PUBLIC AUDIT COMMITTEE

Wednesday 22 April 2009

Session 3

£5.00

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

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PUBLIC AUDIT COMMITTEE
7th Meeting 2009, Session 3

CONVENER

*Hugh Henry (Paisley South) (Lab)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
George Foulkes (Lothians) (Lab)
*Anne McLaughlin (Glasgow) (SNP)
*Nicol Stephen (Aberdeen South) (LD)
*Andrew Welsh (Angus) (SNP)

COMMITTEE SUBSTITUTES

Derek Brownlee (South of Scotland) (Con)
Linda Fabiani (Central Scotland) (SNP)
*James Kelly (Glasgow Rutherglen) (Lab)
John Farquhar Munro (Ross, Skye and Inverness West) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Angela Cullen (Audit Scotland)
Claire Sweeney (Audit Scotland)
Sally Thompson (Audit Scotland)

CLERK TO THE COMMITTEE

David McGill

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Jason Nairn

LOCATION

Committee Room 5

Scottish Parliament

Public Audit Committee

Wednesday 22 April 2009

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

Decision on Taking Business in Private

The Convener (Hugh Henry): Good morning and welcome to the Public Audit Committee's seventh meeting in 2009. I remind members and others to switch off all electronic devices. I welcome any members of the public and Audit Scotland staff to the meeting.

Agenda item 1 is a decision on whether to take items 4 to 6 in private. Is that agreed?

Members *indicated agreement*.

Section 23 Report

"Drug and alcohol services in Scotland"

10:03

The Convener: Item 2 is a briefing from the Auditor General on his report "Drug and alcohol services in Scotland".

Mr Robert Black (Auditor General for Scotland): Good morning, convener. "Drug and alcohol services in Scotland" was published on 26 March. It was prepared by Audit Scotland jointly for the Accounts Commission as well as me, because of the strong local government interest and involvement in alcohol and drug services.

Back in February 2008, the Minister for Community Safety, Fergus Ewing, asked me whether Audit Scotland could review expenditure on and the effectiveness of drug services. Given the importance of the whole subject to the people of Scotland and my conclusion that an independent audit report could usefully contribute, I decided that Audit Scotland should undertake the study. It also seemed sensible to widen the study to include alcohol services.

We all recognise that the impact of drug and alcohol misuse in Scotland is widespread. It affects not only individuals and families but wider society and many public sector organisations. The report is the first to identify how much the public sector in Scotland spends on "labelled" drug and alcohol services. We have not had numbers on that before. It also considers whether evidence of need or what works determines how the money is spent and the difference that the money is making. It brings together in one document a great deal of information about the services in Scotland, some of which has been previously published and some of which is new.

In particular, the report focuses on the scale of the problem, which I am sure is well known to members of the committee; the main areas of spend; how effectively the money has been spent; and where we are with joint working to plan and deliver drug and alcohol services. I will take a few minutes to mention one or two points under each of those headings, if that is acceptable.

First, on the scale of drug and alcohol misuse, members of the committee will be only too aware of the seriousness of the problems in Scottish society as a whole. Compared with the rest of the United Kingdom, Scotland has high levels of drug and alcohol misuse. The levels of problematic drug misuse in Scotland are double those in England, and the levels of alcohol dependency are a third higher. The numbers of drug and alcohol-related deaths in Scotland are among the highest

in Europe; they have doubled in the past 15 years. That has happened at a time when indicators of drug and alcohol-related harm are reducing in other European countries; in other words, we are going against the trend elsewhere in Europe.

Alcohol misuse could be seen as a bigger problem for Scotland than drug misuse in light of the number of people who are affected by it and the harm that it causes to people's health. That is not to detract from the seriousness of the drugs problem, but our report confirms the growing perception of the scale and seriousness of alcohol misuse in our society. In 2007, the number of alcohol-related deaths in Scotland was three times higher than the number of drug-related deaths. Exhibit 1 on page 8 is one of the starkest exhibits in the report. It highlights the fact that the number of deaths from chronic liver disease and liver cirrhosis is increasing at a greater rate in Scotland than in England and Wales. That is in marked contrast to the decline in deaths from chronic liver disease and liver cirrhosis in other European countries.

Drug and alcohol misuse affects the whole of Scotland, but the problems are particularly acute in deprived areas. There is a clear link between problematic drug use and poverty, but the relationship between alcohol and deprivation is more complex. The evidence is that professional people are more likely to drink too much, but people who live in the most deprived areas are more likely to experience health problems and die because of their drinking.

The second issue that the report focuses on is direct expenditure on drug and alcohol services. The costs to society of drug and alcohol misuse are currently estimated at around £5 billion, but that figure is probably an underestimate. It includes the costs to the health services, the police, prisons, courts and the wider economy as a result of lost working days and unemployment. We found that there was £173 million of direct expenditure on drug and alcohol services in 2007-08. Of that, £84 million was spent on drug-specific services, £30 million was spent on alcohol-specific services, and the remainder was spent on joint services. Sixty-eight per cent was spent on treatment and care services; only 6 per cent was spent on prevention services. That breakdown of money does not yet reflect the Government's strategies, which are putting increasing emphasis on the importance of prevention.

The report shows that the amount that national health service boards and councils spend on drug and alcohol services varies throughout the country, from around £13 per person in the Borders to just over £53 per person in Greater Glasgow and Clyde. Some variations would, of course, be expected, but the current patterns of spend do not reflect national indicators of need, such as levels of misuse. We highlighted that in exhibits 8 and 9 on page 17.

Our report confirms that funding arrangements for drug and alcohol services are complex and that they can often be very short term. I think that many of us are aware of that. Services can have a number of separate funding streams with different timescales and reporting criteria. Things can be very difficult for service managers, and it is difficult to be transparent about the funding. The arrangements also make it difficult to plan and ensure the long-term stability of services. Exhibits 10 and 11 on pages 18 and 19 clearly illustrate those points.

Thirdly, on the effectiveness of drug and alcohol services, we found that the services that people receive vary depending on where they live. There are no national minimum standards in place that cover the range, choice and accessibility of services that users and their families can expect to receive. What is being delivered by the money that is spent on drug treatment and services is not clear.

There are local examples of good practice, some of which we mention in the report. However, spending decisions are not always based on evidence of what works or on a full assessment of local need. Assessments of need often appear to be ad hoc, and public bodies do not routinely evaluate the effectiveness of the services that are provided. National information on the cost, activities and quality of drug and alcohol services does not exist.

The final points are about drug and alcohol partnerships. Many public bodies and multi-agency partnerships contribute towards addressing drug and alcohol problems. As well as the main statutory agencies of NHS boards, councils, police and the Scottish Prison Service, we also have community health partnerships, community planning partnerships and community justice authorities, all of which have a role. There is also the very important contribution that is made by the voluntary sector; the work of the sector is not touched on much in this report, but that is not to say that it does not play an extremely important role.

Since the late 1980s, drug and alcohol-specific partnership bodies have existed. Exhibit 15 on page 31 highlights the many partners that alcohol and drug action teams have to work with. There are local examples of good practice, but in general those drug and alcohol partnerships have not achieved everything that was expected of them. Work has been going on for a number of years now—certainly since 2005—to review local planning and delivery arrangements. The Scottish

Government has been working since then on revised guidance.

On Monday, the Scottish Government announced a new framework for local partnerships on alcohol and drugs, building on its drugs strategy, "The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem", and the alcohol framework, "Changing Scotland's Relationship with Alcohol: A Framework for Action". The new framework sets out the responsibilities of the Scottish Government, local government, health boards, agencies and partnerships. A notable feature is the commitment to the establishment of an alcohol and drugs partnership in each local authority, a framework that will be embedded in wider arrangements for community planning.

Our report makes a number of recommendations for the Scottish Government and other public bodies, which are summarised on page 4. A lot of activity is going on in Scotland at the moment, and we hope that our report is a helpful and informative contribution to one of the most challenging and difficult problems in Scottish society.

The Convener: Thank you. It is quite frightening to see the statistics before us. A huge amount of money is spent on drug and alcohol services, but that cannot accurately reflect the human misery that is associated with drugs and alcohol—not just for the individuals who are directly affected but for the families and communities that also suffer. Clearly, a major challenge lies before us.

I hope that this report will contribute towards a debate that is not just about how much we can spend on services. The report brings out the fact that this is not just about the amount that we spend but about how we spend it and how we use resources effectively. We clearly have some way to go to ensure that we spend the substantial resources as effectively as we can.

Another telling point that you made concerned the need for a major debate on prevention. Such a debate has started. If we do not prevent the problem from developing in the first place, we will be throwing money into a bottomless pit in our efforts to tackle the consequences of the abuse that is happening.

10:15

Andrew Welsh (Angus) (SNP): We can see the problem all too clearly, but the key question is what cure will work. I notice that you find:

"There is variation across Scotland in the range and accessibility of drug and alcohol services. The Scottish Government has not set out minimum standards in terms of range, choice and accessibility that service users and their families can expect to receive. Spending decisions are not always based on evidence of what works or on a full assessment of local need."

That takes us to the heart of the matter.

Is there a model of good practice elsewhere that combines a consistent range of services, a set of minimum standards and spending decisions that are based on a full assessment of needs that covers urban and rural situations? Do you have any costings for such a national system of uniform provision?

Mr Black: In England, a special national board has been set up to co-ordinate drug and alcohol services. I am sure that the team can provide further information on that. Secondly, the new framework that was announced on Monday, which I think I mentioned, requires each local authority area to have an alcohol and drugs partnership, which should develop a local strategy and a local outcomes framework, to which everyone signs up. The idea is to make it clear what outcomes people are working towards in each partnership area. In addition, the Government has indicated that it will produce a limited set of national core indicators, which each local partnership should consider including. There is a move to address some of the issues of concern.

The first part of your question was about experience elsewhere that we might draw on. I invite the team to say a little bit more about the situation in England.

Claire Sweeney (Audit Scotland): In the report, we highlight that the National Treatment Agency for Substance Misuse in England examines the cost of particular treatments more rigorously than is possible at national level in Scotland. One of the messages is that it would be difficult to have a comprehensive system that fitted everywhere in Scotland, because clearly the issue is complex. However, we found that there was a lack of basic management information about what services cost and that use was not made of the available evidence. There is a wealth of evidence about how services work in some areas, but it is not always used as effectively as it could be to inform the way forward.

Andrew Welsh: It is a massive task. Your report at least points everyone in the correct direction.

The Convener: I will follow up on that. I welcome the suggestion that we need to have rigorous local structures that are capable of dealing with the problem, because too often confusion has arisen as a result of the existence of a plethora of organisations, some of which have been less effective than others.

Andrew Welsh asked about what works and whether there were any models that we could look to. That is fine up to a point but, given that we are

talking about a national problem that needs a national response, is there a danger that, in setting up local bodies and giving them the responsibility for tackling the issue, we will end up blaming those local bodies for any failure? The national perspective might be, "We have given out the money with the best of intentions, but it is down to the local organisations to meet their obligations." In other words, it might not be possible at national level to influence what happens locally. Is there a danger that, in setting up 32 local decision-making bodies and delegating responsibility down to local level, as the Government is about to do, we will lose a national perspective and will not be able to control or influence the problem at national level?

Mr Black: The evidence is that, certainly until now, the national strategy and guidance have not really been fit for purpose. If the Government at national level is to hold local partners to account for delivery, it must have a clear strategy, so one cannot escape the fact that the Government has a responsibility to be clear about what it wants to be achieved locally. As I am sure we all recognise, these are complex problems on the ground. It is right that there should be a strong emphasis on creating and holding to account strong and effective local partnerships that are focused on alcohol and drug services with a clear commitment to working together to identify the outcomes that they are attempting to deliver.

An important part of the report, which is buried towards the end—it is in appendix 4—although it is a significant element of the report, is the self-assessment checklist that Audit Scotland has prepared. The purpose of that checklist is to lay out, on the basis of the knowledge and intelligence that we have gathered during the preparation of the report, a series of questions for each of the partnerships to start thinking about. New partnerships will come through as we consolidate everything that has been achieved so far and take matters forward in an integrated, constructive way, and I would strongly encourage the new partnerships to use that checklist as one way of trying to be clear about how they are running the services locally, how they are co-ordinating them and how they are going to manage their performance and report it. So far, the response to the idea of that checklist has been very positive. After a period of time, it will enable Audit Scotland to evaluate how well the new partnerships are doing against that sort of assessment.

The Convener: The idea of the checklist is hugely encouraging and I welcome it.

Let us suppose that, at a national level, ministers and Parliament suggest that they would like a reduction in the number of people who use methadone and, in parallel with that, an increase in the number of people going into residential services. Will we be able to deliver those things if the delivery is down to the 32 local agencies, which might well have a different perspective?

Mr Black: That is a policy question that would be better put to the Scottish Government. If there were issues around the volume and effectiveness of residential care, as opposed to methadone prescribing, it might be possible to gather information through the national guidance and the concept of core indicators. However, it is fair to say that, without a clear policy direction, it would not be certain that all partnerships could deliver the information readily to you.

Murdo Fraser (Mid Scotland and Fife) (Con): I want to pick up on that last point. Paragraphs 100 to 104 of the report consider the issue of residential and community treatment. It is clear from the report—I suspect that we already knew it—that the cost of residential treatment can be very high. Are you aware of any assessment having been carried out of the effectiveness of residential treatment and whether it represents good value for money, given its high cost and the investment that is being made, as opposed to community treatments, which are preferred in some areas?

Mr Black: Claire Sweeney or Sally Thompson may be able to help with that question.

Sally Thompson (Audit Scotland): On the evidence of the effectiveness of different interventions, the report states that there is most evidence of the effectiveness of methadone treatment. However, that is because there has been a lot of research into how to make methadone treatment effective.

In comparing the effectiveness of different interventions, we would not be comparing like with like. Most people who enter residential treatment have already been through methadone treatment several times and have tried lots of other community options. It is really hard to get a like-for-like comparison. Some local research suggests that residential treatment is used because it is considered more effective. Similarly, other local areas use community treatment because it is believed to be more cost effective. It is a complicated area.

Murdo Fraser: I am looking at exhibit 12. There is a substantial disparity in the use of residential treatment between different NHS board areas. Its use is as low as 2 per cent in NHS Forth Valley but as high as 25 per cent in NHS Grampian. It seems strange that there are such hugely varying approaches in different health boards.

Sally Thompson: We point that out in our report—it is taken from a review that was carried out by the Scottish Government that suggests that residential treatment is not used in some areas

due to local philosophy and the viewpoints of local clinicians, whereas in other areas many more people will be sent to residential treatment if a board has the budget for it. Residential treatment is certainly an area in which there is a lot of variation throughout the country.

The Convener: Do you have figures for how many people in each health board area received community treatment and how many received residential treatment? It is all very well to look at percentages, but if, for example, we increased the percentage of residential placements and the numbers changed dramatically, it is clear that there would be budgetary implications.

Sally Thompson: On-going information on that at a national level is not really available. I think there were some numbers attached to the review that the Scottish Government undertook in 2005-06, but I will have to get back to you on exactly what those were. It is not monitored consistently on a national basis.

The Convener: From exhibit 12, we are able to determine that 91 per cent of the budget in Ayrshire and Arran was spent on community treatment and 9 per cent was spent on residential treatment, but do we have information on how many people those percentages each represent? How do we know how much is being spent—or whether the expenditure is legitimate, justified or effective—if we do not have a clue how many people have been through the treatments?

Claire Sweeney: We collected some information from all health boards and councils on the amount that was labelled for drug and alcohol services, and we were surprised at how difficult it was to get basic management information on overall costs. I would need to go back and check, but I think that those questions were framed around how much was spent on services.

There are some national data, which we used, on the number of beds that are in place in Scotland, but I do not think that we managed to get down to the individual level and the number of people going through treatment. I see that Sally Thompson is nodding—that is correct.

The Convener: Residential treatment is expensive, as Murdo Fraser commented, but if it is the correct treatment for someone, it is in some respects money well spent. We know that in Ayrshire and Arran, for example, only 9 per cent is spent on residential treatment, but we do not know how many people that represents. If it represents one person, and we want to move towards having another 400 or 500 people going through residential treatment, it becomes a challenge that we cannot meet. However, if that percentage represents 50 or 100 people, it is a different calculation. If, as some do, politicians aspire to increase the number of addicts who have access to residential treatment, we need to know how many people are currently going through residential treatment, how much it is costing, and how much it would be to increase the number of people who are going into residential treatment.

It is all very well for us to demand of Ayrshire and Arran—or Greater Glasgow and Clyde, or anywhere else—that it put more people through residential treatment, but if we do not make the money available, it is merely a pious statement. Politicians have to follow through on their aspirations and, to be able to have a proper and informed debate, we need to know what the numbers are.

Sally Thompson: Our report states that in Aberdeen, it was estimated that a year in residential rehabilitation would cost £20,000, in comparison with £3,000 for rehabilitation in the community. We have highlighted the lack of unit costs for different treatment interventions, which is something that is currently available or being developed in England.

10:30

The Convener: The issue is not so much the cost in Aberdeen as how many people are treated in each category. If we want to shift the balance from one category to another, that has financial implications not just for the health board and the local authority, but for national bodies' allocation of resources.

Mr Black: It is clear that that is an issue. A further layer of complication may apply. As members have seen, paragraph 103 says that we know of an estimated 352 beds that were

"provided by 22 separate services",

that

"Almost a third of the beds and services were located in Glasgow"

and that

"area of residence and age were the main limiting factors in accessing … services."

In Glasgow, a third of beds were available only to Glasgow residents. Just from reading our analysis, it seems that the supply is fixed and is taken up where it is available by whoever needs it, but it is not planned in a way that meets needs throughout Scotland.

Willie Coffey (Kilmarnock and Loudoun) (SNP): I will pick up on the problem of evaluation, which is a common theme for the committee. Anybody would be shocked to read in the report that in some areas services have their funding continued although there is no evidence base. That is a damning indictment of the system since

we started to try to tackle the problem. I am pleased that the emphasis is shifting towards putting in place proper—or any—evaluation.

We have only to look at exhibit 1 on page 8, which the Auditor General highlighted, to see that deaths from cirrhosis of the liver are rocketing in Scotland, whereas the situation has been the opposite of that in Europe from the mid-1970s. What on earth has happened in Europe from the mid-1970s until now to achieve that effect? Why on earth are we in Scotland not achieving the same effect? Why have we allowed so little and such poor evaluation for many years?

Mr Black: That is a key question. The analysis that we captured in exhibit 1—which is not original research; it draws on other sources—raises more questions than we can answer. The problem is serious. Exhibit 1 highlights how deep-seated the problem is, given the commitment that has been made to addressing the issues. Turning round the situation will be a major challenge for all public services. That will not happen quickly. Perhaps the new framework, which places a stronger emphasis on focused alcohol and drug partnerships in each local authority area and signing up to outcome agreements, will help in the longer term.

Willie Coffey: Paragraph 130 says that drug action teams were established in 1995 and that the guidance was updated in 2002. Another revision of the guidance is due in 2009. Do such revisions militate against our undertaking evaluation? It is critical that they should not be allowed to do that. We cannot have local partnership bodies saying, "Oh sorry—we can't give you any data because you've changed the criteria." We must go beyond that to the root of the problems and to find examples of good practice in Scotland or to search for good practice in Europe that can be adopted. I stress that, when we change guidelines and so on, that should not affect our ability to monitor what is happening.

Mr Black: It will be of great help if the Government, with the agencies, clarifies the outcomes that it is attempting to achieve and ensures that good evaluation research is undertaken to identify much more effectively what works for the different groups that require support and treatment. As members well know, the circumstances of different groups of people differ enormously, so services must be tailored.

Perhaps members of the Audit Scotland team will add to that, with their deeper knowledge.

Claire Sweeney: It might be worth stressing that we were surprised at the lack of basic information, regardless of the policies and strategies. Do we know how much services cost? Do we know why we are spending money? Do we know what the outcomes are supposed to be? Is everybody clear about who is responsible for what, what they are trying to deliver and what success looks like? The report shows clearly that there is quite a complex picture. There are different patterns in different agencies and it is difficult to draw national conclusions about whether the money that is spent is making a difference, because there is a lack of basic information in some cases. We highlighted evidence of good practice in some areas, but there is a need for greater clarity.

Willie Coffey: That is a good point. Exhibit 1 shows that we are getting it spectacularly wrong in Scotland, while Europe is getting it right. I do not understand why that should be. Yesterday, the Equal Opportunities Committee discussed alcohol addiction services for women when they are released from Cornton Vale. Many women find that they have to move house to access support services for alcohol addiction. It came as a shock to many members that that is happening throughout Scotland. It has a big impact on tackling reoffending; most of the women whom we heard about end up back in prison—in some cases the following week—because there is no support for them. We have to capture the wider perspective if we are to tackle the issue. I hope that the Government's strategy will begin to do that.

Mr Black: Members of the committee might recall that, a little while ago, we produced a report on the services that are available for rehabilitation in Scottish prisons. One of the key messages was that the service was under a huge amount of pressure because it was running at capacity and, therefore, the amount of time and resource that was available for training and rehabilitation was extremely limited and under pressure. I suspect that members know that from their general involvement in Scottish society. It is a serious issue.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): As everybody else has said, the report highlights a matter of shame for the whole of Scotland. Some of the figures that Mr Black has produced are frightening. The figures show that three quarters of drug users and half of people with alcohol difficulties have mental health problems. We know that mental health services are not as they should be. I am concerned that people with a mental health issue are facing delays in being referred for specialist services.

You highlight the concordat that was reached between the Government and local authorities and the single outcome agreements that were published by the 32 local authorities. The report tells us that alcohol and drug problems were not highlighted in the concordat and that very few of the single outcome agreements mention them. In paragraph 131, you say that each of the local

partnerships has developed different focuses but, often, their influence has been small. The key message is that people have to work in partnership. How confident are you that action will be taken to try to implement the recommendations, so that local partnerships can influence the people at the top of the tree? If we do not commit more resources and expertise to this field, the problem could continue to escalate.

Mr Black: There are two parts to our response to that question. First, on mental health services and the relationship between mental health and drug and alcohol abuse, you are right that up to three quarters of people misusing drugs have mental health problems and up to 50 per cent of people with alcohol problems might have some form of mental health problem. That is one area in which the study found problems with the way in which services work together and a lack of joined-up working. It can be more difficult to deal with people who have more complex needs, such as people who misuse drugs and alcohol and who also have mental health problems. There is evidence that such people are moved from one area to another within the service. It is not accidental that, before the summer, we will bring to the Parliament and the committee an overview of mental health services in Scotland, which will examine those issues more deeply. That is complementary to the work that we are considering at present.

On the outcome agreements, I have mentioned on several occasions—in the committee and elsewhere—a concern that, although the outcome agreement framework has tremendous strengths because it lays out clearly what Government intends to achieve through partnership working with local government and other agencies, it is important that the agreements are underpinned with strong information about the services that are being delivered that really matter for people, how effective those services are and what the costs are. All too often, the outcome agreements deal with long-term trends. To return to Mr Coffey's concern about the steep increase in liver disease and liver cirrhosis, that will not be turned round in the short term. Even if we had an agreed outcome in Scotland of a reduction in those figures, the important point would be how we would get from here to that goal, which brings us back to the question of the services that will be delivered to the people of Scotland.

I wonder whether the team can provide more information on what is happening in the outcome agreements.

Claire Sweeney: The report comments on the first round of single outcome agreements. There is an issue to do with joining up the agreements more clearly with the services, so that there is a clearer feed into the strategic level—the goals and aims—and an understanding of how those relate to the services and what they mean for practitioners on the ground. The outcome agreements are pitched at a different level. We need more thinking about how the two levels work together and how they join up. We will certainly keep an eye on how that develops over time. There is a need for the system to be strengthened. The issue of drugs and alcohol appeared in some of the initial single outcome agreements, and we expect it to appear much more clearly in future versions of the agreements.

Cathie Craigie: I have another question on exhibit 1, the shocking chart that shows how liver disease has increased in Scotland over the past 50 years. I know that the information is as accurate as possible, but does the graph compare like with like? Are the statistics gathered differently in other European countries?

Claire Sweeney: The exhibit is not based on our research, but we are as confident as we can be, based on the available information, that it is a reasonable picture. The chart is commonly referred to in discussions about the picture in Scotland relative to that elsewhere. There will doubtless be issues with the data, but it is a commonly held view that there is a disparity between Scotland and other countries and that a shift over time has occurred. It is generally accepted that nobody has a clear answer about why that is the case. Issues to do with culture and a raft of other issues might feed into that. However, we are as confident as we can be that that is the picture.

Mr Black: The chart is supported by other pretty robust information. Scotland has the eighth highest level of alcohol sales in the world. The countries that are ahead of us tend to be smaller ones such as Luxembourg, Ireland, Hungary, Moldova, the Czech Republic and Croatia. Our high levels of liver-related problems correlate with our high levels of alcohol sales, which are a matter that the Parliament is concerned about at the moment.

10:45

Cathie Craigie: I accept what you are saying and am aware that health professionals have been highlighting this issue as well recently. The information that we have before us is good, and I hope that someone in the health department will pick up the report and go into the issue further to determine, as Willie Coffey said, what other countries are doing differently from us.

Nicol Stephen (Aberdeen South) (LD): The report is a damning indictment of the situation in Scotland. I was keen to explore the extent to

which the figures focus on particular parts of Scotland. The report emphasises that areas of deprivation are particularly badly affected. Health statistics on coronary heart disease, for example, clearly show that there is a specific problem associated with west central Scotland—indeed, if that area is taken out of the statistics, the situation in Scotland becomes similar to that in other parts of the UK and Europe. If certain areas are removed from the drug and alcohol problem statistics, does the same thing apply, or do these problems pertain right across Scotland?

One of the areas that pops out in the report is the Western Isles. I appreciate that its population is small, but it has a significant problem with alcohol and a small problem with drugs, according to exhibits 8 and 9, although the spend does not follow that in any way, unfortunately.

If three or four local authority areas, or one or two health board areas, were to be removed from the statistics would the situation look normal in the rest of the country, or is this an all-Scotland problem?

Claire Sweeney: The short answer is that it is a problem across the board. The report highlights that there are particular areas with particular problems. For example, as you would expect, Glasgow has particular issues. However, you could not say that, if you took out certain areas, the situation everywhere else would appear to be fine. There are issues across the whole of Scotland. Those issues affect both urban and rural areas, for complex and different reasons. The situation is not as straightforward as it would be if there were problems only in certain pockets of the country. We have tried to reflect in the report the fact that the problem affects the whole country.

In the studies, we have attempted to determine whether there are differences between rural and urban areas. However, as the report shows, that does not seem to be the case, which is because the issue is connected with deprivation, which is a problem throughout Scotland. We have lots of information on the various pictures in the different local authority and health board areas but, to put it simply, the issue is a problem across the whole country.

Anne McLaughlin (Glasgow) (SNP): I do not know whether I find that more or less depressing.

We have been asking why Europe is doing so much better than us, and I think that the report makes it clear that one of the key issues is the fact that public bodies do not routinely monitor the effectiveness of the treatments. One approach will not work for everyone, but if we do not know what is working, how can we tackle the problem at all?

In a previous job, I worked with people in a local authority who argued that residential care for alcohol rehabilitation was far more effective than the local trend of home-based addiction treatments. The people who were arguing that point were the residents and staff of an alcohol rehabilitation centre, and they were very passionate and eloquent. They asked me to look into the effectiveness of the community-based treatments that they were saying did not work, but I could not get the necessary figures from the local authority. In some cases, we got figures that showed that, three weeks after the treatment ended, a certain number of people were still sober; three weeks is not a great length of time in someone's lifetime, but that is where the monitoring ended. There was no standard way of monitoring people or agreement about how long that monitoring should last. The situation seemed to be all over the place, to be honest. Indeed, even the people on whose behalf I was seeking information and with whose arguments I was so taken could not provide figures for the success of their service. They gave me powerful anecdotal evidence of its success but could not give us figures that would show us how effectively the money had been spent or how many people had stayed sober in the long term.

I thought that the problem might exist only in that area, but I am horrified to discover that it is such a big problem across the board. I am pleased that the report has highlighted the problem and I look forward to the situation changing.

The report says that there are examples of good practice and discusses in detail a case study of addiction services in Greater Glasgow. Could you tell us a bit more about other examples of good practice in Scotland and—bearing in mind what you said about the good work that was being done in some parts of England—south of the border?

As the key to the solution is knowing what is effective and what works, could you tell us who is collecting that information effectively?

Claire Sweeney: Sally Thompson might want to talk about the detail of some local examples but, basically, you are right about the confusion over what works well and the need to be able to plan services and investment based on proper information. There are pockets where there have been efforts to address that issue, but that is not always the case.

The problem comes down to the fact that the issue is incredibly complex, as the approaches differ between different areas and from person to person. That is the situation at one end of the spectrum and, at the other, there is the fact that we need to know how much things cost and how effective things are. Those two issues have not been joined together until now.

The report makes it clear that, although there is a need to be flexible and to operate in a way that suits a local area, people still need to know how much things cost, why certain approaches are being taken and what differences those things are making to people. Simple issues such as the monitoring of waiting times for services and ensuring that vulnerable people are not being bounced between different services are important. We found examples of people who found that the easiest way of getting into a treatment system was through a criminal justice route. That begs questions about the impact that that might have.

Sally Thompson: Case study 5 on page 25 of the report concerns what has been going on in West Lothian. In the past few years, that area has adopted an outcome-based system for commissioning services and evaluating the effectiveness of their services, which feeds back into what services will be funded. That involves the consideration of the longer-term outcomes of interventions. However, that system is unique in Scotland.

One of the problems is that someone who has finished an alcohol rehabilitation course, for example, might not want to get in contact with the service in a year's time to say that they are doing okay. That sort of thing makes it quite difficult to follow up everybody's case.

In England, the National Treatment Agency for Substance Misuse has systems to track people through the process against the targets that it sets—three months clean, six months clean and so on.

Anne McLaughlin: I am pleased that you mentioned waiting times for treatment. We must understand how important that is for somebody who is an alcoholic or a drug addict, when they come to a decision that they are ready for treatment. I understand that we do not live in a utopia, and that we cannot just tell people that they can go in for treatment right away. However, we must be aware of how important it is to provide treatment as quickly as possible and to reduce waiting times. If people have to hang about waiting, it means a very unbalanced lifestyle. People cannot just say to themselves that they will still be ready to be helped in six months' time. They need help pretty quickly.

We are all critical and we are all talking about the lack of effective monitoring, but we should not forget how committed the people who work with alcoholics and drug addicts are. I was given an example of somebody I worked with last year. It was not that they did not want to do monitoring; there was no clear guidance on it. I have known many of those people frequently to go above and beyond the call of duty. Many recovered drug addicts and alcoholics return and do voluntary work. It is not that the attitude is wrong; people want to do the right thing, but they need a national strategic direction.

James Kelly (Glasgow Rutherglen) (Lab): This is an important piece of work, which highlights serious issues. Others have commented on the exhibit on page 8, and on how it illustrates the depth of the problem. We have spoken about variations across the country. I have seen a similar graph to exhibit 1 for Greater Glasgow and Clyde, which shows a much worse position for that health board area. The graph on page 8 shows an approximate doubling of deaths by cirrhosis since 1990; I think that the graph for Greater Glasgow and Clyde shows a trebling of deaths. That shows how serious the problem is in that area.

The report mentions the concordat and how changes to ring fencing have changed how councils have been able to prioritise. It discusses the importance of having good information systems in place to track how councils follow their priorities through to spending on various programmes. Are there any examples from councils of good information systems that would help to track such spending?

Claire Sweeney: I am not aware of a system in any one council that has come through as being much stronger than any other. We were certainly surprised by the difficulty in matching up funding on drug and alcohol services between NHS boards and councils. We spent quite a lot of time speaking to people at boards and councils trying to reconcile what money was available and what money was being used for the various services. We were trying to get a sufficiently clear picture to present in our report, with some confidence about what was going on at a local level. That was challenging enough. The simple answer is therefore probably no.

James Kelly: As you have highlighted in the report, that is an aspect that really needs to be developed if we are to ensure that the funding that has been made available reaches the correct areas.

The Convener: I thank the witnesses very much for their contribution to the discussion and for the report. I suspect that Parliament will be returning to the issue on a frequent basis.

Section 22 Reports

"The 2007/2008 audit of the Queen's and Lord Treasurer's Remembrancer"

"The 2006/2007 audit of the Queen's and Lord Treasurer's Remembrancer"

10:59

The Convener: Under item 3, I invite the Auditor General to give us a briefing on his reports on the 2006-07 and 2007-08 audits of the Queen's and Lord Treasurer's Remembrancer.

Mr Black: I hope that members who may not be fully aware of the Queen's and Lord Treasurer's Remembrancer do not mind if I use the acronym QLTR from now on.

The QLTR deals with various issues relating to ownerless goods in Scotland, which include the assets of dissolved companies or missing persons; lost or abandoned property; where a person dies without leaving a will and has no blood relatives, or none that can be easily traced; and treasure trove—to use that marvellous phrase—which includes anything taken out of the ground and thought worth preserving for the nation.

I have been obliged to present section 22 reports on the QLTR accounts for 2006-07 and 2007-08 because both sets of accounts failed to comply with the statutory deadlines for laying and publishing accounts.

As the committee knows, the Public Finance and Accountability (Scotland) Act 2000 requires that any accounts sent to the Auditor General for auditing should be sent not later than six months after the end of the financial year to which the accounts relate. The act also requires the Scottish ministers to lay accounts in Parliament no later than nine months after the end of the financial year.

I did not receive the audited accounts of the QLTR for both years until 9 February 2009, well after the statutory deadlines for laying them. The 2006-07 accounts were late for a number of reasons, including the fact that 2006-07 was the first year when the QLTR was required to produce a statutory set of accounts. In 2006, a review of the QLTR recommended that it should produce accounts in accordance with the 2000 act and the "Scottish Public Finance Manual". The review also recommended that responsibility for financial management within the QLTR should be clearly allocated to the most appropriate staff member.

As a result of that review, in March 2007 the Scottish ministers issued a direction requiring the QLTR to prepare accounts for 2006-07 and subsequent years. In August 2007, the accountable officer prepared an initial set of draft accounts for 2006-07, but he left the organisation shortly after and no one within the QLTR was given responsibility for preparing the accounts.

Those initial accounts were incomplete and a number of drafts were required before they were ready to be audited by the appointed auditors for the QLTR. That resulted in a considerable delay and the auditors did not conclude their audit of the 2006-07 reports until 4 February 2009, more than a year after the statutory deadline.

The QLTR experienced similar problems in preparing its accounts for 2007-08. Again, there was a lack of clear instruction within the organisation about whose responsibility it was to prepare the accounts. Not until September 2008 were QLTR staff members given a clear instruction from their accountable officer that accounts should be prepared.

The auditors received a set of draft accounts for 2007-08 in October 2008. However, other issues contributed to the delay in auditing the 2007-08 accounts. The auditors were asked to carry out forensic work on two potential fraud issues, which was not completed until February this year. They also needed to complete the 2006-07 audit to get the prior year balances to do the 2007-08 accounts. As a result, the auditors did not conclude the 2007-08 audit until 4 February this year, more than a month after the statutory deadline for laying accounts in Parliament.

My staff will continue to liaise with the auditors to monitor the QLTR's progress in preparing its 2008-09 accounts in order to meet the statutory deadlines for laying accounts as required by Parliament. I am happy to answer any questions.

Nicol Stephen: Where to begin? This sounds like a total shambles, or potentially worse. It is bad enough that one set of accounts was delivered late, but for two sets of accounts for succeeding years to be late is completely unacceptable. I notice that in the report on the 2007-08 accounts Robert Black stated that other issues contributed to a further delay, and said verbally and in the report that the auditors were required to carry out forensic work on two potential fraud issues. He clearly believes that it was important to highlight that as a factor that contributed to the delay, although it was by no means the sole reason.

It is important that we take seriously the instances of potential fraud and ask the Auditor General further questions about them. More generally, we should ask how the delay happened. Who was the chief executive who departed in 2007 and who was the accountable officer at the time? Were they the same individual? Who are the

chief executive and accountable officer now? Have any other individuals held those posts in the interim? We should consider taking the issue further with the Scottish Government, because it is unacceptable for us to be in this situation.

Finally, are any other organisations that are not audited hiding in the Government, or are we fairly certain that we reach all parts of the public sector? I do not know whether an authoritative answer can be given to that question. However, whatever the name of an organisation and however grand it sounds, it is important that it is accountable, that its audited accounts are available on time and that there is no fraud in the organisation.

Mr Black: I will attempt to address some of the concerns that have been raised—not necessarily in the order in which they were mentioned, but I hope to cover most of them. If I omit any of the points, please forgive me.

It is important first to indicate the scale of the organisation. According to the QLTR's accounts for 2007-08, the cost of running the organisation was £283,000. Those costs are charged on the QLTR's receipts and payments account, reducing the amount that is paid over from the recovery of estates and so on—it is a simple organisation.

As ever, it is important to appreciate the context. Before 2006-07, the QLTR accounts were audited by a firm of accountants in London, appointed by the Treasury, to which the QLTR was accountable before devolution. The review of 2006 recommended that the Auditor General for Scotland should appoint the appropriate auditor to audit the QLTR's accounts to the standards that are required by the 2000 act and the "Scottish Public Finance Manual". The instruction to prepare accounts in that form came from ministers only in March of the first financial year that was affected, so the organisation had to move fairly quickly at the end of the year.

The office of the QLTR is held by the Crown Agent, who is also the chief executive of the Crown Office and Procurator Fiscal Service. Since 2002, the post has been held by Norman McFadyen. Since 15 January 2008, the post of accountable officer of the QLTR has been held by Peter Collings, who is also the deputy chief executive of the Crown Office and Procurator Fiscal Service. Until 31 August 2007, the post was held by Mr Stephen Woodhouse.

The committee will appreciate that the fraud issues are still the subject of criminal investigation, so we cannot really say more about them. The amount of money involved is understood to be something under £100,000. The auditors have concluded their investigation and have assured us that the QLTR has strengthened its control systems.

Nicol Stephen: Is the matter still under investigation by the police, or has a report been made to the procurator fiscal?

Mr Black: The other point that may be worth making is that we understand that the fraud does not relate directly to employees of the organisation—it is to do with inappropriate claims against estates.

Nicol Stephen: You make a helpful point. I was going to ask about that because, although the cost of running the organisation is £283,000, presumably its turnover—the receipts and payments that it makes—is significantly greater.

Mr Black: Yes. It holds a large contingency of £2.5 million to cover its costs.

Nicol Stephen: That is a reasonable cushion.

Mr Black: Angela Cullen will provide more information.

Angela Cullen (Audit Scotland): The latest information that we have is that the police investigation is on-going.

Murdo Fraser: Despite the obvious bemusement of some of my colleagues, I remember dealing with the QLTR on a number of occasions in my previous incarnation in the legal profession. Despite its rather grand title, it is a fairly mundane organisation. Members would be surprised to learn how many people die without leaving a will and without any relatives, so that their estates fall to the Crown. The QLTR collects the cash. I suspect that its turnover—the money that it receives—is fairly high.

I agree with Nicol Stephen's comments. It shows remarkable carelessness in a public organisation that the accountable officer should leave without anyone realising that someone else must be given the job of preparing the accounts. It is staggering that that was allowed to happen. We need to ask serious questions of the organisation.

I appreciate that, for legal reasons, the Auditor General is limited in what he can say about the fraud issues. However, is there any suggestion that there was fraud by someone who was in the employ of the QLTR or was the fraud external?

Mr Black: We understand that the allegation relates to fraud perpetrated by an external person or persons. That is all we know.

Murdo Fraser: Okay.

Willie Coffey: I support the remarks that my colleagues have made. Do you have an indication of the net asset value of the operation—how much money it accrues on a yearly basis—or are we still waiting to find that out? You mentioned the cost of running the organisation and the contingency money, but how much does it ingather annually?

Angela Cullen: In the 2007-08 accounts, receipts from assets and estates were £5.477 million. The organisation received a substantial amount of money in that year, much of which was returned to the Government.

Willie Coffey: It is shocking to hear that no accounts were prepared in at least the past two years. We must investigate the matter further.

The Convener: Thank you for the reports. I ask any members of the public who are present to leave, as we are moving into private session.

11:13

Meeting continued in private until 12:11.

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