HEALTH COMMITTEE

Tuesday 23 January 2007

Session 2

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HEALTH COMMITTEE
1st Meeting 2007, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*Shona Robison (Dundee East) (SNP)
*Euan Robson (Roxburgh and Berwickshire) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Mr Kenneth Macintosh (Eastwood) (Lab)
Dave Petrie (Highlands and Islands) (Con)
Margaret Smith (Edinburgh West) (LD)
Stewart Stevenson (Banff and Buchan) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Ms Rosemary Byrne (South of Scotland) (Sol)
Susan Deacon (Edinburgh East and Musselburgh) (Lab)

THE FOLLOWING GAVE EVIDENCE:

Mark Frankland (First Base Agency)
Cathy Jamieson (Minister for Justice)
Dave Liddell (Scottish Drugs Forum)
Alex MacKinnon (Scottish Pharmaceutical General Council)
Professor Neil McKeganey (University of Glasgow)
Stephen Moore (Association of Directors of Social Work)
Catriona Renfrew (NHS Greater Glasgow and Clyde)
Dr Richard Watson (Royal College of General Practitioners Scotland)
Tom Wood (Scottish Association of Alcohol and Drug Action Teams)

CLERKS TO THE COMMITTEE

Karen O'Hanlon
Simon Watkins

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 2

Scottish Parliament

Health Committee

Tuesday 23 January 2007

[THE CONVENER *opened the meeting at 14:00*]

Subordinate Legislation

Personal Injuries (NHS Charges) (General) (Scotland) Regulations 2006 (SSI 2006/592)

Personal Injuries (NHS Charges) (Reviews and Appeals) (Scotland) Regulations 2006 (SSI 2006/593)

Scotland Act 1998 (Agency Arrangements) (Specification) (No 2) Order 2006 (SI 2006/3248)

Scotland Act 1998 (Agency Arrangements) (Specification) (No 3) Order 2006 (SI 2006/3338)

The Convener (Roseanna Cunningham): I welcome everybody to the meeting. No apologies have been received.

Agenda item 1 is subordinate legislation. There are four negative instruments to consider: SSI 2006/592, SSI 2006/593, SI 2006/3248 and SI 2006/3338. The Subordinate Legislation Committee raised no points on the instruments. No comments have been received from members and no motions to annul have been lodged. Do members agree that the committee does not wish to make any recommendation on the instruments?

Members *indicated agreement*.

Treatment of Drug Users

14:01

The Convener: Agenda item 2 is a one-off round-table evidence-gathering session on the treatment of drug users in Scotland. We have been joined by senior representatives of the health service, academia and organisations that have a direct interest in the treatment of drug users, including organisations that are involved in the delivery of front-line services to drug users. Rosemary Byrne MSP, whose Treatment of Drug Users (Scotland) Bill initiated the session, is also present.

Several committee papers, including the policy memorandum that accompanies the Treatment of Drug Users (Scotland) Bill and a briefing paper from the Minister for Justice, provide background information. Members also have copies of papers that were submitted by Professor Neil McKeganey, who is director of the centre for drug misuse research at the University of Glasgow, and Mark Frankland of First Base Agency.

Before I ask those round the table to introduce themselves, I will give a brief outline of the format for the meeting. When everybody has introduced themselves, I will invite Professor Neil McKeganey, Tom Wood—who is chair of the Scottish Association of Alcohol and Drug Action Teams—and Rosemary Byrne MSP to make brief opening statements of three to four minutes on the broad questions that should be addressed in the session, which are how effective the current approach to drug treatment and rehabilitation in Scotland is, and how the current approach can be improved to address better the problem of drug misuse. I cannot ask everybody to make an opening statement; if they did so, virtually all the available time would be taken up by pre-prepared statements being delivered, which would not be a useful way to proceed.

I begin by introducing myself. I am the convener of the Health Committee.

Janis Hughes (Glasgow Rutherglen) (Lab): I am the deputy convener of the committee.

Kate Maclean (Dundee West) (Lab): I am a member of the committee.

Mark Frankland (First Base Agency): I am the education manager at First Base Agency.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I am a member of the Health Committee.

Euan Robson (Roxburgh and Berwickshire) (LD): I am a member of the Health Committee.

Ms Rosemary Byrne (South of Scotland) (Sol): I am a member of the Scottish Parliament.

Dr Richard Watson (Royal College of General Practitioners Scotland): I am clinical lead for drug misuse at the Royal College of General Practitioners Scotland. I am a full-time general practitioner in Glasgow and deal with drug users every day.

Professor Neil McKeganey (University of Glasgow): I am director of the centre for drug misuse research at the University of Glasgow.

Alex MacKinnon (Scottish Pharmaceutical General Council): I represent the Scottish Pharmaceutical General Council.

Tom Wood (Scottish Association of Alcohol and Drug Action Teams): I chair the Scottish Association of Alcohol and Drug Action Teams and represent the 22 alcohol and drug action teams throughout Scotland.

Helen Eadie (Dunfermline East) (Lab): I am an MSP.

Dave Liddell (Scottish Drugs Forum): I represent the Scottish Drugs Forum.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I am an MSP.

Stephen Moore (Association of Directors of Social Work): I represent the Association of Directors of Social Work.

Mrs Nanette Milne (North East Scotland) (Con): I am an MSP.

Catriona Renfrew (NHS Greater Glasgow and Clyde): I am the director of corporate planning policy with NHS Greater Glasgow and Clyde. We are responsible for providing drug and alcohol services for about a third—35 per cent—of Scotland's population.

Shona Robison (Dundee East) (SNP): I am a member of the committee.

The Convener: We are expecting Lesley Finch from SCOT-PEP, the Scottish Prostitutes Education Project, and she may yet turn up. We have had no indication of whether she will attend. Susan Deacon MSP will join us at about 2.45 pm. The alert among you will have noticed that there are other people round the table: they are the clerks, the sound technician and the official reporters—they are the ones who are taking a note of everything we say.

We will move straight to Professor McKeganey, after which I will ask Tom Wood and then Rosemary Byrne to speak.

Professor McKeganey: I will begin with a brief comment on funding. It is not easy to get information on funding for drug treatment services in Scotland, but the indications are that about £100 million is spent each year. That is a substantial amount, so it is entirely appropriate to consider whether it is being used effectively. Despite the spending, there is clear evidence that drug users in some areas of Scotland do not have ready access to drug treatment services of different kinds.

My colleagues and I have considered the range of drug treatment services. Recently, we have focused on methadone. It is evident that methadone can reduce individuals' drug use and offending. However, when we have attempted to measure the degree to which those services enable drug users to become drug free—which is the stated aspiration of the vast majority of drug users whom we have interviewed—we have found that Scottish drug services are doing less well than comparable services in England. Only 3 per cent of drug users who are treated with methadone in Scotland become totally drug free, whereas the figure in England is well in excess of that—approaching 30 per cent.

We have examined residential rehabilitation services, which we find are the most closely associated with drug users becoming drug free. Three years after the treatment, about 28 per cent of those who use such services are abstinent, which means that they are not using any drugs at all. Those services are the least available in Scotland but, if our research is right, they are the ones that are most closely associated with recovery. In fact, even the existing provision of residential rehabilitation services is underused and some areas in Scotland make no use whatever of such services. Unquestionably, we will continue to use methadone to treat drug users, which is entirely appropriate, but we must bring about greater co-operation between methadone services and residential rehabilitation services so that, once individuals become stabilised, they are referred to services that are oriented more toward enabling them to become drug free.

We have examined the quality of drug addiction services in Scotland. I must say that, using the same measures, Scotland's drug treatment services do not compare well with services in other countries. That is true for a range of measures, including the degree to which drug users feel involved in their care. When drug users are asked whether they feel involved in the major decisions that relate to their care, compared with other European countries, fewer drug users in Scotland say that they have been involved in their care.

We have a major issue with the extent of drug abuse in prison. I have argued elsewhere that our very best drug treatment services should be available in prison. In a situation in which 60, 70 or 80 per cent of prisoners—or sometimes more—are drug users, we must deal with their needs if

we are to avoid the situation in which people go into prison and become drug users there. We are also falling short in monitoring services and evaluating their impact.

Tom Wood: I thank the committee for inviting us. I am sure that all the guests who are round the table will agree that one deficit on the matter in Scotland has been the lack of opportunity for balanced public debate. We are all grateful for the opportunity to debate the issues and say our piece.

It would be easy for me to dive into the faults, but I will spend about 30 seconds talking about the origins of why we are where we are and about some good features of our treatment services.

We should remember that our system was founded 30 years ago in response to an emergency. That emergency was the emergence of heroin and the threat of the blood-borne virus, HIV, and AIDS. It is therefore easy to understand why we have taken a robust, criminal-justice-based, muscular approach to drugs—the enforcement approach. I suggest that, 30 years on, it is perhaps time that we stepped back and considered that, although that might have been right in the past, it might not be right for the future.

There is much that is right and good about drug treatment and rehabilitation in Scotland. A lot of money—tens or hundreds of millions of pounds—has been spent over the past 10 years, as Neil McKeganey said. There has been a lot of innovation and good practice in drug and rehabilitation services throughout Scotland. We have an excellent team of dedicated people. They are not working for the money or the fame, but because they are dedicated to the cause. Let us not forget that. Over the years, tens of thousands of people have been given a good professional service with compassion and professionalism.

That said, there is no doubt that, although many of the components of an integrated system are there, there is a complete lack of cohesion and synergy, which detracts considerably from the efficiency of the system. The effectiveness of treatment and rehab in Scotland is not so much like a postcode lottery as like a local authority lottery. The levels of funding are very different in different parts of Scotland. Some rural areas, which we do not often think about or talk about, have particularly tenuous funding arrangements. No matter how much money there is in certain local authority areas, the complex and convoluted streams through which the funding is delivered present a major problem.

For example, in the City of Edinburgh, 10 discrete funding streams go into dealing with drugs, with a couple more for alcohol. Those present will understand how difficult it is to run a business based on that kind of chaotic funding arrangement. We really need to sort that out. It is not always about a lack of money, although there is a lack of money in some places; it is more about how the money is delivered, who has control of it and the performance outcomes that are demanded of it.

We also lack a common system of performance management, single shared assessment and integrated care. It may seem ridiculous to say that in Scotland in the 21st century, but that is the fact of the matter. We speak about co-morbidity and complex needs, but we still treat drugs, alcohol, mental health, housing problems and family issues separately. We fund them separately, and different local authorities deal with them differently.

There is a lack of choice, and that lies behind the methadone problem that Neil McKeganey was speaking about. There is a role for methadone, and we know what it is. The point is not about methadone itself, but about what should go with it. What supports its use as part of a recovery plan, not a maintenance plan?

As Neil McKeganey said, we have a problem in prisons. I see the drug-dependent prison population as providing a golden opportunity, and literally a captive audience, which we do not make enough of. We wish a pragmatic, not moralistic, approach to the issue to be taken over the coming years. We should view drug treatment and rehabilitation as health issues, with an element of choice and supported by a range of services. We need to engage volunteers and self-help groups a lot more than we do. We need decent access to treatment rather than a local authority lottery. Last but not least, we need integrated services and a more cohesive pattern of funding. We need to judge treatments on their outcomes. That should be done in a way that is compassionate and humane, but also intelligent—we should not simply use a five-bar gate approach.

I wish to end my remarks on a positive note. Literally as we speak, a review is being carried out of alcohol and drug action teams. It is a stocktaking exercise, which is being held throughout Scotland. It is a robust inspection. We have been through it ourselves, and I can tell those present that it is robust. We very much hope that the review will take on some of the issues that are raised today and that it will deliver a plan for the future.

14:15

Ms Byrne: How effective is the current approach? Drug treatment and rehabilitation in Scotland is patchy and unequal, and for those attempting to access services it is often a postcode lottery. In Ayrshire and Arran, as in other

areas, there is a cap on methadone, which means that if someone does not have mental health problems, does not have a child on the at-risk register or is not pregnant, they will not get access to a maintenance programme.

In Dumfries and Galloway, a Social Work Inspection Agency report found that nearly one third—30 per cent—of people with substance use problems who were interviewed did not feel that they had been fully involved in decisions about the help or services they should receive. Thirty-three per cent of substance users said that they had not been given a clear plan. While more than two thirds of people surveyed had seen written assessments of their needs, 67 per cent of those with substance use problems who responded had not seen written assessments. There were significant gaps in services for drug users seeking help from mental health teams, and in services to support children of drug users. That is replicated across the country, in many different health board areas.

Waiting lists is another issue about which research has recently been printed. I will not go through that because I think we are all aware of the mismatch with waiting times in different areas.

Approximately 60,000 children are living with parental drug misuse. However, across the country, child and family teams struggle to make adequate provision due to lack of resources and poor integration of services. In spite of the fact that support work with women and drug users and their families could be up to one tenth of the cost of placing children in foster or state care, little heed is paid to the extended family, involving the family in drug treatment and in looking after the children and ensuring that they are safe. Kinship carers do not get paid allowances in some local authority areas. Again, there is a patchiness of care for the very young and vulnerable.

On crime figures, a recent report to the House of Lords found that the cost of heroin addiction to the United Kingdom economy was approximately £30 billion; the cost to the Scottish economy was approximately £3 billion. There is a revolving door: people are going in and out of prison and are not being given treatment. I agree with Tom Wood that it is essential that the best treatment and support is given to people in prison; in fact, it would be cheaper and would achieve a better outcome to send people into residential rehab rather than prison. There are too many areas in which there is reluctance to send people to residential rehab, yet we hear all the time from the Minister for Justice and from the First Minister that we need more rehab. The rehab is there; it is just not being used.

How can the current approach be improved? The Treatment of Drug Users (Scotland) Bill seeks to address the major issues of inequality and child protection, and crime and its impact on communities, by shifting the focus from criminal justice to health. I firmly believe that drug addiction is a health issue and that it sits in the wrong place with criminal justice in the Parliament. Such a shift would signal a different way of looking at drug addiction, and not the punitive approach that many people take at the moment. Offering a statutory right to assessment and a comprehensive range of assistance would move us forward considerably. That is one of the major proposals in the bill. It is important that people are assessed properly before an holistic care plan is put together. Plans should include all health needs, family support, employability, welfare and housing. It is important that the work and the money we spend are monitored.

Another huge gap where monitoring has been absent is the integration of services through a care worker, who can ensure that that happens. Key to that is ownership of the care plan by the drug user, so that they feel that they are part of the programme. A range of treatments based on assessment could include substitute prescribing and a pilot in Scotland on the use of heroin under clinical conditions. It is important to stress that methadone prescribing stabilises and that the problems highlighted recently have more to do with inadequate rehab services. I would like a definition of what the minister means when she talks about rehab. A range of treatment must be offered. We need to have residential and good community rehab, rather than a script and counselling once a fortnight for 20 minutes, which is what some people think rehab is.

The Convener: A round-table discussion is meant to flow more easily than a question-and-answer session. Witnesses will be entitled to put questions to other witnesses; it will not just be a case of MSPs asking questions of witnesses. However, I would prefer it if people gave me an indication that they want to ask a question. I keep a note and will get round to them.

We have had three presentations, but I will now throw open the discussion. It would be useful to hear from some other people how effective they believe Scotland's drug treatment services are. I ask the three people who have had the chance to speak to desist for a while and let some of the other witnesses respond.

Catriona Renfrew: We could have a pretty strong consensus that drug treatment services are not as effective as they should be. The health board in my area spends about £37 million on such services. It is quite easy to find out how much each health board and each local authority spends on drug services. I am surprised that it has been suggested that that is a challenge. NHS Greater Glasgow and Clyde certainly accounts for

the money that it spends. Although we spend £37 million—which is probably a higher amount, proportionately, than any other health board spends in Scotland—we treat only half the people in our area who have serious drug problems. Even in an area in which a great deal of energy has been focused on providing drug services, we are still not meeting the need. It would be useful to have a discussion about why that is.

Two or three elements of the problem have emerged from the opening remarks. The drug problem is enormously complex and the conflation of it into a few soundbites does not help us to solve it. It is entirely appropriate that some of the drug issues fall within the remit of criminal justice. The point is that treatment and rehabilitation—not the whole of drugs policy in Scotland—should be a health responsibility. We must unpick the different strands of the drug problem if we are to address them properly.

The second issue that has come out is the politicisation of the debate about treatment. That would not happen with other forms of treatment that are offered by the national health service in Scotland. A debate about methadone versus residential rehab takes us nowhere. If we could all agree that a decent set of drug services should provide an enormous range of treatment options, which are delivered to clients or patients on the basis of their assessed needs, instead of having endless debates in which different treatment options are played off against each other in an abstract way, we might be able to make progress.

Mark Frankland: It is worth considering two factors that are particular to heroin addiction, which I think will dominate today's discussion. First, everyone will agree that heroin is an almost unique substance in that it gets people to behave in a most appalling way. Everything—from their family and friends to their willingness to abide by the law—comes second to heroin. We must never underestimate the strength of that drug.

Secondly, if we want to encourage someone to get into treatment, essentially we must take a customer from the illegal drugs industry, which is now the third-biggest business on the planet. It has not reached that position by being bad at what it does. In most small towns in Dumfries, where I come from, a drug user can pick up their mobile phone, dial one of 30 numbers and have a £10 product delivered to them within 10 minutes, 24 hours a day, seven days a week, 365 days a year. Neither Domino's Pizza nor Tesco Extra is that good.

When someone who has a drug habit wakes up one morning and thinks, "I have had enough of this life—I have got to change," they will phone up a treatment centre, only to be told that their name will be put on a list, perhaps for two or three weeks or perhaps for nine months. That is no competition at all for the drugs industry. If we are to compete with and to take customers from that industry, we must offer a much better service. The drugs industry is brilliant at providing customer services. We send people who lead chaotic lives letters in the post with appointment times and we expect them to keep those appointments, but they do not. If we do not design services that are much better at accommodating their chaotic lifestyles, we will continue to lose the battle.

The Convener: If an addict phones up to seek help, would you like contact to be made almost immediately? Should someone come round to see them straight away?

Mark Frankland: Even more simply, I would like to see a system that used to obtain in general practitioners' surgeries when I was a boy. It was possible to ring, get an appointment, turn up and be seen but, if somebody did not have an appointment, they could go and sit and wait to be seen. There are a couple of projects—one in London in particular—where somebody can go and wait. Even if they have to sit for five or six hours, they will eventually be seen. That would represent much better competition for the illegal drugs industry. At least users would know that, if they woke up in the morning needing help, they would get it then, not three months later.

Catriona Renfrew: Almost every part of the national health service now has an access standard. However, there are no access standards for drugs services, so we can keep people with drug misuse problems waiting as long as we wish, which we often do in parts of Scotland. That is a huge issue. A patient can see a GP in 48 hours, but they are not entitled to get treatment for a drug problem in any fixed time. There must be a national standard for access if we are serious about improving services, and we have made that point to the Executive.

Alex MacKinnon: I come at the issue from the perspective of the body that represents all community pharmacists, who are at the sharp edge of delivering services to drug misusers, and as a pharmacist who had lots of experience of dealing with drug misusers earlier in his life. One of the most important points is to get early intervention. Drug users must see some sort of practitioner in the health service as early as possible.

Methadone is extremely useful as a means of getting people off heroin, but not enough is done to try to reduce the dose and much more needs to be done on titration management to reduce the dose to get the person drug free. A lot more needs to be done to find other alternatives. Prescribed heroin has been mentioned. I am not sure that we should go down that route, but we should at least

have the debate. On the continent, dihydrocodeine has been found to be just as effective as methadone.

It is important to understand community pharmacists' point of view on the matter. They look on the drug misuser as a normal patient who must be respected and treated with dignity and who is presenting with a disease—a general health issue. There is much more to supervised methadone than the simple supply of a pharmaceutical. The pharmacist makes a default daily health check and the patient receives counselling and advice on other health matters, with possible referral to a practitioner. However, the service is lacking in the detoxification process and in rehabilitation. After all, most drug users, if interviewed, will say that they want to be free of their drug.

At some stage, but not necessarily today, we should consider the implications of cocaine and crack cocaine for future generations.

The Convener: I ask everybody, when a subject begins to emerge as a discussion issue, not to come in and immediately scatter-gun around with another set of issues as well. We are trying to explore access, which has been raised as an important issue.

Dave Liddell: It is clear that big issues remain in access to services, but access is only one aspect, because we have to deal with the quality of the services. There are areas in which access is fairly immediate but the quality of the service is such that that is fairly meaningless and ends up reinforcing the revolving-door syndrome. People are dealt with in such a way that they come round again to the front end of the services in a short time, having been pushed off the services.

Over the past year, the Scottish Drugs Forum has held a number of focus groups throughout the country, as well as interviews with service users. The issues that have emerged clearly from that work are choice and flexibility. Neil McKeganey made a point about the need for users to be more involved in the service that they receive. That must be the starting point, because too many of the people who currently present for help have to fit the service that is on offer, rather than the service fitting the needs of people with drug problems.

We could probably debate endlessly the necessary amount of resources. Neil McKeganey's figure of £100 million represents only £2,000 per problem drug user in Scotland, so I would still take issue with the idea that we are putting in considerable resources, as there remains a question as to whether those resources are sufficient.

14:30

Another theme that I want to pick up is holistic services. In the long term, we need to consider how we can commission services that deliver across the whole range of people's needs. As Tom Wood mentioned, at the moment the funding silos that exist at Scottish Executive level are mirrored within the alcohol and drug action teams and, in turn, in the services that are delivered on the ground. We need to consider how those funding streams can be brought together so that we commission services that deliver across the full range of needs, both medical and social, that people with drug problems have.

For example, although I do not have the precise figures with me, I believe that, for drug treatment and testing orders, we have about 700 places across Scotland. In funding terms, that represents about £7,000 per person. Those orders provide the holistic service that should be provided across the board. We do not need too many more than the 700 places for drug treatment and testing orders, but the lesson that we should learn from those is that we need to provide holistic services that respond to a whole range of people's needs, including access to education and training. Those are key issues.

Finally, I think that, in many respects, we have got too caught up in the argument about abstinence versus harm reduction. We need to ensure that people have routes out of their drug problem so that they can leave that crutch behind them. However, we are in danger of removing the crutch from people before we have put in place the support that will sustain their long-term recovery.

Professor McKeganey: It is often said—I think that this is quite uncontroversial—that we need to provide a bit of every kind of treatment. At the moment, we do not do that. Predominantly, we offer methadone. Methadone is offered to most drug users. It is estimated that approximately 20,000 drug users in Scotland are on methadone. The total number of addicts is only about 51,000. If half of our addict population is in treatment, that means that virtually every addict in treatment is on methadone. We have created a situation in which methadone is the default treatment for virtually all addicts. That is not appropriate because it does not help the vast majority of addicts to move to a drug-free lifestyle.

We absolutely need to provide treatment services that do not aim simply to maintain addicts. If we think that we have a big drug problem now, in 10 or 15 years we will look back and say, "We should have got it right then because we now have a situation in which every single service that tries to meet the needs of drug users is overwhelmed." We need to provide treatment that gets addicts off drugs. On that

measure, services in Scotland do less well than comparable services in England. We should not be proud of that. We should feel desperately concerned about that.

We should make sure that our services get addicts into a drug-free lifestyle. All the evidence shows that it is only when addicts come off drugs that they can rebuild their lives and that the circumstances of their children and other family members such as siblings can improve. When drugs remain within the lives of those individuals, they continue to cause massive problems for the users, their families and the wider community. Abstinence must be the focus of our treatment services. That is not to say that we should demand that of addicts, but we should have services that can work with addicts to bring them to a drug-free lifestyle.

Dr Watson: It is hard to describe how much I disagree with Professor McKeganey.

The Convener: Go on. Try.

Dr Watson: Retaining patients in treatment—mainly methadone treatment—represents not failure but success. It is used as an indicator of success in research papers and studies published in medical journals all over the world. I can provide the committee with references if it wishes.

There is no doubt that getting large numbers of patients off methadone, as three previous speakers have suggested, would increase the death rate. I prescribe methadone not just because it reduces the use of illegal drugs and illegal activity but, primarily, because it decreases the death rate certainly to half but probably to an eighth of what it otherwise would be. Very few medical interventions are as effective as that.

Remember that I see patients on methadone practically every day of the week. Many of them are working, bringing up their children and going to college. If they were not on methadone, they would be unlikely to achieve that.

Mr Wood said that he wanted a recovery plan, not a maintenance plan. That is a false dichotomy. Being on methadone maintenance may be part of someone's recovery—a person may be able to have a healthy life while on methadone. Of course, when Professor McKeganey asks people whether they would rather not be on methadone, many of them say that they would rather not be on it. If I asked type 2 diabetics whether they would rather not be type 2 diabetics, they would say that they would rather not be, thanks very much. However, that is not an option for them.

The two recognised classifications of dependence are the ICD-10 and DSM-IV—"International Statistical Classification of Diseases and Related Health Problems", 10th revision, and "Diagnostic and Statistical Manual of Mental Disorders", fourth edition—classifications. Under those classifications, patients who do well on methadone maintenance—I acknowledge that many do not do well—do not fulfil the criteria for dependence. They may be dependent according to the dictionary definition of the word, just as patients with diabetes or any other chronic illness are dependent on their drugs, but they are not dependent according to the psychiatric definition of dependency.

Janis Hughes: My question relates to Professor McKeganey's written evidence, what you have said and what Alex MacKinnon said about managed titration of the methadone dose. Professor McKeganey says that

"There is very wide ranging variation across Scotland in methadone prescribing"

and that

"the recommended guidelines"

are

"of between 60mgs to 120mgs a day"

but GPs are prescribing an average of 50mg, although in one case up to 900mg a day is prescribed. If there is a recommended dose, why does prescribing vary hugely?

Dr Watson: Being within the average recommended dose works better for most people, but a small number do well at lower doses. Some of the people who are on lower doses are decreasing the dose with the aim of stopping it—they might not always have been on that dose. I have never had a patient who is on as much as 900mg, but I certainly have patients who are on 600mg. That is unusual and only a handful of doctors in Scotland prescribe hundreds of milligrams.

Some people metabolise methadone differently—they are called rapid acetylators. They have different enzymes in their liver, so they break down methadone and similar drugs much more quickly, which means that they may require higher doses.

Dole and Nyswander developed methadone maintenance in the 1960s in the USA and their average dose was 180mg per day. Professor McKeganey was right to say that the average of 50mg is a source of concern. The figure should be higher.

Janis Hughes: So you think that that figure results not from good managed titration but from GPs underprescribing methadone, perhaps through continuing to prescribe the same dose without doing good follow-up work.

Dr Watson: Several GPs—and not just GPs but psychiatrists and people who work in specialist

services—may do that. That is why the Royal College of General Practitioners is offering a certificate in managing drug misuse to educate GPs about appropriate prescribing.

The Convener: Many people have indicated that they want to speak. I will read out the list that I have now—one or two people who are starting to put up their hands will not be on it. I ask people to indicate whether they want to say something or ask a question that arises directly from what we are discussing. Otherwise, I ask people to hold off. I ask everybody to put their hands down, thanks. The list so far contains Shona Robison, who is next, followed by Jean Turner, Catriona Renfrew again, Mark Frankland again, Rosemary Byrne, Tom Wood, Kate Maclean and Helen Eadie.

Mr McNeil: I, too, indicated that I wanted to speak.

The Convener: I did not pick that up. Of the people whom I named, who wants to speak on what Richard Watson's discussion has been about? I see that Catriona Renfrew, Helen Eadie, Tom Wood, Kate Maclean and Mark Frankland want to speak. Is Duncan McNeil included?

Mr McNeil: I want to return to some of the presentations.

The Convener: We will deal with Richard Watson's issue now and I will note that you want to speak. I ask for another indication of who wants to speak—more hands are going up now than before. I call Shona Robison.

Shona Robison: I want to respond to the discussions about access and treatment.

The figures seem to show that there is a growing wait for access, particularly for addicts who are not deemed to be at risk. They may be heroin users who are not injecting, people for whom there are no child protection issues, and people who do not have mental health problems. In my experience, they can have to wait for two years or more. Going back to what was said earlier, could a solution be that the treatment of drug users becomes the responsibility of everybody in the services rather than addicts just being directed to the drug problem service? In Dundee for example, all the addicts go through one door, which means that there is a huge wait. For example, when social workers are making family interventions, is it not right that they should pick up on the drug issues, rather than waiting for one service to respond to them?

On the choice of treatments, Catriona Renfrew is right that there is a sterile debate, as it is not a question of one treatment being better than another. There has to be a range of treatments, and my concern is whether there is such a range, because it appears from what addicts have told me that residential rehab is difficult to access. There needs to be some honesty in the debate. There should be a range of treatments, but there appears not to be and the situation varies from health board to health board. I would like to know from the health boards what the barrier is to addicts accessing residential rehab. Is it funding? The places seem to exist. We need to work that out, because this is a question of theory and practice.

The Convener: I have Catriona Renfrew to speak next, but I wonder whether, as that was a specific question, anybody else could respond too. I know that Tom Wood had his hand up, so he can perhaps respond after Catriona.

Catriona Renfrew: I am happy to comment on that question as well.

One statement from the earlier discussion should not go unchallenged. To say that there is clear evidence that people need to be drug free before they can rebuild their lives is not true. There are thousands of addicts on the methadone programme, and we can provide clear evidence that they are rebuilding their lives while on methadone. It is simply not true to say that methadone treatment does not stabilise people to the extent that they can move from a chaotic drug lifestyle to, for example, getting their children back, getting off street prostitution and doing many things that we would all recognise as rebuilding their lives. We can evidence that and, whatever any of us might think about methadone, the earlier statement should not stand.

Mr McNeil: Can we have note of the detail—how many thousands, for example—to evidence those comments?

Catriona Renfrew: Yes.

Tom Wood: What I am going to say addresses both issues. Let us be clear that there is no doubt about the efficacy of methadone in doing what it is meant to do. The trouble is that, in many cases, it has been left alone to do what it was never intended to do.

On the range of services, I have with me an interesting handout that shows the matrix of treatments and goals in one of our European neighbours. It shows exactly the range of services that we need to provide, including the care plan that Dave Liddell rightly emphasised. It covers everything from compulsory to voluntary and from abstinence-oriented treatment to harm reduction, including prescribing heroin and methadone and treatment in prisons. I am happy to leave a copy of the handout with the committee.

Most of the treatments are available in Scotland in some place or other, but there are not enough of them and, crucially, they are not tied together in

any systematic, integrated way. It is those lines of integration, control and management that we miss most of all.

The Convener: I will bring in Mark Frankland at this stage, and if Catriona Renfrew has a specific short response, that will be fine.

Mark Frankland: I would like to make three points about methadone.

First, there is often pressure from above to cut waiting lists, so all resources are focused on getting more people on to methadone as quickly as possible. It is not uncommon for someone on prescription to be seen only once every four months. During that time, they can start to take on board a cocktail of chemicals, on top of the methadone. They are taking valium and heroin, when they can afford it. Sadly, it is becoming more prevalent for people also to be drinking lots of super lager. For people in that condition, the methadone is no longer a stabilising influence; it is probably no more than a base for a potential overdose.

14:45

Secondly, a new theory that seems to have come in over the past year—I gather that it has come from America—is the concept of flooding. When treatment centre staff see someone on the street whose behaviour is chaotic, their response is to give them higher and higher levels of methadone, with a view to flooding the receptors. That may work—I do not know; I am not a doctor—but the road back off methadone is long. Someone's methadone levels can be put up very quickly, but coming back down is tough.

Thirdly, when clients go to the treatment centre and say that they want to reduce their methadone dose and eventually to come off it, the request is met with very little enthusiasm. That is because the process is labour intensive and it involves more appointments and the use of Subutex, which is prescribed only reluctantly. We seldom find that treatment centres offer an enthusiastic response to the person who says, "I have been on methadone long enough. I would like to come off now, please."

The Convener: That strikes me as being a bit of a challenge to Dr Watson. I will ask him to come back in on those issues. I will then bring in three MSPs: Jean Turner, Kate Maclean—if she still wants to come in—and Helen Eadie. Depending on where we are after that, I will move on to different issues, including those that Duncan McNeil wants to raise. Before I bring in Dr Watson, I see that Catriona Renfrew wants to come in. I ask her to do so quickly.

Catriona Renfrew: The access question was put directly. The patchiness of services makes it extraordinarily dangerous to generalise. In Ayrshire and Arran, there is a problem with access to methadone. In other parts of Scotland, there are problems with residential rehabilitation. In my area, the problem is with access to social care support. The patchiness of services across Scotland means that different areas have different pressure points.

The Convener: I ask Richard Watson to come back in, particularly to pick up on the points that Mark Frankland made.

Dr Watson: Certainly. If patients are being seen only once every four months and are being maintained on methadone, the doctors or service providers involved are in breach of United Kingdom guidelines, which say that someone should be seen at least monthly. The guidelines may occasionally be breached in special circumstances, but four-monthly appointments as routine would not be deemed acceptable.

The term is "blocking" and not "flooding" as Mark Frankland said. Higher doses of methadone block all the neuro receptors. If someone uses heroin on top of methadone, there are no neuro receptors for the heroin to hit, so they get no positive reinforcement from using heroin. That is why higher doses are more effective. That is well evidenced based and it is not a new idea, as it has been around since the early 1960s. It is the right thing to do if someone continues to use illegal drugs.

Ms Robison was correct in saying that it is almost inevitable that forcing all patients to go to a centralised service instead of their GP will build up waiting lists. That is why it is better for GPs to be the main providers.

The Convener: Right. As I said, I will bring in some of the MSPs. I see that Neil McKeganey also wants to come back in and Rosemary Byrne, too. I will not include her in the MSP group, as she is the promoter of the bill.

Dr Turner: From my past job, I recognise much of what Mark Frankland said. When people come in for help, they need that help now. We are working against a professional criminal world that is trying to countermand everything that we do. I am interested in the differences between Scotland and England that have been raised. In England, the same criminal world is plying its wares to the vulnerable. In Scotland, people tend to use a multiplicity of drugs. I believe that that is the case in Scotland, particularly in the Glasgow area, although I am no longer working on that side of things. I would like to know more about the differences. Why is England managing to do

something that we are not? What are the merits of—

The Convener: Could we just hold off on that just now? I am trying to wind up the generalised debate on these issues before we move on to what I think is a slightly different set of questions.

Kate Maclean: I do not disagree with what Dr Watson said about maintenance and about regarding certain addictions as conditions that have to be treated. It is obviously important to keep people well and to keep them able to function in their families and at their place of employment.

Dr Watson, you made a comparison to type 2 diabetes: someone who has diabetes is not going to ask to be taken off their drugs gradually, but will want to be kept healthy. Would you take that idea further? What if people could get legal access through general practitioners or pharmacies to the drugs to which they are addicted, such as heroin? That sort of thing has happened in other countries and pilots have been run in England.

Dr Watson: Heroin prescribing has gone on in England for 30 or 40 years; a few hundred people are maintained on heroin, which they inject. There have also been positive studies in Holland and Switzerland. Unfortunately, such things are very expensive, and people are already concerned about the costs of methadone maintenance. The term that is used is "substitute prescribing". There is no philosophical distinction between giving people Subutex—buprenorphine—that they dissolve under their tongue, dihydrocodeine tablets that they swallow, heroin that they inject or occasionally smoke, or methadone that they swallow. They are different ways of delivering the same service.

It is unlikely that heroin will ever be prescribed widely by GPs; such prescription would be more likely to be done by some centralised service. If patients take heroin two or three times a day under supervision in an injecting room, that is very restrictive. If they take it home, there is the concern of leakage into the wider community.

Kate Maclean: Do you think that it is not necessary for every drug misuser to have the aim of being completely drug or methadone free and that, for some people, being able to maintain a normal lifestyle using methadone is sufficient? Alternatively, do you feel that the aim for everybody should be to be drug and methadone free?

Dr Watson: The evidence is that substitute prescribing saves lives and that anything that reduces such prescribing is liable to cost lives.

I have a wee quote here. I have been prescribing to drug misusers for more than 16 years and I find it depressing that I am going over very old ground and answering questions that I thought had been resolved 16 years ago. The quote is from a paper called "Leaving Methadone Treatment: Lessons Learned, Lessons Forgotten, Lessons Ignored". The paper is already six years old, but it was old hat when it was published. It details more than 60 studies from around the world showing the increased death rate among patients when methadone is stopped. The final sentence says:

> "Until more is learned about how to improve post-detoxification outcomes for methadone patients, treatment providers and regulatory/funding agencies should be very cautious about imposing disincentives and structural barriers that discourage or impede long-term opiate replacement therapy."

Helen Eadie: I was at a dinner just before Christmas at which we met some of Dr Watson's colleagues from the Royal College of General Practitioners Scotland. At the dinner, it was said that it is possible for patients to be on methadone for a very long time, just as people with diabetes can be on treatment drugs for a very long time. However, during the conversation buprenorphine or Subutex was mentioned too—just as you mentioned it a couple of minutes ago. One of your colleagues said that that treatment had the possibility of getting people off drugs completely.

In preparing for today's meeting, we considered what is happening in France. In France, 88 per cent of people on this kind of treatment are given buprenorphine and only 12 per cent are given methadone. The report that I read highlighted some of the other benefits of buprenorphine. In comparison with methadone, there is less depression of the respiratory system and reduced likelihood of cardiac arrhythmia, and people experience less severe withdrawal symptoms when detoxing. In its work on drug-related deaths, the Scottish Advisory Committee on Drug Misuse expressed concern at the relatively low levels of prescribing of a high dose of buprenorphine in Scotland, compared with England and Wales. It went on to recommend that the Scottish Executive

> "confirm evidence that the increasing use of high dose Buprenorphine in France and elsewhere is associated with a substantial decline in drug related deaths."

Would you like to comment on that point?

The Convener: Comment briefly, Dr Watson. The committee is not qualified to judge on the efficacy of one drug versus another.

Dr Watson: The increased use of buprenorphine in France was not planned—it just happened, because initially there was very little methadone prescribing. I am sure that in a few years' time much more buprenorphine will be prescribed. The disadvantages are the price of the drug—it works out at about four times the price of

methadone—and the fact that Subutex tablets can be and often are ground up and injected, which leads to severe injecting injuries. In several countries, Subutex—often taken from France—is now the major drug of abuse.

The Convener: I have not forgotten that Rosemary Byrne is here—we will get back to her. We will hear first from Alex MacKinnon, Stephen Moore and Neil McKeganey.

Alex MacKinnon: I support what Dr Watson has said. Methadone comes in for a lot of criticism, but as a substitution therapy it is extremely effective, especially if a daily dose is given supervised. It has a long half-life and one oral dose is sufficient to maintain a person's well-being and to keep them off heroin.

The issue of heroin prescribing has been raised. Heroin is five times more expensive than methadone. For a drug to be successful, it must have general support from the practitioner group that will use it. Buprenorphine is a partial opioid agonist, which means that it is not so good for people who are taking high doses of heroin. It can precipitate more severe withdrawal symptoms, is very expensive and is more open to abuse and dependence potential.

Stephen Moore: Social work is increasingly about managing risk in our community. In the area of drugs, our focus is on the management of welfare issues such as child protection and the welfare of looked-after children. However, we also manage criminal justice services. I want to focus on the consequences for child protection of not managing drugs properly. Every seven days in my council area a baby is born to a mother who is addicted to drugs. Every 23 days in my council area a baby addicted to drugs is born. The situation is no different elsewhere in Scotland. We have record numbers of pre-birth case conferences in Scotland. In such cases we are concerned about the welfare and well-being of the baby because of the mother's or father's misuse of alcohol and drugs.

Half of the children on the child protection register in Scotland are under five. They are there because of their parents' misuse of drugs. Those children cannot run away or tell us what is happening. They depend on competent, capable, qualified staff being able to intervene to support them in their families. As we all know, the consequences of not getting that right are child death and child injury. Social work is managing record numbers of children who are affected by parents' misuse of drugs. There is a 10 per cent increase, year on year, in the number of cases in the children's hearings system, which is due largely to the misuse of drugs by young people or their families. The consequences of not managing the issue correctly are dire for those who are vulnerable. The victims are often children.

15:00

Professor McKeganey: It has been suggested that methadone is a treatment that keeps drug addicts alive. Consistently for the past few years, 300 addicts have died each year in Scotland. That is the equivalent of a jumbo jet crashing every year, with metronomic regularity. Many of those addicts were on methadone and we now have a tranche of methadone-related deaths. The mortality level has stubbornly refused to change, despite the fact that an increasing proportion of drug users are on methadone. Methadone is not keeping those addicts alive.

Catriona Renfrew offers a reassuring image of drug users stabilised on methadone, being good parents and in employment. That image is as far from reality as it is possible to get. When we follow drug addicts, we find that 70 per cent of those on methadone also use heroin. They are obtaining an illegal drug and their lives still involve criminality—some 80 per cent continue to commit crimes. In many cases there is serious concern for the welfare of their children. Less than 10 per cent of addicts in treatment get employment over three years. The idea that through methadone we are opening the road to the new Jerusalem whereby stabilised individuals are happily going along getting their methadone, are in employment and are living in stable circumstances is not the reality. Those people are living in desperate circumstances—even when they are on methadone. We must address the problem because it has increased massively over the past 30 or 40 years. If we see anything like an equivalent increase over the next 30 or 40 years, we will have no services that stand even the remotest chance of meeting the needs of those addicts in Scotland.

The Convener: There is a lot of harrumphing and shifting around at those comments. We will now broaden the discussion.

Ms Byrne: I will pick up some of the points that have been made. I think that the major issue is to have the right kind of assessment for someone who accesses services with an addiction problem and then to provide the right kind of care plan for them. For some people, that will be a methadone programme to stabilise them, while for others the abstinence route may be appropriate. We must be clear that if detoxification is to happen, decent rehabilitation services must be provided or the danger is that people will go back and overdose. There is no point in hiding the fact that we must deal with that issue.

We must have the right rehabilitation services in our communities and residential rehab for people who need it. The services should all be based on a good assessment, and we must train people to ensure that they can perform the assessments appropriately. I think that a small number of people will always have to stay on methadone. The argument about whether abstinence is the appropriate approach hides all the other issues. Most people want to get on to a route off drugs if they can and the appropriate support must be there for them. However, some people might be in a stable lifestyle on methadone for the rest of their lives. We must all start to understand that.

I am glad that Stephen Moore raised the issue of children and families. Alongside the treatment that we provide, we must ensure that support is provided to address the needs of children and families and that risk assessments are conducted appropriately. We must discuss co-morbidity, because lots of people will not get off methadone or the drug of their choice because no one is dealing with any of their mental health problems. Many drug users have told me that when they ask the services whether they can be referred for their mental health issues, they are told either that there is such a big waiting list that it would be a waste of their time or that they can be referred but they will have a very long wait. The integration of services is important.

My Treatment of Drug Users (Scotland) Bill covers those issues very well. I wish that we could have a signal from today's meeting that the bill should be scrutinised further. I hope that an outcome from today's meeting might be a recommendation that the bill should go to stage 1 in the Parliament to open out the debate. The round-table session has been good, but it is obvious that we do not have sufficient time as there are so many issues. The input from the experts has been excellent. I would like to take the matter further.

Mr McNeil: I agree with Rosemary Byrne that this is a very big issue. It has been difficult and frustrating for us all this afternoon to try to focus on the issues.

Tom Wood said that the strategy was right for the past but might not be right for the future. Most people agree that the strategy was focused on the addict. Do people agree that we were dealing with HIV and AIDS and whatever in the past and that the strategy must now move forward? The aim of harm reduction must broaden out because, after all, those who are on methadone or who take drugs are more likely to be unemployed or homeless; more likely to be on benefit; more likely to lose a child in labour or to deliver a harmed child and so on. I accept that we need to do something to reduce deaths, because we certainly do not want our young people to be found dead on our streets every other morning or every weekend.

Do we not agree that we need to raise our ambitions? For example, do we need to focus more on cessation? Moreover, I get attacked when I mention the word "contract", but would contracts be useful both for individuals and for the delivery of and effective access to quality services?

As for the Tories' proposals on drug rehabilitation, you would think that there were no addicts or rehabilitation centres in England and that they had to come up here to see them. In any case, if £100 million were to become available, should it be used to provide rehab facilities, given that after rehab 70 per cent of people are back on drugs within a very short time?

The Convener: Okay. Mark Frankland wants to come in and then I will take Dave Liddell.

Mr McNeil: Is it too much to ask for a response to my questions?

The Convener: As Mark Frankland put up his hand while you were speaking, I assumed that he wanted to respond.

Mark Frankland: As far as the debate on cessation and abstinence is concerned, we might have had something of a breakthrough with a drug called naltrexone, which members might have heard of. Someone with naltrexone in their system experiences absolutely no effect from heroin. Although, up to now, the drug has been available in tablet form, it is now available in implants that last 12 months. Several clients have taken the treatment—for which, unfortunately, their families have had to pay £2,500.

The treatment should be given far more consideration; it could, for example, be used in prisons. If an individual is facing an eight-month sentence for a drugs offence, the sheriff might say, "I'll tell you what—you can detox for a month in a bespoke prison and then you can be released with a naltrexone implant". If that happened, that person would not be able to use heroin for a whole year.

A young man we know wanted to try out the treatment. We approached our local MSP, who worked with our local chief medical officer on the case, and in the year that that young man has had the implant, he has not touched heroin at all.

As a result, I believe that there is huge scope for naltrexone. Clients often tell me that getting clean is not that difficult, but staying clean is really hard. I can certainly confirm that drug dealers completely lose interest in anyone who has had an implant, because they know that there is no business to be had from them.

I would be interested to hear Dr Watson's thoughts on whether naltrexone implants have a role in abstinence.

The Convener: I will not bring in Dr Watson just now, as other people are waiting to speak.

Dave Liddell: I hope that I have picked up Duncan McNeil correctly, and I certainly agree that we have not really mentioned the effect of poverty and deprivation on this matter. There is a clear link between poverty and hospital admissions for drug problems, drug-related deaths and so on, and we should consider the backgrounds of the 50,000 people who have drug problems. For example, many of them have had experience of the care system and have low educational attainment and low self-esteem. We cannot ignore such elements if we are to respond to the current drug user population as well as prevent a future generation of problem drug users.

Of course, we can deal with the criminal justice and health aspects of the problem, but we also need to recognise that this is a social issue. Indeed, that is our biggest long-term challenge. As I said, we need services that respond to the full range of people's needs, including their education and employment aspirations.

To pick up on Duncan McNeil's point, it is important that the goal is delivering the aspirations of people with drug problems. Neil McKeganey made a point early on about people being involved in the services that they receive, but there is a potential contradiction in that argument. On the one hand, he is arguing for people to be more involved and on the other, he is arguing for fixed time limits for methadone treatment. Our biggest concern is that that would waste more resources by increasing the rate at which people are pushed out of the revolving door. The big issue is dealing with people's social problems and how we deliver social inclusion for people who have drug problems. That is primarily what people talk about.

Methadone and other substitute drugs are there only as a crutch and support. The bigger issue is how to move people on, and that is how we should view the support issues; support needs to be put in place and then people will choose to leave behind the substitute medication, heroin or other drugs once the other things in their lives have been sorted out. The real risk, if we are not careful, is of putting the cart before the horse.

On abstinence, one of the papers shows a slight increase in rates of HIV infection among drug injectors. That is a bigger concern. We need to have the full range of services—we can all agree on that—but I am concerned that the services will focus heavily on people who are motivated to become drug free. On the back of the HIV epidemic in the mid-80s, we had to change the way in which our services were delivered by working only with people who were motivated to become drug free. There is a real danger that we will move back to that situation. Tom Wood is right to say that we need to move to a new strategy, but we must learn the lessons of the past otherwise we are in danger of repeating previous mistakes.

Mrs Milne: Some of the discussion has been profoundly depressing. The drug addicts whom I have spoken to, even those who are on methadone, would like to have a drug-free existence and do not want to use drugs of any kind.

I have had some contact with a very good residential rehabilitation institution in my area. Its emphasis is on dealing with addictive personalities, whether the addiction is drugs, alcohol, gambling or whatever. They start doing rehab properly by doing detoxification first. Beyond that, there has to be continuity of support and care. The institution is finding that, if that is done properly, addicts are not coming back and saying that they were on methadone or heroin; they are saying that they have got their lives and families back and that they are now able to get jobs.

I cannot help feeling that we are despairing by saying that we should be content with keeping people on methadone in the long term when they could be getting their lives back. Perhaps we would have to spend more money—Duncan McNeil talked about £100 million—on getting people into residential rehabilitation and then supporting them throughout the rest of their lives. I would be interested to hear the comments of the people around the table about that.

At the moment, 46 per cent of funding goes on enforcement, 38 per cent goes on treatment and rehabilitation, and 16 per cent goes on prevention. Is that the right mix? What should we be doing to turn things round?

15:15

Tom Wood: First, I will address Duncan McNeil's question about the contract arrangement. There is absolutely nothing wrong with a contract in the context of a service plan. As we have heard before, it is absolutely right that the client should have some buy-in. They should know what success looks like and how to get there over the stepping stones. The problem arises if the contract is seen as an imposition. We have good evidence that imposed drug treatments do not tend to be as successful as those that clients buy into.

We need to succeed with all three pillars—prevention, treatment and rehabilitation, and enforcement. If we fail at one, we fail at them all. Up to now, because of where we have come from, we have spent a lot of money and done well on

enforcement. I was part of that work in my previous life. We have not done very well on treatment and rehabilitation even though we spend a lot of money on it. The thing that will make a difference to our future success is prevention, which involves awareness and information. We must invest the most in that. However, I emphasise again that we must be successful in all three areas at once.

We have been talking about heroin and methadone for most of the meeting. That is understandable because they are the problem of the past and, to some extent, the problem of the present. However, we passed over a point that Alex MacKinnon made. In the future, the problem in most parts of Scotland might be not heroin but psychostimulants—particularly cocaine—mixed with alcohol. In most parts of western Europe, the future threat that is envisaged is not opiates but lethal combinations of strong cannabis and alcohol, and psychostimulants and alcohol. That problem might come to us. In five years' time, it might be the major issue in Edinburgh and the east of Scotland, but we are poorly equipped to deal with it because all our services are focused on opiates rather than psychostimulants. That is the threat of the future.

Mr McNeil: I appreciate that you answered one of my questions, but should any future strategy place greater emphasis on cessation? If we had a magic wand and another £100 million, should we spend it all on rehabilitation?

Tom Wood: Can I tackle the second question first? If I had another £100 million, I would take a model such as the one that I am holding up—I will pass it around—and fill in the vacant spaces. I would ensure that we did not have a postcode lottery between local authorities and that waiting times were reduced. As was said earlier, if someone is at the point of coming forward with a problem, we should take their hand and get them into a service there and then, while they are willing and able.

The answer to your first question depends on where we start from. We should not forget that every individual is different and comes into service at a different time in their addiction. To say that everybody should have the same goal of cessation is perhaps simplistic. Of course, wherever possible, we should try to aim people towards absolute cessation, but we must be pragmatic and realise that some people come with a long history of drug abuse.

Mr McNeil: We all recognise that. We deal with addiction in the terms of a contract. We expect some people to fail, and the contract allows us to challenge that behaviour. We know what addiction is about, but it seems that at present most people are offered methadone. There is a single approach.

Tom Wood: We have been around and around the methadone issue. Dr Watson is right—we know what methadone can and cannot do. The issue is that all the other bits that are supposed to support methadone and lead us forward do not exist in an integrated way in Scotland.

Dr Watson: I am sure that naltrexone implants have a role to play, albeit for a small number of people. Their main advantage is that they not only discourage illicit heroin use—because the person will get no hit from it—but protect against overdose. I have the impression that you do not all realise or accept that detoxification increases the risk of death from overdose. It is a counterintuitive treatment. The doctor gives a treatment that increases the risk of death. Patients lose their tolerance to opiates, then they relapse, as the majority of them will, and they are at much greater risk of death. Many papers have been published in the *British Medical Journal* and other journals to show that. It is not just a crazy idea that I have picked up.

The Convener: Does the same argument apply to alcohol?

Dr Watson: No. It might apply, but to a much lesser extent.

Contrary to what Mrs Milne said, detoxification should not necessarily always precede rehabilitation. Patients can be rehabilitated, get their lives together and get training while they are maintained on methadone or other substitute drugs.

For many patients, we are not talking about rehabilitation; we are talking about habilitation—I do not know whether that word exists, but it needs to if it does not. Professor McKeganey is right to point out that only a minority of patients on methadone do as well as Catriona Renfrew and I have said that some patients do. However, that is partly because of the backgrounds that they come from. As Dave Liddell said, they come from backgrounds of high unemployment and criminality and they probably would not have been working and being ideal citizens even if they had never been introduced to injecting heroin. Detox need not precede habilitation.

Mr McNeil asks whether we should emphasise cessation. By cessation, I assume that he means cessation of prescription of methadone or some other substitute rather than simply cessation of illegal drug use. Is that correct?

Mr McNeil: To give people a route out of drugs.

Dr Watson: A route out of all drugs? I do not call the drugs that I prescribe "drugs", because it

upsets my patients; I call them "prescribed medication".

Mr McNeil: A rose by any other name.

Dr Watson: No, there is an important difference. We should not emphasise cessation of prescribing, because of the reasons in the quotation that I read out before and which I will not bore you with again. We should invest more in habilitation services.

The Convener: There is a forest of raised hands. However, as we have only another 10 minutes in which to deal with this subject, I will not be able to get to everybody. After Alex MacKinnon has spoken, I will take any brief comments on the exchanges that we have just had. If there are none, I will allow Jean Turner to ask the question that she wanted to move on to.

Alex MacKinnon: I want to re-emphasise what Tom Wood said. As well as thinking about the drugs of the past, we need to think about the drugs of the future. In community pharmacy, more and more people who are on methadone—and are, therefore, off heroin—are taking cocaine and crack cocaine and are mixing that with alcohol. When alcohol and cocaine are mixed together, the liver metabolises that to a compound called cocaethyline, which enhances the euphoric effect of cocaine. However, new evidence suggests that the effects of the combination of cocaine and alcohol might be the biggest cause of drug deaths in the United States of America. We should be aware of that because we do not know how many of the sudden deaths that are associated with methadone are due to the use of a cocktail of drugs rather than the methadone itself.

The Convener: If Jean Turner asks the question that she tried to ask a while ago, we will be able to have 10 minutes on some of the comparisons between England and Scotland.

Dr Turner: I was thinking about the differences in situation between England and Scotland. One thing that has been made clear by this afternoon's discussion is that research is definitely needed. Professor McKeganey's paper talks about the drug outcome research in Scotland study and says that there are no resources to develop that area of work.

We want to keep an open mind. We do not want to always be defending, or hearing people defend, methadone treatment. It definitely has a place but we have to look at the bigger picture. Research is important in that regard. Why do some people take drugs? Why are there differences in different parts of the country and why does the way in which we deal with the situation differ across the country? We need research to address all that. We need facts and figures.

The Convener: Jean, you are supposed to be asking about the comparisons between the English results and the Scottish results.

Dr Turner: Those comparisons are important, but the discussion that we have had since I asked my first question has shown that everything is tied up together. The picture is complex and research is important.

The Convener: I ask Dave Liddell and Neil McKeganey to talk about the differences between Scotland and England.

Dave Liddell: One of the differences that Neil McKeganey picked up on related to retention rates, which is an interesting issue in itself, particularly with regard to the issue of low-dose prescribing that we talked about earlier.

We had an example of that recently. Somebody's parents had fought to get them on a methadone programme but they were put on too low a dose. When they went to the service to talk about that, they were told that the consultant was on holiday for three weeks and that they should use heroin on top of their prescription for two weeks but should stop using it before their clinic appointment, or else it would be caught in their urine test and they would be put off the programme. Obviously, that is not typical, but it is an example of the kind of practice that is found across the country and which leads to the revolving-door effect.

Considerable stigma is now attached to being on a methadone programme. Many people to whom we have spoken recently talked about having moved on. One person talked about having been clean for six years, but they were on a methadone programme. A number of people in work are on methadone programmes and some of the recent debate threatens that because people are terrified of admitting to being on a programme. Many people who are on methadone programmes and seeking employment are also very fearful. One of the issues that we need to acknowledge is the stigma of such programmes. People find the daily supervised dispensing particularly hard to deal with. The fear of stigma is part of the reason why people do not come forward, whereas in some areas less stigma is attached to receiving treatment than to not receiving it.

Professor McKeganey: The research that we did at the University of Glasgow identified a worrying disparity between the recovery rate of addicts in England and Scotland. It is essential to explore that further to find out why we are bringing so few addicts to full recovery. In Scotland, we allocate less than a quarter of 1 per cent of the budget to researching ways in which to tackle the drugs problem. We talk about evidence and we all say that it is essential to get evidence into the

debate and yet we allocate a meagre amount of resource to it. My university research team, which carried out the drug outcome research in Scotland study, is being dismantled at a time when the Home Office is mounting a similar study in England. We will lose the evidence that we have gathered so far and our policies will be guided by conviction rather than evidence if we continue down this road.

Shona Robison: Much store is set by the Home Office study. I think that it is the Burt report that will frame drug treatment services in England in the future. Do we need the same to happen in Scotland to help us to move on from this afternoon's debate and decide on which services we need to meet the need here and now, which everybody agrees is patchy? To pick up on Alex MacKinnon's point, do we also need to look to what the future need will be and is there agreement around the table that that would be a good starting point from which to make a clear recommendation?

Euan Robson: It struck me forcefully that there is an absence of good evidence—of proper statistics. From looking at some of the reports that we have been given and hearing the witnesses, it appears that there are part surveys, bits of information and assumptions based on small samples. Is it the general impression of the professional witnesses that we need to know an awful lot more about the drug-using population? Might we find that we are pursuing certain areas of policy inadequately or indeed incorrectly because of the absence of proper evidence?

Catriona Renfrew: I would put it the other way—there is a plethora of evidence and research from throughout the UK and abroad that we choose not to use because we get hung up on ideological debates. Members will find in their papers reference to some very good research evidence that supports some of our discussions today that would take us in a somewhat different direction.

Although Neil McKeganey obviously has a problem with his research funding, I am not here to pitch for resource. There is a lot of UK and international research and evidence that we have not applied systematically in Scotland—it would fill in the grid or matrix that Tom Wood keeps showing to the committee—about the range of treatment services that should be available to people based on an individual assessment of their need. We should not take an ideological position about what they should or should not have.

Dave Liddell: Quality standards for drug and alcohol services are now in place. One of the challenges is to create a climate of change and reflection within the services. Services are looking at current practice and ways to improve it, whether through user focus groups or user surveys. We need to develop and build on the work that is being done to ensure that agencies look continually at how they use their resources and deliver them to best effect.

Stephen Moore: Euan Robson spoke about the integration of services. We need to look at national as well as local policy, particularly where one part of national policy impacts on another. I do not want to raise any issues about the merits of the GP contract, but in my area, it increased the waiting list time from one week to 23 weeks because GPs do not have to offer the same service as before. We need to be very careful that we do not change one bit of Government machinery without considering the impact on another.

I offer a quick example of that—we lost 13 men in one year. Those men died within one week of being released from prison because we did not have adequate treatment services in prison. We need to join together our drug policy at all levels.

The Convener: We need to bring to a close this part of the afternoon. The minister will arrive shortly. Everybody present is welcome to sit in the public gallery to listen to our questions to the minister. I see that Susan Deacon, as well as Rosemary Byrne, has joined us so I assume that she will stay on for the next panel. I suspend the meeting for 10 minutes.

15:31

Meeting suspended.

15:40

On resuming—

The Convener: I bring the meeting to order. I ask members of the committee to come back to the table and witnesses who want to stay to listen to the remainder of the proceedings to take their seats as soon as possible, please.

I welcome to the meeting the Minister for Justice, Cathy Jamieson MSP, and her officials, who are Nadine Harrison, Patricia Scotland, Carole Ross and Elaine Bell. Rosemary Byrne MSP, who is the promoter of the Treatment of Drug Users (Scotland) Bill, which triggered the debate, has again joined us, and Susan Deacon MSP is here. In line with the Health Committee's standard practice, I will bring in Susan Deacon and Rosemary Byrne once committee members have asked their questions.

I thank the minister for her briefing paper, which has been circulated to all members. I understand that she watched on a monitor most of the lively session that we have just had involving people

from various organisations that have a direct interest in treatment and rehabilitation of drug users. I expect that members will have many questions to ask the minister.

I invite the minister to make a brief statement before we move to questions.

The Minister for Justice (Cathy Jamieson): Thank you, convener. My statement will indeed be brief. I heard much of the previous discussion and am pleased to have an opportunity to make opening remarks because the debate is important.

The paper that the committee has received and what was said in the round-table discussion amply illustrate the challenges that we all face in addressing the problem of drug misuse. I want to leave the committee in no doubt about what I think are the key things that must be done better if we are to improve the lives of drug users, their families and the people in their communities.

A strategy to tackle the use of illegal drugs must be built on prevention and education, treatment and rehabilitation, support for and protection of communities that suffer the effects of drug misuse, and robust enforcement. Those four pillars of our drugs strategy are as valid today as they were in 1999, when the strategy was first published.

However, we must constantly reassess our priorities and develop our approach, which is why several pieces of work are under way. We are reviewing the place of methadone in drug treatment, for example, and are trying to obtain more information on the circumstances in which methadone is used and the level of use. We are establishing current policy and practice and taking action to improve practice throughout Scotland. We have also reviewed the provision of residential rehabilitation in Scotland and we have, as members will be aware, agreed to introduce a national directory of drugs services.

The key point that I want to make about drug treatment is that we must move beyond the notion that one type of treatment will provide a solution in all circumstances. I do not know whether anybody ever believed in that notion, but today's debate has certainly highlighted the fact that we must move beyond it. We must understand that it is unlikely that people will get away and stay away from the grip of drug addiction unless immediate treatment is linked to longer-term support. We will not make enough progress in reducing drug abuse or the misery it causes unless we improve the arrangements for integrating early treatment with wider rehabilitation and support work.

That is a major challenge, but we must do better than we are currently doing. Drugs damage people's physical and mental health, their employment prospects and their family life. Addiction cannot be treated in isolation from those other problems. Unless we deal with it, not enough people will move on from treatment and rehabilitation to what might be described as productive lives.

15:45

We also need to do more to persuade young people to make the sensible decision not to become involved in drug misuse. If they have begun to experiment, we must prevent them from moving on from that to hard drug use and addiction. We need to find better and more innovative ways of getting that message across, especially to the young people who are most at risk. There has been some progress in that area—the level of drug misuse by young people is stabilising, but we must question whether stabilising is good enough. I argue that it is not and that we must ensure that fewer young people get involved in drug misuse in the future.

We are also making progress on what I describe as the supply side with, for example, record numbers of class A drug seizures. Ultimately, we all aspire to a drug-free Scotland, but we must be realistic about what we can achieve in the context of drug misuse being a worldwide problem. It is a difficult and ever-changing problem, and tackling it requires long-term commitment, which is why it is important that we listen to discussions and debates of the sort that the committee is having today, so that we can adjust our priorities in the light of experience of what works and ensure the best possible delivery of treatment and rehabilitation.

I hope that this afternoon's discussion will help us as we move forward and that it will contribute to an objective ad reasoned debate about how, as a country, we can all work together to tackle more effectively the problem of illegal drug use.

The Convener: Thank you, minister. This is the Health Committee, so I want to steer members away from asking about enforcement measures, which are not the principal subject of today's discussion. The discussion is about drug treatment services. Minister, you said that we are not getting everything right at the moment. Can you identify some of the key areas on which we need to work most? Once we have heard your answer, I will invite members of the committee to ask further questions.

Cathy Jamieson: I appreciate that this is the Health Committee and that members are interested primarily in treatment and rehabilitation. Enforcement and giving communities confidence that we take the issue seriously helps to build a perception that we are not abandoning people to the miseries of drug misuse. Enforcement also helps us to gain permission to deal with some of

the other hard issues that exist. I understand that today the committee does not want to focus on enforcement, but I have always believed that it must be one of the strands of what we do.

You asked about where specifically we can do better. I am sure that members will want to raise a number of issues, such as access to initial treatment. There are also concerns about waiting times that members may want to explore in more detail. We must accept that a range of services is needed and we should not limit ourselves to the medical model—the point at which people go to a general practitioner or a medical service to get advice or help with their addiction problem. Is the necessary range of services available? Are services signposted well enough? If one service is not right for a person, is that person passed on appropriately elsewhere, or are people still falling through the gaps?

We must also begin to focus more on targeting young people who are most likely to be at risk from drug misuse. From some of the work that has been done, we know what encourages young people to lead healthy lives and to stay away from drug misuse. We also know which young people are more vulnerable because of the circumstances in which they find themselves. Are we getting the messages right?

Another issue is what we do when people enter the criminal justice system. I appreciate that this is the Health Committee, but we cannot get away from the fact that many people first come into contact with the authorities when they have committed an offence. In my view, the criminal justice system should offer people an opportunity at every stage to get into treatment or to access services that will help them to deal with their addiction and to get back to a law-abiding lifestyle. There is also the issue of what happens in prisons.

The issues that I have raised are probably enough for a whole debate. I hope that my comments will provide a starting point for members.

Shona Robison: I have two questions for the minister. I agree with her on the need for a range of options. Given that need, why is the option of residential rehabilitation so difficult to access in certain areas of Scotland? On waiting times, from what we have extrapolated from ISD Scotland—which I must say was not easy, because we had to get the information and then work out what we needed to know—there have been alarming increases from the end of 2005 to the end of 2006. I will give three examples: the 60 per cent increase in people who wait a year or more for referral to assessment; the 64 per cent increase in those who wait a year to access community support and rehabilitation; and the 33 per cent increase in those who wait a year for residential rehabilitation. Those figures are cause for concern. Will the minister comment on them and say how the situation can best be addressed?

Cathy Jamieson: I agree absolutely with Shona Robison's point about the way in which the figures are collated—they do not always give us the information that we want. We take that matter seriously, so a new method will be introduced.

We have increased the availability of residential treatment and rehabilitation places. The number of places has risen across the board and the number of services that offer such treatment has also increased.

On waiting times, additional money has been put into areas where people have the most difficulty accessing services. It is important to remember that the waiting times are based on the point at which people come into the system and then wait for access to treatment and rehabilitation services, which might be on the health side. As part of that process, people begin to take clinical judgments about the right approach. However, I feel strongly that people who are waiting for access to places should not simply be left waiting with no other support provided to them. Therefore, when people come into the system, through whichever agency they contact, an assessment should be done quickly and they should at least be offered some kind of support.

The figures suggest that we are beginning to make improvements and to increase the number of people who are assessed in a shorter period of time. I can never keep the figures in my head, so I will need to refer to my papers. The figure for people who are assessed within 21 days went up from 40 per cent in October to December 2005 to 46 per cent in July to September 2006. That is far from good enough, but at least the emphasis that we have put on the issue is beginning to produce some success.

Shona Robison: You said that the number of residential rehabilitation places has increased, but there is a question whether health boards purchase those places. The experience that has been brought to my attention is that places lie empty because they are not being purchased. What is the problem? Is it funding or a lack of priority?

Cathy Jamieson: The solution is not simply to provide more and more money. The earlier debate highlighted that we must ensure that we get outcomes for investment. People in my area have told me that they have not had the opportunity to get a residential place but, from the information that I have received when I have asked about that, it seems that the matter often comes down to a decision by those who are involved in the assessment process that, for whatever reason,

residential treatment or rehabilitation may not be the best approach. At the end of the day, someone must make the clinical judgments. I am aware of the range of different opinions on the issue, but research shows that, for some people, residential treatment may be the right option whereas, for others—at least in the early stages—community detoxification facilities can have equally good outcomes.

I am worried that there may be an assumption in the debate that people can spend time in a residential rehabilitation unit, receive treatment and come out at the other end with their problems sorted. Evidence suggests that such treatment is but one part of the process, and that other processes, such as relapse prevention, are equally important. The debate is not simply about money—it is about the way in which people are assessed and given access to places that are appropriate for them.

Helen Eadie: We have heard that the problem is enormously complex. As one of my colleagues said, it is hugely depressing for us that there is no easy answer. Nevertheless, we have to stick with it. With the help of one of the researchers here in Parliament, we have identified that there is no single treatment that represents best practice or is the best source of evidence on what works. That was repeated during our round-table discussion today. However, we were pleased to hear that the Cochrane Collaboration gives a systematic review of the evidence.

The joint working between you, the Minister for Health and Community Care and other ministers is welcome. Will you ensure that Scotland plays a full part in relation to the European Monitoring Centre for Drugs and Drug Addiction, which is concerned that there has been a lack of consistent national monitoring of drug policy approaches? We want to be sure that Scotland plays a full part in that work so that we have standardised instruments for monitoring and evaluation and can assess best practice.

Secondly, I ask you to comment on the report by the Scottish Advisory Committee on Drug Misuse's working group on drug-related deaths, which asks the Scottish Executive

"to confirm evidence that the increasing use of high dose Buprenorphine in France and elsewhere is associated with a substantial decline in drug related deaths."

Obviously, we are concerned about the number of deaths.

Finally, I ask you about waiting times, which were mentioned by Shona Robison and by Stephen Moore from Fife Council, who said that the general practitioner contract has resulted in some 13 deaths in the past year. That is a huge concern for us.

The Convener: I am not sure that Stephen Moore said that people had died because of the GP contract. That is a slight conflation of what he said about the lack of integrated care.

Cathy Jamieson: I managed to hear Stephen Moore's contribution, but thank you for that clarification, convener.

I assure Helen Eadie that we will look into the European issue. We are already involved in the process and we will continue to be involved. It is important that we have as much information as possible to ensure that we have best practice.

On drug-related deaths, there was a peak of such deaths but the trend is moving in the right direction. That relates to what Stephen Moore said. Various measures require to be adopted, whether people are in the community or in prison, to try to ensure that they do not overdose unintentionally.

We know that there is a serious problem in respect of people who are released from prison. I do not suggest that it is in any way connected to the GP contract, but we know that there have been problems with access to GP services and medical services on release from prison. We want to work at local level to ensure that the issues are identified and that the health service is involved in offender services in general. That will be partly the responsibility of the new community justice authorities, which will take up their full responsibilities from 1 April.

Some work goes on in prisons to try to identify people who are likely to be at risk when they leave prison. The way such treatment is offered in order to try to see those people through their early days back in the community can sometimes be controversial.

16:00

Helen Eadie: I asked you to reconsider an issue that was raised in the report by the Scottish Advisory Committee on Drug Misuse's working group on drug-related deaths.

Cathy Jamieson: We will consider that. We can reconsider the issue in the national forum and keep people in touch with it.

Dr Turner: My questions are along a similar line to Helen Eadie's. From the minister's answers, it sounds like things have not improved that much over the years. People can go into prison as alcoholics and come out as heroin addicts. What improvement has there been in provision of treatment programmes in prison and in their continuation as prisoners come outside? There has always been a problem in respect of people accessing treatment at weekends and in respect of people going into rehabilitation programmes,

perhaps residential programmes, knowing that they are not a cure but a way of moving on. What has the Executive done recently to improve on that?

Cathy Jamieson: I certainly want us to do more on prisons and I have asked officials and the Scottish Prison Service to work together on determining what more we need to do. The throughcare addiction service is now operating. It is intended to improve how we deal with people in the prison system. In prison, we have the opportunity to get people on to detox programmes or whatever other treatment programmes might be best for them, but the point at which they go back into the community is crucial. Some prisoners will, depending on the nature of their sentences, be in the community for periods before they finally leave prison. At times, it has been difficult to manage that process. People who leave prison can find it difficult to access all the necessary services, but the throughcare addiction service should help with that. Early evidence suggests that it is having some effect.

I believe strongly that we must get the right links in place at local level. The community justice authorities will have a significant role in that.

Dr Turner: Do you have figures for the number of people who have been through the system since you started to change the links between the community and prison?

Cathy Jamieson: Off the top of my head, I could not quote the figures for the number of people who have gone through the throughcare programme in prison, but I can get that information, which would be useful for the committee.

Mr McNeil: We heard in previous evidence that services can be varied and disjointed: in some cases, a strict testing regime is in place, but we also heard about the breaking of the guidelines on regular appointments for the administration of methadone, and about variations in prescribing and dosage. Furthermore, Professor McKeganey's paper has told us that 70 per cent of addicts who have been prescribed methadone are topping up with illegal heroin. Another important point that we heard is that users of the drug treatment service do not feel involved in the treatment. Would a contract that laid out what the user could expect and what we expect of the addict be useful in addressing some of those issues?

We have heard from Tom Wood and the minister about the importance of preventing people from getting into a drug-addicted lifestyle. Have the previous strategies placed enough emphasis on the children who are most at risk? That is a big issue. I would like to hear what the minister has to say about that and how we can address it.

The Convener: Are you talking about early identification of children who may grow up to start using drugs?

Mr McNeil: The minister knows and we know that those children are most at risk. The issue is whether we have addressed the issue in previous strategies.

The Convener: Are you talking about children who are at risk of becoming drug users themselves?

Mr McNeil: Sorry. Yes.

Cathy Jamieson: I will deal first with the idea of contracts, although I know that some people find such language difficult or worry about it. However, as a former social worker, I can say that the idea of having a contract and a plan to work with people on their problems is not a particularly new idea. It is not something about which I have concerns; it can be a positive way of being clear with people not just about the kind of service that they will get, so that they know what to expect to receive, but about their responsibility to comply or at least do some work to ensure that they move towards the agreed goals.

Nevertheless, I would like contracts to be viewed in the wider context. I hope, when we talk in those terms, that we are not talking just about what could be described as the medical treatment aspect of dealing with drug misuse. We all know that a wide range of social problems are likely to accompany drug misuse. We must ensure that people concentrate on dealing with those other issues, which may be the underlying reasons why they are involved in drug misuse or may have been caused by drug misuse. In implementing the whole package of measures—whether we call it a care plan, as Rosemary Byrne suggests in her bill, or a contract—the important thing is that we are clear with people about what the expectations are and what they should be involved in.

In relation to prevention and whether we have got the strategy right, we need to look again at how we deal specifically with young people. Are the messages that we are putting across to divert young people away from certain behaviours the right ones? Have we focused too broadly across the whole range of young people? Has drugs education in our schools been effective, or can we do more? Often, we identify the young people whom we think are most at risk, but we should also turn that around and think about the reasons young people give us for their not getting involved in drug misuse—usually because there are other positive things going on in their lives. They might receive parental support and involvement, or they might be involved in sporting activities or other

activities that would be put at risk if they were involved in drug misuse. It could also be that they have a strong peer group who are not involved in drug misuse. The challenge is to target the general message at those young people as well as to focus specifically on the ones who are most likely to be at risk.

We know that when young people live in drug-misusing households or in communities where, for whatever reason, people have been so worn down by drug misuse that they turn a blind eye to what is going on, they begin to think that drug misuse is the norm and that it is acceptable. We need to do more work on refining the messages that we send out and on targeting them better in the future.

Ms Byrne: First, I want to ask about the idea of what I would prefer to call an holistic care plan. In order to have a plan that is owned partly by the user or client and which is monitored effectively, there needs to be a good assessment. However, I am hearing from those who work in the field that the training that people are given before they can undertake a full assessment is problematic and that there are not enough people who feel adequately equipped to do that. The message is coming from drugs workers themselves that there is an issue around having the initial assessment conducted properly. I believe that the assessment should cover the needs of the extended family—meaning any children—and should include the family in the treatment process, so that families are made aware of the impact of a substitute prescription, for example, and the kind of support that is needed by somebody who has been detoxified. I wonder whether the minister can give me her thoughts on that.

Secondly, I want to ask about the difference between residential rehabilitation and someone being detoxified in hospital. There is a huge leap between the two. I was looking at figures for national drug treatment waiting times. It was difficult to tease out from that information what was residential detox and what was residential rehab. We hear in our communities that it is very difficult to get anyone into residential rehab, whereas detox beds tend to be available. I have spoken to people who have been through the process, and they usually fall off the far end of it because the rehab element is not there. It is the definition of rehabilitation that is the issue.

How can we ensure equality of services across Scotland, given that some areas have caps on methadone, for instance? Some areas will refer people for residential rehab and others will not—and there is the myriad of other things that we have also been discussing.

Cathy Jamieson: There were a number of important issues in there. I hear what Rosemary Byrne says about preferring an holistic care plan. There is not actually very much that divides people on the issue. It is a matter of ensuring that people with a drug misuse problem seek to do something about it and approach services accordingly. People need some kind of assessment, then a plan for getting the right treatment at the right time in the short term, and then a longer-term plan to sustain them. For some people, that will mean detox in the local area, with additional support. For others, it might mean residential rehabilitation. The important thing is that we should view such plans as something that will get people out of the life cycle that they are in, that will get them off drugs and that will get them back into the local community.

That links to Rosemary Byrne's point about the needs of extended families. I might be at risk of speaking more as a former social worker here, rather than as Minister for Justice—I apologise if it sounds like that—but, if the assessment is to do with only one aspect of a person's life, the plan will inevitably cover only one aspect of the person's life, and not all the problems will be addressed. The role of the extended family is important in a number of ways. Often, it is the extended family who will provide much of the support and care. It is often the extended family who suffer the brunt of it when things go wrong. They have needs, too. If we expect the extended family to help and support the individual, we need to consider the impact of the situation on them.

We also have to address the impact of what is going on in the wider community, I would argue. If an individual is in a community where drug taking is considered to be the norm or is somehow encouraged, that can make it particularly difficult for the person to change their behaviour. I would argue that assessment must take account of all those things and that we must tackle all those different aspects of the problem.

Rosemary Byrne asked about ensuring the quality of services. That is an important point, and the Executive has undertaken work to ensure that we have quality standards. There are some serious questions to be asked in that regard. As a minister, I am thinking about how to proceed in that area in the future. This might be a controversial question, but should we now be reaching the stage where, unless services are able to meet certain standards and do the things that we expect of them, we need to attach conditions of funding to them? It is public money that is being used, after all. We speak a lot about inputs and getting more people to use services, but we also need to consider the outputs. If services cannot deliver those outputs, why continue to put the money into their resources? Those are difficult questions, but they are ones that we must address.

Mrs Milne: The questions that arise in this area are indeed difficult, and funding is obviously one of them. My own local authority is facing budget problems—and I am sure that they are not unique to its area. Demand for children's services has increased hugely over the past few years, and that is partly tied into the drugs problem that we are discussing today. There is also, of course, a high demand for services for elderly people.

There is currently a proposal before my local council to withdraw funding from residential rehab because of a budgetary overspend in social work. Do you have any comments to make on that? There is a lot of interplay between the various demands, and I do not know what the right answer is.

16:15

Cathy Jamieson: The Executive officials who are here today know my frustration about funding. It is very difficult, if not impossible, to identify all the different bits of funding that are provided to deal with drug treatment and rehabilitation. Money is provided through the health service, through the work that comes under the Justice Department, through various other strands of funding that have been identified as well as through local authorities. That is a problem that we need to look at. With all the funding streams that we have identified as trying to tackle the problem, we need to try to ensure that they all deal with the issue in the right way. As members will know, part of the reason why money is provided through local authorities is to ensure that local authorities have some say over the work that is done in their areas so that it meets local needs. However, there are questions about whether the current way in which funding is distributed is the best answer in the longer term. Again, we are looking at that issue.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): Convener, I am grateful for the opportunity to attend today's meeting. Part of the reason for my interest in the subject—this will be the third parliamentary committee that I have voluntarily attended today—is that, over the past couple of years, I have been involved in a United Kingdom-wide piece of work on drugs policy. Therefore, I ask my first question as someone who has wider UK experiences. South of the border, a national treatment agency has been established. I do not for a moment advocate that we should mirror that. However, in the absence of such an agency in Scotland, how can we get better at gathering the required data, achieving better co-ordination of services and creating more equity of access and of targets across the country?

Another dimension that I want to ask about also relates to the comparison with the rest of the UK. I detect a growing concern—in particular south of the border, although I have heard echoes of it in Scotland—about the emphasis that has been placed on the criminal justice dimension of drugs policy. Indeed, both north and south of the border, the lead responsibility for dealing with drugs lies in the criminal justice area. There is a concern that, more and more, it is becoming almost a requirement for drug users to have entered the criminal justice system before they get access to treatment services. Certainly, some emerging evidence in England suggests that that provides a quicker route to treatment services. What is being done in Scotland to avoid that kind of imbalance? I am sure that everyone will agree that it is perfectly acceptable and appropriate that the criminal justice system should provide people with a route into treatment, but people should obviously be able to get treatment without having committed a crime.

If I have time, I also want to lob in some questions on a couple of different areas. It would be helpful if the minister could comment on the range of treatment services that is available. In the earlier evidence session, Tom Wood and others pointed out that much of the debate is about heroin—and, by extension, methadone—whereas there is emerging evidence of people using a wide range of drugs. Increasingly, treatment for non-opiates is one of the biggest challenges that we face.

Finally, as colleagues will know, I also have a profound interest in sexual health issues so I would be grateful if the minister could comment on two further aspects. First, the original report "Hidden Harm: Responding to the needs of children of problem drug users" that the Home Office's Advisory Council on the Misuse of Drugs published in 2003 stated very clearly that services such as family planning and contraception should be firmly integrated with, and developed alongside, treatment and addiction services. What progress has been made in that regard?

Last but not least, I want to ask about HIV. Globally, there is enormous evidence that countries with cultures very different from ours—and with attitudes towards drugs use that are considerably less tolerant than our own—are putting in place what might be dubbed harm reduction measures so that, first and foremost, they can stem the spread of HIV. Can the minister assure us that that remains part of the approach that is being taken here in Scotland?

The Convener: Before the minister launches into her answer, which I hope will be encompassed within a reasonable space of time, I advise members that I will let Shona Robison ask a further question and we will finish with a question from Rosemary Byrne. I say that just so

that members are clear about how we will proceed.

Cathy Jamieson: I think that that was a hint that I should not spend too much time covering all the detail of this matter.

On UK issues and the National Treatment Agency for Substance Misuse, at the risk of relating this subject to wider work that is going on in the Justice Department, I will say that we had to take a decision in relation to the Management of Offenders etc (Scotland) Act 2005 with regard to how to put in place a national strategy that would ensure a uniform quality of approach and standards on certain issues across Scotland but would also allow local delivery and decision making. Similarly, in relation to drug treatment, there are certain services that we would like to be of the same quality across Scotland. There should be a coherent approach and national strategy. However, within that, there needs to be an ability to take account of the particular problems in local areas. We need to think about our present system. Currently, we are examining the work of the drug action teams to determine whether the structure that we have in place will deliver that. I suspect that we need to do some more work on that issue and, in the light of experience, change some things.

On the question whether there is too much of a criminal justice emphasis, I would hope that people do not think that the answer is to be found only in justice, in health or in communities. As the Minister for Justice, I have tried to take an holistic approach—to use Rosemary Byrne's phrase—to the issue. There is no one person who has the answer; everybody needs to be involved in tackling the issue. I have taken the same approach with regard to the politics of the issue and have tried to build some consensus in the political parties.

Having said that, we have to recognise that many of the people who are involved in the system are acting illegally because they are involved in illegal drugs or because they are involved in criminal activity to raise money to keep their drug habit going. We cannot ignore that. The issue is not so much to do with people aligning themselves with the criminal justice system but to do with the criminal justice system aligning itself to ensure that, when people come into contact with it, they are presented with opportunities for routes out of drug misuse, such as the proposal on arrest referral and drug treatment and testing orders, which have proved to be effective. It is important to keep people in the system in that regard.

On the range of treatment services, it is right that there is a range of services on offer. Recently, the Executive took the decision to fund a number of projects relating to abstinence models and various other issues. Of course, we have to evaluate those and see what works. However, it is important to recognise that we do not favour one treatment model over another.

Susan Deacon referred to the "Hidden Harm" report in relation to family planning. Again, with regard to the work that we have done, I think that there is nothing wrong with ensuring that, when people are making choices, they think clearly about the impact of their lifestyle choice on their children, whether they are unborn or in existence.

On HIV and the issue of harm reduction, the needle exchange programme is still running, although it has been controversial in some quarters. It was designed to reduce some of the harm that can be done by people sharing works.

Shona Robison: With regard to the idea of contracts that you discussed earlier, what do you think the sanctions for the breach of such a contract would be?

Cathy Jamieson: On sanctions, it is important that we do not end up with a range of things that would be completely inappropriate in the circumstances. That goes back to getting the assessment right in the first place. You will be aware from your background that it is important to ensure that the assessment is right, that a plan is put in place and that there is some monitoring of that to ensure that people are progressing towards their agreed goals. However, I think that people have assumed that the sanction for failure to comply would be the removal of someone's children. The important thing is what is in the best interests of the child.

In terms of the contractual approach, if people are clear about what the expectations are, they are more likely to be able to deliver on that than they would be if there was just some sort of open-ended commitment. If people are coming into the system and no one says to them, "Look, we expect you to do some work towards getting off drugs," so people think that, once they are in the system, they will not have to change their lifestyle or do anything different, that will not send out a good message.

I am not trying to avoid saying what the sanctions would be. I think that the sanction must suit the individual case and must be considered in the light of all the circumstances.

Ms Byrne: This has been a useful start in opening up the debate. As I said earlier, I feel frustrated because I feel that my bill covers the range of areas that we have discussed and that there is quite a bit of consensus around some of the issues. In that regard, I refer to what the minister said about assessment, planning and monitoring, which the bill deals with to a great extent. The bill also deals with the family support

element and the employability, education and training element, which gives people a glimmer of hope that they might get back into society again. For someone who has gone through years of drug misuse, that is an important issue.

There are areas on which we have a consensus. We need to think about how we can move forward and make the situation work. I would like us to come up with some kind of recommendation from today's meeting that can take us further and can result in further scrutiny of the draft bill, which has been consulted on. Rather than simply having engaged in a talking shop today, I hope that we are in a position in which we can take the next step in improving the lives of the people who are affected by drugs, including the families of drug misusers and the communities in which they live. We need to get something concrete out of today's meeting.

Cathy Jamieson: I assure the committee that, if the committee makes recommendations as a result of the meeting, I will be more than happy to hear them. I assure Rosemary Byrne that many of the things in the work that she did on the bill fit with our approach. However, I have to say that the legislative route would not bring all the solutions to the problems that we face. Having said that, we have taken on board the points that Rosemary Byrne made. I am more than happy to work with any member of the Parliament who has an interest in the matter, because there is enough work in the issue for us all.

The Convener: Indeed. I thank the minister and her officials for attending.

That ends today's meeting. The committee has a private, minor housekeeping matter to attend to, so I ask the members of the public to leave the committee room.

Meeting closed at 16:28.

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