provide me with an answer.

David Liddell: I was pointing out that the DWP has funded things such as the progress to work project, which is directly aimed at getting people into work. The point is that, if you are trying to plan all your services strategically, you do not want to have things that are outwith that strategy—it is the same with some of the criminal justice programmes that have not come sufficiently into the sphere of drug action teams.

On evidence, my first plea is that we should not be gathering more, but using what we have to inform how we deliver services. We have lots of evidence-based practice that we are ignoring just now in terms of delivering our services. I would not, however, disagree that we need more evidence.

The Convener: We will stop there because of the shortness of time, but it would be useful if you would write to the committee about the things that you say are being ignored, so that we know what you are talking about—in your initial remarks you said that you queried the evidence on which the funding decisions are based. Unless you do it very briefly now, it would be useful to tell us in writing about the evidence that is being ignored and that we ought to be paying attention to. Can it be done briefly, or do you need to write to us?

David Liddell: It would probably be better in writing. There are specific things, such as the prescription and the dosage levels of methadone, and the social care aspects of that—all the wraparound issues—on which there is significant evidence, as there is concerning the building of relationships, which I mentioned. I will write to you in support of that.

The Convener: If you have additional points to make, write to me in my capacity as convener, so that those points can form part of the consideration of today's proceedings and can be put in the public domain.

I am conscious that we have another panel of witnesses and that we have overrun, but I am sure that committee members agree that hearing from this panel has been extremely worth while.

11:35

Meeting suspended.

11:45

On resuming—

The Convener: Item 3 concerns evidence on the sport budget. We have before us Julia Bracewell and Stewart Harris, respectively the chair and chief executive of sportscotland. Welcome to the committee and thanks for your forbearance during the previous extensive evidence-taking session. You may make a short opening statement.

Julia Bracewell (sportscotland): I want to lay out the general landscape of public funding for Scottish sport, particularly in relation to sportscotland.

In the period from 2000 to 2006, the total public expenditure on Scottish sport was £473 million. That figure was made up of local authority expenditure of £426 million, which was around 90 per cent of that figure, £26 million of exchequer funding, which was 5.5 per cent, and £22 million of lottery funding, which was 4.5 per cent. Delivery of national priorities within that relatively small amount of expenditure requires a high degree of targeting and prioritisation.

Of the local authority expenditure, £215 million was grant-aided expenditure from central Government and the rest was the net expenditure by local authorities. Therefore, in round terms, 51 per cent of public expenditure on sport comes from the Government, 45 per cent comes from local authorities and 4 per cent comes from the lottery.

Unfortunately, lottery income that is available to sportscotland has fallen from a peak of £33 million in 1997-98 to £18.5 million in the current year. That is partly because of the inevitable decline in ticket sales, but it is also because, in 1999, a share of our income was top-sliced for elite sport at a United Kingdom level. Further, future lottery income to sportscotland will decline due to the funding of the London 2012 Olympic games. That decline will be the effect partly of a diversion of lottery ticket sales and partly of direct contributions to the Olympic Delivery Authority. Taken together, that drop in income will total about £13 million and will mean that we will have an annual income from the lottery of just under £17 million.

In keeping with Westminster's requests, we have been reducing our lottery balance. Given our current commitments, including the completion of the Government's national and regional facility strategy, by the end of our current plan, in 2010-11, our lottery balance will be a negative amount of about £3 million.

The recent spending review announcement gave us an additional £31 million over the next three years, which is a welcome balance to a fairly

depressing picture. However, the difference that that funding might make is entirely dependent on whether it is new money. We currently have £27 million sitting in capital reserves for the national and regional facilities strategy and we still do not have clarification of whether the £31 million includes that money or is in addition to it, which is fairly fundamental.

In general, we foresee a period in which we have to severely prioritise our investment to make key improvements to the state of Scottish sport.

The Convener: You have given us so much detail that I will ensure that copies of the paper that you have given me to accompany your opening remarks are circulated to members who, I see, are busily trying to scribble figures down. It would be quite useful for members to have those figures before them this morning.

Julia Bracewell: That is a good idea.

Scotland has just won the 2014 Commonwealth games bid. That gives us a huge opportunity. What we have to decide is how ambitious Scotland wants to be for the games.

First, we have to get our athletes, officials, volunteers and referees up to scratch, because we will need more of them than we normally need. More important, we have to decide what the legacy of the games will be. Are we going to set out to increase sports participation and deliver a healthier and fitter Scotland? If we are, that will have an impact on funding for sport, not just sportscotland.

The Convener: Thank you very much. I remind members that we are dealing with the budget and not the life hereafter—or otherwise—of sportscotland, which we will deal with in January. Members should keep their questions to money and budget matters.

Michael Matheson: You referred to the decline in the lottery fund and the further decline to the budget that will be caused by funding for the Olympics. What are the practical implications of that? How will it play out for sportscotland?

Julia Bracewell: We are forecast to lose £13 million. Given that our current elite sports funding runs at £5 million a year, we could say that no money will go into elite sport for three years. Alternatively, given that governing bodies take about £4 or £5 million a year, we could say that no money will go to them in those years. Obviously, there is also the building for sport programme in communities, which could be wiped out. If we were to lose £13 million, we would have to say, "Do we take the cut out of one of those areas, or do we spread it across the whole? If so, what will that mean?"

Clearly, the Commonwealth games are coming to Glasgow, but they will take off and get their heart only when Scotland wins its first gold medal and our teams continue to perform and do well. It will be very difficult to take money out of elite sport. At the same time, if we want facilities, or for the governing bodies to cope with what we hope will be increased demand as a result of the games, it will also be difficult to take the money from those areas. If we lose the £13 million, we will be between a rock and a hard place.

Michael Matheson: The decision to take away the additional funding from the lottery budget was made by the DCMS. I understand that you are involved in the regional group that discusses—

The Convener: For the record, would you say who that is?

Michael Matheson: It is the Department for Culture, Media and Sport at Westminster.

What representations have been made to the DCMS? Have you made clear to the DCMS the implications for Scotland if lottery funding is cut to help to support the London Olympics? At the very point when we are building up to the 2014 Commonwealth games, we are facing a serious funding shortfall for our athletes. The dilemma is real. If you have raised the matter with the DCMS, what was its response?

Julia Bracewell: We raised the matter with Scottish Government officials who, we understand, made representations to the DCMS. Clearly, I also sit on the UK Sport board, which wants to ensure that elite funding is not affected. The DCMS has given us assurances that certain current projects will not be affected. We have also been told that, when the land is sold after 2012, some money will be put back into the lottery fund as a result. The representations were made by the Scottish Government on behalf of Scotland. I suggest that it will have more of an insight into that than I have from anything that I have learned in conversation with ministers down south.

Stewart Harris (sportscotland): We have taken steps to ensure that written representation is made by all the home country lottery distributors that the amount of money that we are projected to lose should be capped. We are trying to have it put in writing that all the distributors are finding the matter uncomfortable and that we are not keen that this should go any further.

Michael Matheson: Has the DCMS been able to give you that assurance?

Stewart Harris: We have not had a response as yet.

Michael Matheson: Okay. If the cut goes ahead and you have to consider ending the funding for an area—whether elite sport, community sport, or

whatever—how will you arrive at the decision on where cuts should be made?

Julia Bracewell: Obviously, we have budgets for future years. Over the past year—certainly, over the past two years that I have been on the board—we have been looking at projections for the possible decline in ticket sales. We have already taken account of some of the lottery considerations. The sportscotland board will scrutinise the officers' plans and will ask various questions. Recently, for example, the board took the view that, because it regards coaching as highly important, it would direct officers to shift money from a budget that was underallocated into the coaching budget.

There is an active board that is very involved, considers the priorities and then debates which priorities are necessary. It then tries to come up with a fair and balanced approach to deciding where money should be spent. It is all about prioritising, targeting and considering outcomes if money is spent on something. Historically, sports got money, but the old days have gone. There is now a much more integrated approach in considering how local authorities get their money. There is no point in giving local authorities money for facilities if they do not have a coaching programme. The board carefully thinks about what the big priorities are and then asks officers to go off and do the operational stuff on a day-to-day basis.

Michael Matheson: So sportscotland's board will decide the areas in which the £13 million cut in lottery funding will have to be felt.

Julia Bracewell: We are all ministerial appointees who take into account ministerial directions, and if the minister says that something is our priority, we obviously take on board what is said. We do not ignore such things. We work with the minister and the Government to ensure that we know what the national priorities are. If the national priority is to win more medals in Glasgow, to have a bigger team or to increase participation in grass-roots sport and we do not have enough money to achieve all of the aims, we will probably have to work out a balance in consultation with civil servants and the minister.

Mary Scanlon: I would like to talk about another £13 million—the £13 million increase in sportscotland's budget over the next two years, until 2009-10. The figure is up from £34.3 million to £47.3 million. The Howat report states:

"Sportscotland is also expected to deliver £200k of efficiency savings. We believe this to be tokenistic and non-challenging. *We would suggest a target of around 7% of its gross budget to* ***secure savings of around £1.7m annually***."

Howat has also strongly stressed over and over again not only in relation to sportscotland but in relation to the Scottish Institute of Sport that there is no effective delivery model. The report states that there is

"a worrying trend of reduced participation … no objective basis on which to measure sportscotland's performance"

and

"an absence of SMART goals and deliverables".

How can the committee consider sportscotland's budget if we have so little to measure it by, apart from the

"worrying trend of reduced participation"

that the report mentions?

Julia Bracewell: I will divide that up into three different issues. The first issue is the Howat report. Around 88 per cent of the exchequer and lottery money that sportscotland receives is given to local authorities and Scottish governing bodies. We have only £6.2 million left on which we can make an efficiency saving. If the £1.7 million is set against that £6.2 million, Howat is actually asking us for a real efficiency saving of 27 per cent, which is quite a high saving.

The second issue is goals and outcomes. Through business planning within sportscotland and looking forward to the next corporate plan, we are up against specific goals by which we will measure our performance. If better goals or targets come from the Scottish Executive, we will be happy to work with them, but those that the board has set are clear, and they will be available to the committee in due course.

The third issue is decreasing participation in sport. It is interesting that Scotland is not alone in that respect. We are no worse off than other countries—indeed, Australia, which is often held up as the great sporting model in the world, has roughly the same decreasing participation rates as we have. Decreasing participation in sport is a worldwide issue, and we are keen to tackle the decrease here on the back of the Commonwealth games. Now that people understand how sports events deliver an economic legacy, the holy grail for sports events nowadays is to leave a sports participation legacy. To do that—to try to avert the worldwide change and change behaviour—is a huge task.

12:00

If the committee wants, I can give you all kinds of costings on which areas need to be addressed, how we attract people who are minded to do sport but are not currently doing it, and how we get the 25 per cent of the nation who are not involved in sport back to sport or a physical active lifestyle

that would lead to a healthier and fitter Scotland. I can take you through any range of figures that you want.

Mary Scanlon: I understand goals and targets, but I am looking for the inputs in terms of value for money and effective and successful outcomes. Where is it best to spend the money?

One thing that you did not mention was the £13 million increase in your budget in the next two years. Do you have specific inputs for that? Do you have research that shows the best place for the investment of resources to get the maximum output in the lead-up to the Commonwealth games?

Julia Bracewell: As part of our submission for the spending review, we took the whole of sport to bits and then built up from that, asking what we needed.

The major asks that we put in, excluding facilities, totalled an extra £30.5 million per annum into sport. That covered the following areas: £5 million to deliver the coaching network under the UK coaching certificate; £9 million to get secondary schools fully into the active schools programme; £7 million for our Commonwealth games team to ensure that we have competent performances from all and we sustain the medal tally; £4.5 million for club development, which helps the links from active schools into clubs; and £5 million to pay for the Scottish Institute of Sport so that it is paid for by the exchequer rather than lottery money. That comes to £30.5 million.

In addition, as the committee will be aware, there is a £2.1 billion shortfall on facilities in the next 20 years. We said that an extra £20 million per annum for facilities would begin to make a dent in the facilities problem across Scotland.

The Convener: Sorry—how much was that?

Julia Bracewell: It was £20 million per annum—a drop in the ocean.

Our total ask was £50.5 million per annum. Given that we are looking at receiving £31 million in the next four years, we have to go back to prioritising. The funding is £9 million extra per annum plus another £4 million in one year. The £9 million per annum would cover our Commonwealth games team preparation, leaving us with £2 million. So, what do we do? Where can we strike the balance? Will we roll out active schools to secondary schools to try to get a fitter nation? Are we going to compromise success in the Commonwealth games to deliver other programmes?

Mary Scanlon: I appreciate what you are saying, and the Commonwealth games team is important. You have just given us a list of investments, for example in coaching and active schools. To use the previous speakers' phrase, are they the best bangs for the buck? Are they programmes in which the minimum investment will achieve the maximum output, or are we missing something else?

Julia Bracewell: The investments deal with the "Reaching Higher" strategy. Do they do enough to avert decreasing participation? I do not think that they do. They are foundation programmes that begin to build capacity. The clever bit is the legacy plan, which is still embryonic but will, we reckon, cost about £20 million per annum. That will involve a proper community coaching system that gets into the communities at grass roots and has a role in active workplaces.

There are a couple of big drop-offs in sports participation. One is between the ages of 22 and 45, one reason for which is that people are working and their time is pressurised. Part of the active workplaces idea looks at what we can do with employers to encourage and help their staff to be more active. We know that the fitter that a company's staff are, the better their productivity is. From speaking to people at Diageo, which was a sponsor of the 2014 bid, I know that the programmes that it ran with its staff have had huge benefits. They have made their staff fitter and made them enjoy working at Diageo more. There are big wins in that for employers.

That is why I began by asking what the ambition is. If it is just to sort sport, that will cost £50 million. If it is also to try to use activities in workplaces and at the grass roots to attract people who are minded to do sport but do not participate in it, that will cost a further £20 million. If we want to tackle the 25 per cent not involved in sport at all, then we will be into a huge social marketing project, which Scotland is extremely good at. We have been very good at preaching alcohol, drink and food messages, but we have not gone to people with an exercise message.

That is how I compartmentalise sport. We need a better legacy from the Commonwealth games to get people involved and then we need to go for the big dream: a healthier and fitter Scotland. Those are different parameters.

Dr Simpson: Will any of the money that is being passed to the Olympic effort and therefore causing us a loss come back to Scotland?

Julia Bracewell: Yes.

Dr Simpson: Could you illustrate that?

I understand that only one Scottish university is a member of the Wallace group, and it is not specifically designated as a sports university. In contrast, England has two sports universities, the funding for which is massive compared with the funding in Scotland. With the Commonwealth

games coming along, are there proposals for us to have a specific sports university, whether or not the current member of the Wallace group? Has anybody costed the idea? I must declare an interest, because I am an honorary professor at that university.

The Convener: I was beginning to wonder whether you would have an interest to declare. Yours has been an active life.

Dr Simpson: I am not pushing that university but advocating the concept of having—in addition to the Scottish Institute of Sport for elite sport—a specific university to provide co-ordination and fitness laboratories. Loughborough University and the University of Bath provide those things in spades and produce huge numbers of gold medals as a result. What are we doing about creating a sports university in Scotland as a focus?

Julia Bracewell: The £13 million that is going out for the 2012 Olympic games is going from grass-roots sport. However, the UK Government has announced £300 million extra in total until 2012 to help elite sport. We benefit from that because any of our Scottish athletes who are on world-class performance plans or development plans get money back. I think that about 11 per cent of the athletes currently on world-class performance plans are Scots, so we punch way above our weight. That is not to say that 11 per cent of the money comes back, because it depends where the squads are based, but individuals are being looked after.

I know that the University of Stirling has requested special sports university status.

Dr Simpson: I was careful not to mention the University of Stirling.

Julia Bracewell: I am involved in a UK Sport project on elite training centres. A lot of it is concerned with what can go wrong on university campuses and how they could work better for sport. UK Sport came up to look round the University of Stirling. It does not have a lot of the issues that Loughborough University and the University of Bath have; it is a really good model.

I am all for a sports university, whether it is the University of Stirling or somewhere else, because something magical happens when people are in a really good learning environment in which they are being taken on to excellence not only in their learning but in their sport. There is an awful lot that we can learn from US and Australian models. That has not necessarily been a priority of sportscotland, but it is a national priority. There is no doubt that the Scottish Institute of Sport has benefited not only from being so close to the wonderful facilities at the University of Stirling but from being in the environment of academic excellence. When it comes to sport science and sports medicine, we want to push the boundaries.

The Convener: What would the cost of all that be?

Julia Bracewell: I have not priced a Scottish university model, so I leave the answer to others who have.

Dr Simpson: I can help in that regard. It would probably cost around £20 million.

Ross Finnie: At Stirling prices.

The Convener: Heavens! That was such a bad pun.

Helen Eadie: In your opening remarks, you welcomed the £31 million from the Scottish Government that was announced as part of the spending review, but with a caveat. You said that the effect of the money would depend on whether the capital reserves that had been laid aside would be available to you. How much are those capital reserves? Have you made representations to the Government about that and, if so, when? Have you had a response?

Julia Bracewell: We have £27 million on reserve to pay for our existing commitments on the national and regional facilities strategy. Stewart Harris will be better able to fill in the detail, but we have been making inquiries of the Government ever since we knew what money would be made available as part of the spending review. We have not yet had clarification of whether the £31 million is in addition to the £27 million or whether it includes the £27 million.

Stewart Harris: We will meet the Government sports division to ascertain that as soon as we can. We will do that before we even begin to prioritise allocation of additional money.

Helen Eadie: When did you first make representations—in July, in September or just last month?

Stewart Harris: The national and regional facilities strategy has gone on for such a long time—for some, probably too long. We have had continuing discussions about it. We have had to take steps to ensure that projects in Edinburgh and elsewhere are either accelerated or we make another decision about their future. There has been on-going discussion about those budgets.

The Convener: I want to clarify what you are saying because lots of figures are flying past me—figures tend to be a bit of a blizzard in my life. You are saying that you will get an additional £31 million over the next three years, but you seek clarification as to whether that includes the £27 million in reserve. The Cabinet Secretary for Health and Wellbeing will appear before us next

week, so we can put that question to her and get the answer for you.

Helen Eadie: Would it be fair to say that the discussions have been going on for more than six months?

Stewart Harris: We did not know what the outcome of the spending review would be until last week, but we have had an on-going conversation about the projects in the national and regional facilities strategy, which it has been a massive task to finish.

The Convener: You should get an answer next week; we will certainly pursue the matter.

Ian McKee: I will go back to basics, although, in doing so, I will probably just reveal my ignorance of the topic. As far as I am aware, there is little evidence that participation in elite sport is healthy. I suspect that if we looked into the subject, we would find that, in later years, elite sportspeople probably pay for their elitism with their health.

As far as I can see, we encourage elite sport on the ground of national prestige—we all feel better when we know that Scots are doing well on the international stage—and to encourage the couch potatoes among us to get off our couches and do some exercise, thereby benefiting the health of Scotland. If you are short of money, should your function be to further elite sport by fostering potential participants in the Commonwealth games? In other words, do you just forget the other goal and hope that the example of people participating in elite sport will, on its own, succeed in encouraging others? Alternatively, should you spend less on encouraging success in elite sports and more on the much duller aim of getting people to take minimal exercise—which is much better than their taking no exercise at all—on the ground that it might represent a better investment for the health of Scotland?

Julia Bracewell: I regard elite sport and grass-roots sport as being intrinsically linked—we cannot split them. The people in the governing bodies and the volunteers who give up their time to help others to get involved in sport have a dream that one day their team will win, whether we are talking about the local league or a gold medal. People are in sport to do well—even at the grass-roots level people are always pushing.

The elite athletes are incredible. If somebody who has a medal in their hand goes into a school, all the kids want to touch the medal. The athletes have an aura, or status, which means that they can put across messages that others cannot. One measure that we would like to take in relation to the Commonwealth games is to use our elite athletes properly and in a focused way, which probably has not been done before. A great example is that of the football player who asks kids what they ate last night and the kids say fish and chips or pizzas. The guy says, "Really? I didn't." He says that he eats such and such and plays football and now owns however many houses and plays at Hampden. The kids realise that there is a link between food, fitness and success.

12:15

Elite athletes are important, not just because they win gold medals and make us feel good, but because of the images that they portray. Therefore, for us, there is a balance to be struck. Last year, I asked the Australian Sports Commission about the legacy from the Sydney Olympic games. Obviously, Australia has great elite athletes who did really well in the games, but the commission told me that it did not have a participation legacy and that the opportunity was missed. With hindsight, the commission realises that it should have started building the necessary capacity seven years earlier. Australia's athletes performed really well and lots of people in sport wanted to involve them, but there was no capacity for that. Some sports there now have fewer people participating than in the three years leading up to the Sydney games. I hope that we can learn a lesson from that for Scotland.

Ian McKee: I thought that you said that you did not have funding for elite athletes.

Julia Bracewell: We do not. There is a hugely important balance to be struck. If you are asking whether we would get away with not funding elite sport and having the most disastrous Commonwealth games in Scottish history, the answer is that I do not think that the nation would allow us to do that. In every other nation, as games get closer and closer, people focus on the performance of those athletes and forget or do not concentrate on the wider participation and health issues. Right now is the time for us to say that we in Scotland are going to do something different.

Ian McKee: I may be missing something, but I thought that you also said that 11 per cent of the UK elite sports budget was being spent on Scottish athletes, so why will they not benefit?

Julia Bracewell: They will, but the Commonwealth and Olympic sports are different. For example, rugby, netball, bowls and squash are in the Commonwealth games and some other events have different disciplines. So although some of our cyclists, swimmers and athletes will be paid at UK sport level, an awful lot of other sports are not Olympic sports, so we need to do something. For example, if we want to get into the last eight of the rugby sevens competition, a lot of work will have to be done. Scotland has not even

been represented in netball at the Commonwealth games.

We want every Scot who buys a ticket to watch a Scottish team perform in the games to come out knowing that they have been entertained and have seen Scots doing their absolute best. In Australia, I made a point of going to watch Scotland versus Australia at basketball: we were tanked. It is a rotten feeling walking out of a venue after seeing your country get absolutely tanked. Now that we have the Commonwealth games, we owe it to anybody who buys a ticket to ensure that they watch good performances. We might not win, but as long as the competition is close and we are beaten narrowly, we will be okay.

Stewart Harris: We must consider the participation budget as a whole. The national budget is dwarfed by the budget that goes to local authorities. We take account of that and we work with all 32 authorities to consider how they spend their money, how they prioritise and how we might complement that work with the money that we have.

The Convener: You do not need to remind us what it feels like to lose, given recent events.

Michael Matheson: Julia Bracewell said that sportscotland has requested £20 million a year to help deal with the deficit of just over £2 billion in funding for sports facilities. I presume that she was referring to the sportscotland audit of sports facilities, which identified that deficit.

Julia Bracewell: Yes.

Michael Matheson: Why do we have a deficit of just over £2 billion in funding for sports facilities?

Julia Bracewell: That is because facilities have not been maintained. Many facilities were built in the 1960s and 1970s and are now past being usable. The point is that we need to either knock down and rebuild the facilities or spend a lot of money refurbishing them. Over the years, facilities have not been maintained as well as they could have been, which would have made them last longer.

The £2.1 billion relates to swimming pools, pitches, sports centres and the whole gamut of facilities. The figure that was arrived at for getting those facilities into the right state, and to give Scotland the facilities that it needs at community level, was £2.1 billion.

Michael Matheson: The report is useful and detailed, and I would recommend it to any members who have not yet read it. It is an eye-opener.

What representations did sportscotland make in the past by way of budget requests for helping to fund the increasing deficit for maintaining sports facilities? Why has it been left until 2007 before making such a request?

Julia Bracewell: I have been in my post for two years. We have been making that request for as long as I have been there. Stewart Harris might know about what happened before that.

Stewart Harris: In the main, we have relied heavily on lottery funding for facilities. When the initial £33 million was in place in the very early years—the mid 1990s—the entire amount was spent on facilities. The amount has declined, but asks have increased.

We have begun discussions with our local authority partners to find out what they can put in. In recent years, we have received some additional resources from the Executive to tackle the issue, including end-year funding, which we can easily put in place to allow projects to go ahead. There is no longer a reliance on lottery funding, and we need to make representations for some amount of catalytic or seedcorn funding with which to lever in other funds and to help our local authority partners deliver projects. The funding for the schools estate will help: there is a large building programme included in that, which will put more facilities in place.

Michael Matheson: I want to stick with facilities. You both referred to the national and regional sports facilities strategy. Am I correct in saying that it should deliver 10 different projects?

Julia Bracewell: Yes.

Michael Matheson: How many of those projects have been delivered?

Julia Bracewell: They are all at different stages. Work has certainly started on seven of them—I am thinking of Toryglen in particular. We are still waiting for stage 2 applications for the two Edinburgh projects.

Stewart Harris: The projects that are currently missing are in Edinburgh and Falkirk. We hope to hear decisions on both soon.

Michael Matheson: My understanding is that all the projects are well outwith their original completion timescales. Why? What budgetary lessons can we learn in order to carry out such projects more effectively and quickly in the future?

Julia Bracewell: It was great to get £50 million to spend on national and regional facilities. That £50 million was intended to leverage out the total costs of £250 million. The lesson is that £50 million from central Government and £200 million from local authorities was just too difficult to secure. It has often purely been a case of whether a local authority has been able to raise the additional finance to make the money from central Government work. Either you need to find the right

ratio of central Government money, local authority money and other money, or you do fewer projects. However, the projects that are on the list are all really good projects, which Scotland needs. It is about striking a balance. Perhaps we were too ambitious about how much £50 million could lever out of the local authority sector.

Michael Matheson: You have given us two options: fewer projects or shifting the balance of funding. In your experience as head of sportscotland, what do you think would be the best route?

Julia Bracewell: I would say that there should be more investment centrally. We are talking about providing really good national and regional facilities that people are crying out for throughout Scotland. It is no secret that sportscotland has found a bit extra from other budgets to ensure that a couple of those projects can go ahead. We are severely limited, however. We might be able to find another £1 million from somewhere, but we cannot find extra sums of £10 million or £20 million, so some projects might come in with huge deficits. We can perhaps do a little bit, but we cannot address the whole deficit.

Michael Matheson: So the original leverage level was wrong.

Julia Bracewell: I am not sure that it was wrong. It was highly ambitious, or something did not quite come through in the calculations.

Michael Matheson: Who made the calculations?

Julia Bracewell: I do not know.

Stewart Harris: It was clear in the original strategy what we were setting out. At that time—2004—we were setting out the cost for each facility. There was a list, or menu. Local authorities bid into that and we indicated how much of the central resource would be available. That is when we got into the initial leverage discussion, whereby £50 million would free up another £250 million. As you know, costs increase in the construction industry as time goes on, so the funding gap increases.

There was a great desire from us and the local authorities to make the project happen. It was probably not dynamic but it was certainly ambitious. At the least, we have seven projects that will be fabulous, and with a bit of luck we will get the other three as well. Otherwise, we will need to reprioritise and make decisions about resources.

Michael Matheson: That is helpful. Thank you.

Dr Simpson: I have two quick questions. First, I understand that regional centres of excellence are being established as part of the drive towards the Olympics, and that some Scots are having to travel down to centres in England. I do not know how the costings for that work, but have we bid for and been successful in achieving any of the UK regional centres of excellence? If so, in which sports have we bid and in which have we been successful?

My second question is on a different matter. The previous Executive had a drive to persuade local authorities that there should be at least two hours of physical education per week in primary schools. That has not been achieved, despite the target having been set. The matter is one for local authorities and will continue to be so under the new situation in which grant-aided expenditure is not ring fenced. What costs are involved for local authorities in delivering on the target, which remains, and how will that affect the rest of the budgetary process?

Julia Bracewell: There is money within certain sports to deliver regional centres. UK Sport funds the UK or British governing body, which then decides where the regional bits go. For example, we would love to host cycling in Scotland, but we cannot do that until we have a velodrome. We cannot bid for some sports because we are facility constrained. That said, we are strong in sports such as judo and we are working with UK Sport and the two governing bodies to see whether we can get a judo centre in Scotland. Also, I think that a regional centre for athletics is due to be put into Scotland.

Handball is a new sport that is getting big investment and 40 per cent of the squad are Scots. We would have loved the opportunity to bid for the national handball centre, but I believe it has gone to Sheffield. In canoeing, I understand that three quarters of the places for which people have qualified for Beijing have gone to Scots. Again, to get the white-water canoeing up here, we would have to substantially upgrade our facilities. There are sports in which we are trying our best behind the scenes at least to get into the tender process, but we understand that that would cost us when we are up against places where facilities already exist.

Dr Simpson: That is exactly my point. The Scottish Executive and sportscotland should be looking at the sports in which we have the best chance, where an investment now will allow us to win the tenders. That will give us a long-term benefit. Do you agree?

Julia Bracewell: Absolutely.

The Convener: I have a brief question—

Dr Simpson: I asked a second question.

The Convener: I beg your pardon.

Julia Bracewell: Sorry. Stewart Harris was going to answer that.

Stewart Harris: Back in the late 1990s, we were at the forefront of advocating two hours of PE. There has been progress. I know that the target has not been achieved, but 2008 was given as the date when it should be measured. I hope that progress will continue. We continue to advocate that there should be at least two hours of PE, but the budget is purely the responsibility of the education authorities. It has no impact on the sport budget.

12:30

The Convener: I have a brief supplementary question that follows up Ian McKee's question about the elite versus couch potatoes like me, and your argument that elite athletes encourage others to participate. You said that Sydney had not cashed in on what happened there. Does an example exist of an Olympic or Commonwealth games host nation that has delivered—to use the dreadful expression that has been kicking about—a bigger bang for the buck, so that giving money to the elite has resulted in payback later?

Julia Bracewell: Every nation that has hosted an Olympic games has seen its elite athletes perform better at those games. If you ask whether any games have helped to increase participation in sport, the academics will say no, but that is where Scotland is well placed. As I said, having attended a couple of conferences on legacies, I know that a desire is felt for nations to crack that. Vancouver, which will hold the 2010 winter Olympics, has been the first place to consider whether it can achieve a legacy. It is doing all the learning and making all the mistakes. In 2014, we could take the benefit of others trying to create a legacy. Scotland could lead the world.

The Convener: You will appreciate that as we are the Health and Sport Committee, I am trying to make the link. Ian McKee made a valid point. Jings! We are going to be pioneers.

Julia Bracewell: The aim is to have a healthier and fitter Scotland. The factors that influence the rate of cancers and heart disease are alcohol consumption, smoking, diet and exercise. We have not gone after exercise. If we can use the Commonwealth games as a catalyst not just to encourage elite athletes to do well, but to bring people together to ask how they would, as their contribution to the 2014 games, crack the problem, they will begin to think and act in a way that means that the dynamic is understood. A fitter person can get away with eating a wee bit more. People's bodies crave different foods, but we have missed out on exercise. Exercise can be a walk up the hills.

The Convener: A couple of us are exchanging glances, because we have missed out on a bit of that recipe. The eating bit is all right, but we need to deal with the other bit. I am not looking at anybody in particular—I am deliberately casting my eyes downwards.

Thank you for your interesting evidence. That concludes our business in public.

12:32

Meeting continued in private until 13:01.

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