SOCIAL INCLUSION, HOUSING AND VOLUNTARY SECTOR COMMITTEE

Wednesday 10 May 2000
(*Morning*)

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SOCIAL INCLUSION, HOUSING AND VOLUNTARY SECTOR COMMITTEE
† 17th Meeting 2000, Session 1

CONVENER

*Ms Margaret Curran (Glasgow Baillieston) (Lab)

DEPUTY CONVENER

*Fiona Hyslop (Lothians) (SNP)

COMMITTEE MEMBERS

*Bill Aitken (Glasgow) (Con)
*Robert Brown (Glasgow) (LD)
*Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Alex Neil (Central Scotland) (SNP)
*Mr Lloyd Quinan (West of Scotland) (SNP)
*Mr Keith Raffan (Mid Scotland and Fife) (LD)
*Mike Watson (Glasgow Cathcart) (Lab)
*Karen Whitefield (Airdrie and Shotts) (Lab)

*attended

WITNESSES

Iona Colvin (Convention of Scottish Local Authorities)
David Liddell (Scottish Drugs Forum)
Alex Meikle (Scottish Drugs Forum)
Councillor Kingsley Thomas (Convention of Scottish Local Authorities)
Justine Walker (Convention of Scottish Local Authorities)

ACTING CLERK TEAM LEADER

Stephen Imrie

SENIOR ASSISTANT CLERK

Mary Dinsdale

ASSISTANT CLERK

Rodger Evans

LOCATION

Committee Room 4

† 16th Meeting 2000, Session 1—held in private.

Scottish Parliament

Social Inclusion, Housing and Voluntary Sector Committee

Wednesday 10 May 2000

(*Morning*)

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

The Convener (Ms Margaret Curran): We have a lot to get through, even in the private session, so we should get started. I formally open the meeting, which is now technically in public session. I move that item 2 be taken in private and that the item on next week's agenda covering questions for witnesses also be taken in private. Is that agreed?

Members *indicated agreement.*

The Convener: That is agreed. We shall now move into private session to discuss item 2.

10:03

Meeting continued in private.

10:19

Meeting resumed in public.

Drug Inquiry

The Convener: We now move back into public session. I warmly welcome everyone to the meeting. We usually have a lot of members of the public at our meetings, so I take it that they will turn up—here they come now.

I thank representatives from the Convention of Scottish Local Authorities for coming today. We have communicated with you before—you have provided private briefings for us—so you know about our interest in the subject and the nature of our inquiry into drug misuse. We are grateful for your written submission and for your other work. We have a series of questions to ask you on a number of topics related to your evidence, but I ask you first to introduce yourselves to the committee.

Councillor Kingsley Thomas (Convention of Scottish Local Authorities): I am Councillor Kingsley Thomas, COSLA's drugs spokesperson and chair of social work on City of Edinburgh Council. On my right is Justine Walker, who is COSLA's local government drugs officer. On my left is COSLA adviser Iona Colvin, the principal officer for addiction from the social work department of Glasgow City Council.

We welcome the opportunity to attend the committee in person to answer your questions on our submission. The three of us were here back in November, when we said how much we welcomed the committee's investigation, which we see as one of the key areas in pushing forward the new Scotland that we all want.

Our submission aimed to give the overall local government view. We are aware that individual councils and drug action teams gave specific evidence to the committee and may have gone into more detail about what services were being provided in various localities. We did not want to duplicate that information; we tried to give an overall local government view.

We see drugs as a social problem with legal, medical and public health consequences for communities. Over time, we would like resources to be shifted from reactive services to more prevention and targeting work in communities. As an analogy, in my other role as chair of social work in Edinburgh, we are looking to shift resources from older institutionalised care settings to more community-based settings. That is appropriate for social work services in general, as well as for drugs issues.

In our submission, we identified a number of priority areas. First, we aim to expand community-based treatment services. Secondly, we want to create more services for vulnerable young people in our communities. Thirdly, on the criminal justice side, we aim to provide more alternatives to custody for drug-using offenders. Where prison sentences are appropriate for drug-using offenders, we must examine how we can provide more prison-based treatment and how that treatment can continue once the offender has left prison and returned to the community. We see treatment services as being linked to education, training and employment opportunities. The new deal and other such initiatives may be brought into drugs services.

Evidence from around the country shows that drug misuse affects disadvantaged communities and socially excluded young people. We gave some examples of that in our submission and we know that you will have read many other examples in the submissions that you have received from individual councils and drug action teams. We will be happy to answer any questions.

The Convener: Thank you very much, councillor—that was very useful.

I would like to begin by exploring COSLA's role in the drugs debate. I know about the local government drugs forum, and that you provide an overarching local government view. How does that work? Do you try to pick up good practice and

advocate it for the whole country? Do you make recommendations to Government? How does COSLA collect people's views? How do you work?

Councillor Thomas: COSLA does not directly provide any services, but we have a key role in spreading good practice among councils. People such as Iona Colvin and other officers from councils throughout the country advise me and the local government drugs forum about what is going on. They advise me on how we can share best practice, how we can advise ministers, how to pull together the good work that is going on and how to examine some of the areas where work is not as good as it could be. We also act in an advisory capacity.

Justine Walker (Convention of Scottish Local Authorities): The all-party local government drugs forum is in its infancy—it is less than a year and a half old. It began at the time of the local government elections, so there was a time delay initially.

The forum is intended to provide an overarching view. It has advisers at officer level. My post in COSLA is new—less than two years old—and is funded by the Scottish Executive. I report directly to a Scottish Executive steering group, with which we liaise by sending it information. My post is funded from a community care budget, from the crime prevention unit and from the public health policy unit. There are a number of council contact offices in each area for social work, housing, community education and education. About half my time is spent with councils, finding out what is happening and making them aware of key Government initiatives and areas that COSLA has identified as a priority. Those are the direct links.

The Convener: As you can imagine, substantial evidence has been presented to us—we have been ploughing our way through it. It does not all follow the argument that there is a link between drug misuse and social deprivation; there is also a strong case against that.

You will know the complexities better than I do. One of the themes that is strongly emerging is the need to measure effectiveness, to consider outcomes and to assess how to achieve results effectively with value for money in the investment that everyone agrees is required. Members will want to pursue specific questions about funding.

Do you give assistance to local government—and can you assist us—on how to set targets and measure outcomes? Everyone says that we should do that, but not everyone tells us how to do it well.

Councillor Thomas: I remember saying in November that there is no one easy answer to the drugs problem; there is a series of answers because there is a series of problems. We have to consider local solutions, as well—what might be effective in a rural area may not be effective in an urban setting. We have to examine closely the services that are available and consider what performance and outcome measures we use to monitor them. We have some examples of the work that is going on throughout the country. We are considering development of the type of targets that I have mentioned.

The Convener: Can you give an example of one that you have recommended?

10:30

Justine Walker: May I come in to talk about effectiveness? One area that COSLA has been trying to develop is the sharing of good practice. That is different from the effectiveness side. The gap, as we see it, relates to longer-term outcomes. For example, we know that treatment services are best provided if there are good community links and good links with training and employment. That means moving people on from a health model to a social model.

Our difficulty is with longer-term outcomes. When we responded to the Government's white paper, we were aware of the need for longer-term tracking of people who have had treatment; we need to establish whether they come back and what happens to them. We have discussed that with the information statistics division, and I know that the Scottish Advisory Committee on Drug Misuse is considering how to progress the issue.

We are working towards effectiveness outcomes in school-based drug education. For example, I have been a member of the school and drugs safety team as a COSLA representative. The team examines good practice in order to establish what information is effective. In the longer term, we need to identify what changes people's behaviour; there is less information on that. Therefore, there are two strands to our approach: identifying what informs people and what changes behaviour.

The Convener: I understand that. Do you have a model of good practice, or of poor practice, which Councillor Thomas referred to?

Iona Colvin (Convention of Scottish Local Authorities): One of the problems of treatment and care for service providers and purchasers such as local authorities is that there is always competition between funding direct treatment and care and funding research to evaluate treatment and care.

We welcome the establishment of the national effectiveness unit, which, we presume, will pick up on prevention and education as well as on treatment and care. At the local level, we will consider the effectiveness and evaluation of

services. I agree with Councillor Thomas that that work must be done at a local level. The problems in Glasgow are different from those in Ayrshire and Arran or from those in more rural communities.

I welcome an approach that marries the national and local agendas and that considers evaluation across groups of services, such as residential, through-care and after-care services and their links to employment services, which are key. For example, evaluation would be helpful of the range of services that have been working or that have just been funded in Glasgow. However, as most of our money comes through social work, which is about providing services, it is difficult for us to spend money on research.

The Convener: I quite understand that argument about evaluation.

You said that social work is a key service. I have been dealing with a number of local social work issues, but do not panic—I will not take you through my constituency cases. Recently, addiction issues have been brought home to me starkly. I am interested in how much work is done on those issues, with particular reference to chronic drug misuse. How much is that work at the core of the range of skills used by social workers daily, or does it require specialist skills? I am talking about Glasgow as well, but I know that we cannot just talk about Glasgow. What is the Scottish picture?

Iona Colvin: I guess that work on addiction issues, as a core element of a social worker's day, has grown dramatically over the past five or six years, whether in the areas of children and families or criminal justice social work. Day in, day out, most generic social workers deal with families with drug and alcohol problems—some families have both problems.

The situation is slightly different in Glasgow, because the local authority is the main service provider. We have a specialist service, to which social workers often refer their clients. Social work provides a greater level of service, because social workers have direct access to that specialist service, which is not the case with all local authorities, many of which have contracted out such services to the voluntary sector.

Was your question about the links? The key issue for work with children and families and in criminal justice social work, when dealing with drug misuse, is how that work is best tackled. Different local authorities have made different arrangements for dealing with that point.

The Convener: Does COSLA think that there should be a core service, which should be integrated into social work practice?

Justine Walker: I will speak about some of the work that we have been doing on children of drug-using parents and the inter-agency guidance on which we are working with the Scottish Executive. That is related to the role of the specialist drugs worker, who is perhaps better able to respond to issues that arise. There are difficulties for more generic workers in knowing the assessment. We recommend that training on drug issues should be done across the board in social work training. We discussed with the Executive the future of its allocation of moneys for the training of social workers, health workers, teachers and so on. We think that training should be broadened out. Generic social workers have to deal with drug issues in a variety of ways that may be difficult for them. We think that they should be given the appropriate support.

The Convener: I may follow up on that issue, which is interesting.

My final question is on your very strong case about links with social deprivation. There is a lot of sympathy in the committee with that argument. Should local authorities receive extra funding because of the scale of deprivation? That is a stupid question—I dare you to say no.

Councillor Thomas: Given all the work that local authorities are doing on the social inclusion agenda—through social inclusion partnerships or general department services—we are best placed to identify and react to the problems. Whether we provide services or contract them out to voluntary agencies, local authorities are the best network to identify problems and to do something about them. Obviously, I will say that we need more money to do that.

Justine Walker: COSLA and the Executive have discussed the key indicators for any change in the general allocation to local government. Obviously, deprivation has been discussed as one indicator, and drugs misuse has been part of that discussion. We have been supportive of the inclusion of drugs misuse in that discussion.

The Convener: Do you support that? It is not just about discussion.

Justine Walker: At this early stage, we support the idea that discussion should take place and that we should examine these issues. The difficulty is how to devise a sensible formula, especially in view of the underestimation of the number of drug users.

The Convener: I could pursue that, but I will not take up all the time—Keith Raffan may return to that point.

Alex Neil (Central Scotland) (SNP): Following on from that is the question of the funding regime at local and national level. I was surprised by the

lack of a coherent strategy across the country on the link between drugs and social deprivation. For example, is the allocation of funding to national organisations trickling down to front-end delivery organisations, or are a lot of resources being held at the centre, among the policy makers? Is there an uneven distribution to the organisations that deliver on the ground?

Another issue is the reliance, to some extent, on challenge funding, particularly through the lottery. It seems to me that funding should be about needs funding rather than challenge funding. What should be done to improve the funding regime and to ensure that funds are allocated to those areas that really need them?

Councillor Thomas: One of the problems that we face—I know that drug action teams are examining this—is identifying the money that is being spent on drugs services. We can identify grants that social work departments give to voluntary agencies in the field, but it is difficult to get a global figure.

On challenge funding, although the extra funding for specific projects over the past few years has been welcome, now, two or three years down the line, a number of organisations that received lottery funding and are applying to have it renewed are experiencing difficulties because their projects are not new. Those organisations often have to look to local authorities for funding, which in many cases we have not been able to provide. There is a problem. The extra funding was welcome at the time, but we are now dealing with the consequences as we try to keep good services going. Crew 2000 in Edinburgh is a good example.

Justine Walker: COSLA has had a number of discussions about challenge funding in general. Challenge funding is not just about drugs; it comes down through a lot of avenues. A substantial amount of officer time is taken up in supporting bids, and only 10 out of 32 councils are going to be successful with their bids. Marrying national challenge funding to local priorities and needs is complex and difficult. We are especially concerned about that.

Alex Neil: How much of the money that is being spent on drugs ends up delivering services at the front end, and how much ends up being paid to middle-class people in suits to sit and talk about it?

The Convener: Like the witnesses?

Justine Walker: Yes, like us?

Mr Keith Raffan (Mid Scotland and Fife) (LD): Or like Alex?

Alex Neil: I am working-class.

What changes would COSLA like to see in the funding regime—not just the lottery regime, but the overall funding regime? Do not avoid the first question.

Councillor Thomas: Do you know how much councillors get?

There will always have to be some kind of bureaucracy for dealing with funding issues. It is difficult for me to comment on whether that bureaucracy is top-heavy or at the right level. Since the reorganisation of the local authorities, there has been a big clear out of management staff at all levels. All departments in all areas have slimmed down, perhaps by too much. I am reasonably satisfied that we are as efficient as we can be and that we are not holding any processes up. A lot of time and effort is taken in getting the different organisations together—health bodies, local authorities, voluntary organisations, and so on—so that they can move in the right direction. That is a challenge that we have to address.

Alex Neil: Do you think that there needs to be a switch of resources from enforcement to treatment and prevention?

Councillor Thomas: Both are important. All studies have shown that treatment offers value for money. The often quoted example is that £1 spent on treatment saves £3 elsewhere in the criminal justice system. We all accept that. Enforcement is important, but we need to consider boosting the amount that we spend on treatment as well.

Alex Neil: I have been impressed—or not impressed—by the multitude of organisations involved. Even within the Scottish Executive there are working parties, steering committees, advisory groups, you name it. At national and local level, we have a morass of organisations, which is one reason why resources are not being used effectively and why there does not appear to be one national strategy that is being followed by all the relevant agencies.

Iona Colvin: I agree that it looks extremely complicated. In Glasgow, we have the greater Glasgow drug action team that involves six local authorities. The system that we have set up looks fairly complicated from the outside, but it is a difficult thing to do. We have brought together a huge range of agencies on a wide-ranging subject. We are trying to address the whole drug issue, from prevention and education, through to treatment and care, through to enforcement. Necessarily, we have ended up with a lot of agencies around the table. Different drug action teams have different experiences. In most areas, there is a high degree of commitment from the local authorities to bring everything together. However, that entails a fair investment of time from the agencies and officers involved.

All the money that came through the year before

last in Glasgow for treatment and care was spent on treatment and care. In fact, the amount was doubled by a match funding arrangement between the partner agencies and the drug action team. If the drug action team had not been functioning in that way and had not been there to pull the agencies together, I do not think that would have happened. There is a sense in which it is obviously worth investing that money in pulling the agencies together. Apart from anything else, no one agency can deal with this issue; it will also increase the funding opportunities and the amount of money that is going into treatment and care. The other issue is putting money into prevention and education.

10:45

Mr Raffan: Following on from your last answer, the truth is that of the 22 drug action teams, substance abuse action teams and so on, the Glasgow team works best. Is it not regarded as the most effective?

Iona Colvin: I will take your word for it.

Mr Raffan: I am not just trying to flatter Glasgow. I am pointing out that the performance of the others is uneven. Councillor Thomas might find it easier to answer that point.

Councillor Thomas: There are all sorts of reasons why a drug action team works effectively. There have been problems in the west because of the boundaries of health and local government reorganisation, which means that Glasgow has taken some time to operate at the level that it is at now. Edinburgh has perhaps not had the same problems, being able to work as effectively with Lothian Health as we did prior to local government reorganisation. It is patchy—it is down to the commitment that local authorities and the local health services give to the DATs and whether the right people are on the team in the first place. There needs to be someone senior enough to give it the clout that it should have and people who have the commitment to ensure that things are moving forward.

Mr Raffan: The overriding theme that has made an impression on Alex Neil is the multitude of organisations. What keeps on coming back to me is what you said, perhaps in a rather diplomatic phrase, in your written submission:

"the inequality of service provision . . . throughout Scotland."

That is one of the main issues. How unequal is the service provision from health board area to health board area and from DAT to DAT?

Justine Walker: I will go back to the original question as well. There is great diversity in the drug action teams. It is fair to say that they are all moving forward and there has been quite a change in a number of them in the past year, even since the COSLA drugs forum started up.

Mr Raffan: Do you think that DATs are an advantage? Some drug workers think that they are a block to money reaching the front line.

Justine Walker: Having previously been a chair of a drugs forum and having expressed that opinion, I can appreciate that view. However, having seen matters from a different perspective now, I think that some co-ordination function is necessary, whether it is a drug action team or a similar organisation. DATs are what we have and, from the local authority side, we are keen to make them work. It is completely accurate to say that there is an inequality of service provision.

Mr Raffan: How unequal?

Justine Walker: The difficulty when we talk about—

Mr Raffan: I am trying to get an idea of the extent of the divergence.

Justine Walker: It is difficult to answer that, because we would only look at it from the local authority side of the matter. Obviously, we would need to take on board health provision and so on. Our experience is that, in some areas, it is difficult for people to access services. The types of services that are available to them vary greatly from area to area. That is probably the most accurate answer without taking a more in-depth look at that in relation to where our finance goes.

Mr Raffan: It is difficult to get equal service provision, or even to give an answer to that question, simply because of what is mentioned in paragraph 15 of COSLA's written submission, which is the database and the information that you are relying on. We are talking about allocation of funding. I was going to say how the hell, but how on earth do we know where to allocate the funding, when we do not know exactly—or more precisely than we do now—the extent of the problem and where it is?

Justine Walker: One of the first things that COSLA undertook to do was to examine how accurate the standardised mortality ratios for 22 and 23-year-olds are. In all areas, they say that there is a high under-representation of people. Bear in mind that that system is about people presenting for treatment, so if we are aware of people who are in need of treatment but might be in a generic council service, they would not necessarily be recorded.

We have a joint working group with the ISD that is considering how we could improve the system. Some proposals for that have been sent to the Scottish Executive. We were concerned about several areas. First, the database is focused only

on drug use and at a local level we need information on drugs and alcohol, which cannot be easily separated. Secondly, it relates to people accessing fairly traditional, opiate-based treatment services. Problem users with stimulant drugs and recreational drug users would not necessarily be accessing those services. We are very aware that that has been underestimated.

Mr Raffan: Margaret Curran and I visited the Glasgow Drug Crisis Centre on Monday and we discussed the estimated number of addicts in the Glasgow area, which seemed to vary between 8,000 and 12,000. Can I ask Iona Colvin what her estimate is? Is it 10,000?

Iona Colvin: No. We carried out some work, in conjunction with colleagues in Greater Glasgow Health Board, on people currently in receipt of services in Glasgow, across the range of agencies, from GPs to our specialist services and the drug crisis centre. Our estimate, based on that work, was that there are 12,500 to 15,500 problematic drug users within the Glasgow city boundary.

I would like to say a few words about the funding of services. Some of the services require major capital investment, particularly residential services and drug crisis centres. The Glasgow Drug Crisis Centre costs the council and the health board £1.1 million per year. Between us, we also spend about £3 million on other residential services. The scale of that investment is beyond the capability of small local authorities. That is one of the reasons why those services are concentrated in the central belt, across Edinburgh and Glasgow. However, Aberdeen is considering investing in some additional services.

Mr Raffan: Tomorrow, the Deputy Minister for Justice will make a statement on the Scottish Executive's drug strategy. Councillor Thomas, have you been consulted on that?

Councillor Thomas: No, not personally.

Mr Raffan: Has COSLA been consulted?

Justine Walker: COSLA has not been consulted on that particular statement, although we have had discussions with the Executive, which will, I hope, inform that statement.

The Convener: You are a born politician, Justine.

Mr John McAllion (Dundee East) (Lab): Alex Neil asked you about COSLA's views on changes to local authority funding, which would enable councils to target deprivation and the damage and drug misuse that is associated with it. You said that greater weighting had to be given to the deprivation factor in the distribution of local government revenue.

Three of the councils that have the highest concentrations of deprivation are Glasgow City Council, Dundee City Council and West Dunbartonshire Council. They also have some of the most severe funding problems of Scotland's councils—council tax is very high and increasing and there have been cuts in the level of spending. In order to change that situation, COSLA would have to redistribute money from the other 29 councils. What chance is there that the majority of councils would vote to give up money to redirect it towards Glasgow City Council, Dundee City Council and West Dunbartonshire Council?

Councillor Thomas: That argument is about the way in which the cake is divided up, rather than the size of the cake in the first place.

Mr McAllion: COSLA has to agree to it. Will you get the other authorities—Highland Council, for example—to agree to take less money in order that Glasgow City Council, Dundee City Council and West Dunbartonshire Council can have more?

Justine Walker: That relates to the weighting factor and the priorities that are set in the general allocation. A joint Scottish Executive-COSLA group is currently considering that.

Mr McAllion: Would it not have to be agreed by the councils, through COSLA?

Justine Walker: I am not able to respond to that in detail because it is largely a financial issue.

Mr McAllion: There cannot be an official COSLA policy on that until COSLA votes on it. The majority of councils would have to vote to give up money in order to give it to less fortunate councils. Is that the problem?

Councillor Thomas: Yes. Councillors are there to represent their own areas.

Mr McAllion: Should there be some national override of that situation in the interests of the areas of highest deprivation? Perhaps the Scottish Executive should force money to be redirected from the better-off areas to the deprived areas.

Councillor Thomas: That is assuming that only local authority spending can be targeted on these areas. There are other areas of spending, such as the health service.

The Convener: So it is not about increasing the deprivation factor; it is about increasing the national level of spending and targeting it on those areas.

Councillor Thomas: Yes, it is a bit of both. It is targeting for the areas that need it, but considering the overall spend of all the agencies, not just local authorities, to determine how the resources can be better targeted.

Mr Lloyd Quinan (West of Scotland) (SNP):

Your report makes it fairly clear that you believe that drug misuse has been worsening in all council areas. Do you have a view on why that is?

Justine Walker: Part of it is about councils becoming much more aware of their requirement to respond to this. For example, providing improved access to children's and family services, through criminal justice, has become more of a priority over the past few years. Corporately, drug misuse has become more of a priority for councils, and it is from that side that we are responding much more proactively.

The response that we received from councils in collating our written evidence to you showed that the feeling on the ground is that drug misuse is an increasing problem. Although councils are becoming more proactive, the problem itself is increasing and ever-changing. By its nature, drug misuse is changing in relation to where the problems lie, the types of drugs that are misused and the services that people are accessing.

Mr Quinan: So, you are saying that, because there has been an examination and people have addressed the problem, you have discovered that there is a problem and that that problem is getting worse.

Justine Walker: Yes, twofold. That is part of it, but the problem is getting worse, parallel to that.

Mr Quinan: What is your view on the fact that, whether we like it or not, the drug business and its related structure have become an option in terms of income generation in our deprived communities?

Councillor Thomas: You mean, for the users?

Mr Quinan: No. It is an option in terms of income generation in deprived communities. It is irrelevant whether that is for the user or the non-user.

Councillor Thomas: Sorry, I do not understand.

Mr Quinan: Do you have a view on the fact that, whether we like it or not, the drug business and its related structures—fraud and crimes of other natures—have become an option in terms of income generation in our deprived communities.

Councillor Thomas: It certainly seems that way. Where there is no hope of getting a job, or no hope of getting a decent house, many people are turning to drugs. That is why the investigation here cannot address the drugs problem alone; that problem must be considered in the context of other social problems and what the Government is doing in the UK and in Scotland to get people out of excluded areas through employment and training initiatives. Those people should be offered an alternative career.

Iona Colvin: The local availability of drugs is a key issue, and the reason for the spread of drug misuse. It is linked to deprivation and the lack of opportunities for people. The European Monitoring Centre for Drugs and Drug Addiction has conducted some research into the spread of drug misuse, which shows that, in the past 10 years, Glasgow has changed from being a city with two main marketplaces for drugs to being a city in which drugs can be bought almost anywhere in the north and in two or three places in the south. The children and young people who live in those areas are much more likely to be offered drugs than children and young people who live in other areas, and they will consistently be offered drugs.

It is difficult for families that are bringing up children in those areas to help them to avoid using drugs in the first place. Some people are making large amounts of money from selling drugs in Glasgow, and they are not generally the people on the street. Some areas are targeted, where it is known that there is a market for drugs. There has been a significant expansion in the marketplace for drugs. They are more readily available in communities than they were 10 years ago.

11:00

Mr Quinan: I fully accept that. However, I am not talking about people's ability to get drugs for their own use, but to take part in what is effectively a business, which has been described as having a larger turnover in Glasgow than FirstBus. They are people who, one way or another, are part of the ancillary business. We have to accept that, black economy though it is, it is a huge business, generating enormous amounts of money, and that most of the profits go to single individuals. However, that money is spread about; it does not all go under floorboards in Newton Mearns, Bearsden and Milngavie. It is a means of generating income.

Iona Colvin: Yes, but in my experience of working in treatment services, that does not generally apply to the people who use those services.

Mr Quinan: I accept that, but has COSLA examined the contribution that drugs make to communities? It is generally accepted across the world—not just in the UK—that if we attempt to eradicate a drugs problem, we have to replace the money that is being removed from the economy. It is not about enforcement or treatment, but the fact that if we knock a £1 million black economy out of Glasgow's economy, we have to find £1 million to put back. It does not go back in treatment services or in enforcement; it is about replacing that economic power.

Justine Walker: We have not considered that in detail. The areas that we are aware of relate to

economic regeneration and so on, in the sense that if we take that black economy out of local communities, we need to build those areas up. However, you are talking about something much larger scale: the industries or individuals that are behind that economy.

Mr Quinan: That is not what I am talking about.

Justine Walker: You are not—sorry. We have considered in detail how we support communities in building up economic regeneration. In relation to social inclusion, we would say that that was key to the delivery of any drugs-related measures in communities. Unless economic regeneration runs parallel to that, the effects will be minimal, because people are not being given other options.

Mr Quinan: What is COSLA's view on whether we can eradicate chaotic drug misuse in Scotland?

Councillor Thomas: Do you mean, do we have an aim?

Mr Quinan: Do you believe that we can eradicate it?

Councillor Thomas: It would be difficult, but that does not mean that we should not try to do it.

Mr Quinan: Do you believe that we can? Do you believe that that should even be an aim? I do not find an answer to that in your evidence.

Justine Walker: COSLA has discussed that in relation to the drugs forum and has concluded that, with all the resources in the world, there will always be drug use in society. We are realistic about that. We would aim to reduce chaotic and problematic drug use to as little as possible.

Mr Quinan: Do you have a target?

Justine Walker: We have not set targets for that. The UK strategy sets targets for reducing drug misuse by 50 per cent and 25 per cent and so on. We feel that that would be inappropriate for us, because we are not fully aware of the level of chaotic drug use in the first place. Setting a target would be fairly meaningless.

Mr Quinan: Kingsley, you referred to problems with the extension of lottery funding, specifically in respect of Crew 2000. What funding has the City of Edinburgh Council provided to Crew 2000 over the past few years?

Councillor Thomas: Until this year, City of Edinburgh Council did not give Crew 2000 any money. However, we have just approved a grant of £30,000 through the Edinburgh drug action team.

Mr Quinan: Was that approved by the drug action team or was it a decision of the local authority?

Councillor Thomas: All decisions by the drug action team are fed back for approval, through the council's policy and resources committee. The money was identified through the drug action team, but it comes from council sources. It will allow Crew 2000 a few months during which we can identify other funding sources.

Fiona Hyslop (Lothians) (SNP): I want to return briefly to the issue of reporting. As part of our inquiry, we have been visiting different areas. I was in Edinburgh yesterday, where I talked to women who work with women drug users. They voiced concerns about reporting. Women take longer to present themselves to social workers, and when they do, it may not be to talk about an issue that is directly related to drugs. Do you think that there may be under-reporting of drug use by women and that the traditional notion of a two thirds-one third split between male and female drug users may not reflect what is happening on the ground?

Councillor Thomas: It would be fair to say that.

Fiona Hyslop: If the allocation of resources is based on such assumptions, are there ways of ensuring that you reach women? The allocation of resources should reflect need, rather than the fact that men tend to present themselves to social workers more than women do.

Iona Colvin: In Glasgow we have just reviewed the addiction services that we provide, and we are finding a two thirds-one third split between men and women. The number of women is slightly higher in some areas, where there are specific initiatives to encourage women to make use of services. I know that Glasgow City Council is not the only council to put money into developing services specifically for women drug users.

The other major agency that is providing services is Aberlour Child Care Trust, which provides residential and day care services for women with children. There are also issues to do with women who do not have children. Women do not present themselves to social workers as early as men do for various reasons, although in Scotland presentations generally take place quite late. In Glasgow, people are coming in after they have been using drugs for six or seven years, which is later than in other European countries.

Most local authorities recognise the need to work with women. Women are afraid that if they present themselves to addiction services they will lose the care and control of their children. There are specific child care issues that need to be dealt with.

Fiona Hyslop: I want to move on to the Scottish Executive's current policies for addressing social exclusion. At the time of the drugs debate in the Parliament, it was announced that money would

be available but that it would be distributed through SIPs. How appropriate and helpful do you think that is? How does it tie in with the work of DATs, which are meant to be accountable for the drugs policy in their area? Is that co-ordination or a bit of a bureaucratic tangle?

Councillor Thomas: One area where the performance of the DATs can be patchy is in how they represent community and local interests. A DAT might be effective in drawing together the professionals to discuss the needs of an area, but not in pulling in users or providers of services at a local level. In an ideal world, all the money would be channelled through the DATs, but given that at the moment DATs are perhaps not reflecting local needs as well as they should, the SIPs, which do have a strong local and community voice, are an appropriate vehicle for distributing the money.

Fiona Hyslop: Who decides where the money goes? In Edinburgh, for example, difficulties have been identified in Wester Hailes, which is not a SIP area. There are also difficulties with young people in an area where there is a SIP. Those two areas have not had funding, whereas other SIPs have. As an Edinburgh councillor, you will be aware that there seems to be an imbalance between where the need is and where the money has been distributed. If the distribution is made by challenge funding at national level, how do those responsible for allocating the money know which of the SIPs should get the money?

Iona Colvin: I have seen the allocations for the west of Scotland and I do not know how the distribution was decided. I am not sure whether COSLA knows. Specific amounts of SIP money were allocated to each area. I presume that those amounts were decided by the Scottish Executive.

Fiona Hyslop: Are you saying that, from COSLA's perspective, the distribution does not necessarily make sense when compared with the situation on the ground?

Councillor Thomas: As a councillor for an area that is not a SIP area, I know that it can sometimes present problems. It is a way of targeting resources to where they are most needed, but that does not mean that non-SIP areas do not also need funding.

Mike Watson (Glasgow Cathcart) (Lab): I want to ask about how children fit into the equation. Paragraphs 8 and 9 of your submission mention the effect on children of experimenting with drugs and the position of even younger children whose parents are drug misusers. What is your view of the resources that are available to local authorities to provide appropriate social care support?

One of the roles of the new community schools has been to include full health education, which would include drug education and drug awareness. Do you think that education services are providing a useful role from primary school upwards in their approach to drugs? Do you think that the new community schools can make a real impact, improving on what the more run-of-the-mill schools have to offer?

Justine Walker: The school and drugs safety team has debated the role of school-based drugs education. Although we felt that that broad-brush approach was valuable to pupils, it does not target drugs education at those who are most at risk. Although it is correct that the Scottish drugs strategy is broad, we feel that some key areas should be targeted and that the resources should follow those targets. Children and vulnerable young people are among the groups that we think should be targeted.

One of the questions about school-based drugs education is how adequately it addresses the situation of children who are already using drugs or who have other problems that might influence their drug use, such as being excluded from school or having a drug-using parent. A number of councils have now started to address such problems through their children's service plans and are considering children of drug-using parents as an at-risk group. We have not yet gone as far as we need to in that area, but there has been movement.

COSLA's view is that, although school-based drugs education is important, teacher training is needed. Research shows that the majority of teachers have not undertaken training in the past two years. One of the key factors that teachers cited as essential for delivering good school-based drugs education is up-to-date training and information. We must consider how far we expect schools to provide parallel education to communities. Although the proposal is at an early stage, the school and drugs safety team has agreed that community-based provision of drugs education is as important, if not more so, to complement the basic level of drugs information that pupils receive.

Mike Watson: I welcome the emphasis on community in your report and in Kingsley Thomas's opening remarks. I thought that the role of new community schools should be to target areas in which there is most deprivation and greatest need. Are they not already addressing the targeting problem?

Justine Walker: One of the criteria for becoming a new community school is that a school must be a health-promoting school. The five pilots that have been set up are being evaluated. I understand that the Executive has set a target of having 60 new community schools in place by 2001. For us to answer that question now would be to pre-empt the evaluation.

Mike Watson: I accept that. However, did COSLA support the pilot project as worth while?

Justine Walker: Yes.

Mike Watson: I want to ask about social care support. You mentioned the question of at-risk children. I know that a high proportion of children who are taken into care have drug-using parents. Do you think that in general—this question may invite an obvious, "No," answer—local authorities have adequate social work care support to deal specifically with the children of parents who are drug misusers? Perhaps Iona Colvin could answer from a Glasgow perspective

11:15

Iona Colvin: The number of children who are being accommodated has increased by 25 per cent in Glasgow, and we have certainly not had an increase in the social work budget to allow for that. We are examining ways of supporting families through the children's service development fund. I know that other councils, too, have been doing that.

There are two issues. First, we need to protect children who need protecting; we need to be able to assess situations so that we can take adequate measures to protect them. However, we also want to encourage drug-using parents to come into the service because the earlier they do that, the earlier they can be treated and offered support and the less impact there will be on their children. That is a key issue; we must encourage drug-using parents to come into the service voluntarily. In Glasgow, 53 per cent of those who seek services from social work specialist services do so voluntarily—they are self-referrals. We need to be able to work with families to support them if they are able to continue to care for their children, although, obviously, there are times when families are not able to do that. A huge amount of support for the children of drug-using parents is given by members of extended families and, in particular, by grandparents.

Councillor Thomas: I do not suggest that this is what Mike Watson argues, but a possible extension of the point that he made is that local authorities should be taking more children into care. I do not think that anyone in this room would agree with that.

In Edinburgh, we are trying to carry out more effective early intervention work with families such as those that Iona Colvin described, to prevent children from having to go into care. If the problems that are being presented to us are increasing through drug misuse, we need to be able to adapt to deal with those problems.

Mike Watson: I was not suggesting that more children should be taken into care; I was asking about the resources to prevent them from having to be taken into care.

Iona Colvin talked about European comparisons. To what extent does COSLA, or major authorities such as Glasgow, Edinburgh or Dundee, examine models in other countries, particularly in relation to child care and child drug use? Do you have links with major cities in England or with Dublin? The committee will visit Dublin to make comparisons. Do such links enable you to draw on experience and adapt it in Scotland?

Justine Walker: COSLA has a European office, and we access research from the European Commission. In general we do not visit other countries or consider in detail models from other countries. That is because I am the only drugs officer in COSLA, and half my time is spent in councils. We try to examine what is happening in other European countries. However, it is difficult to do that in a detailed way or to implement what is learned in Scotland. We try to examine models in other countries, but cannot do so to the extent that we would like.

Iona Colvin: Some of the bigger authorities have been involved through joint European social fund projects. Glasgow took part in one such project on employment several years ago. Also, Glasgow participated in the World Health Organisation's multi-city action plan on drugs, which involved several European cities. There is much that we can learn from other countries. I know that there is a lot of contact between Dundee and the European Monitoring Centre for Drugs and Drug Addiction.

Mr Raffan: My point follows on from the point that Mike Watson raised. The Scottish Drugs Forum's written evidence states that, in Glasgow, resources are being made available from the children's service development fund for work specifically with young people who are being looked after. That is commended as good practice to be shared.

My second point concerns school exclusion. The Executive is running pilot projects, one of which is in a secondary school in Alloa and has been very successful in reducing school exclusion. What worries me is that, although all these different pilot projects are going on—some of which are successful—we need to extend them nationwide and share best practice.

Councillor Thomas: When I took up my post as chair of social work, this time last year, I probably said exactly the same thing about the pilot programmes that were running in our department. Some of them were successful, and I was keen to extend them to the whole city. We need to start drawing together some of those projects and if

they are working well, we must extend them. COSLA will be keen to be involved in that process.

Mr Raffan: What about the crisis in resources?

Justine Walker: In Glasgow, we have devoted specific resources to working with looked-after and accommodated children, recognising that they are often missed out of other, school-based initiatives because they are not in school. There has been an increase in the number of young people under 16 who are physically dependent on drugs. This is of particular concern regarding the increase in heroin use.

Karen Whitefield (Airdrie and Shotts) (Lab): I would like to ask a couple of questions about the criminal justice system. In the evidence that you gave to the committee, you indicated that you would like the Scottish Prison Service and community agencies to work much more closely. How can that be achieved?

Some of the evidence that I have received from constituents has raised concern. Somebody who has been arrested might seek help with their addiction problems, particularly in Lanarkshire, where we are promoting the methadone project, but if they then go to prison, they might not be supervised or given any help, even though the withdrawal symptoms are worse for coming off methadone than for coming off heroin. When that person is in prison, they might be lucky enough to get help to deal with their drug problem, but what happens when they come out?

What are your views on those three issues?

Justine Walker: COSLA is keen for a broad range of alternatives to custody to be available to each of the sheriff courts. Those alternatives would have strong links with treatment and employment, so that people are not just treated, but moved on to ensure that they do not reoffend.

COSLA is in discussion with the Scottish Prison Service over the contracting out of services. The Justice and Home Affairs Committee might pick up that issue, so I shall not go into it in detail. We have said that we would like national protocols to be set on through-care back into the community and the delivery of treatment services in prisons. That is one of the reasons why we need a targeting of resources. In England, significant resources have gone into arrest referral, treatment services in prisons and through-care. That has been backed up by people being employed in those areas. That is not what has happened in Scotland, and we would like the Executive to pick up on that.

Iona Colvin might want to talk about the practicalities at a local level.

Iona Colvin: The practicalities are difficult, particularly for prisons such as Barlinnie, where there is an extremely high turnover—around 80 a day. Only half those people come from the city of Glasgow; the other half come from around the country. We have had long discussions with Barlinnie, through the drug action team.

The drug action team in Glasgow is currently undertaking a mapping exercise with all the prisons in the central belt, to find out where the gaps are in the treatment and care of prisoners while they are in prison, and in through-care, and how we can better link services between prisons and communities. There are major resourcing and co-ordination difficulties.

Councillor Thomas: Often, effective work with a prisoner takes a bit of time. The main problem is that people are going to prison for a month or six weeks, which is not long enough to work effectively with them. That is where the link between services in prisons and services in the community is vital. We need to address that failing.

Karen Whitefield: I have one final question, on community disposals, which are useful in cases in which someone will not be in prison for very long and there are perhaps other ways of dealing with the problem. How can we work to ensure that the judiciary and sheriffs support community disposals and that communities understand them? People who live in communities in which there is problematic drug use and a high level of crime and violence would ask why those people are back on the streets destroying our communities and wrecking our children's lives. How do you balance those considerations?

Councillor Thomas: An alternative to a custodial sentence is not a soft option. To some people, it can be much harder than serving a sentence. It is not a problem for a hardened criminal to serve a month or so inside. There should be a closer link between the court system and drug treatment. Where a link has been maintained, particularly in north America, where judges have a personal interest in how an accused person responds to treatment, it has been shown that that can be effective.

I suppose that work must be done to sell that idea to communities. Ultimately, if we can show that people can reduce their drug use or, we hope, come off drugs, it will be understood that communities can be made safer.

Bill Aitken (Glasgow) (Con): Surely your paper shows that there is nothing in the Scottish criminal justice system that would prevent sheriffs from taking similar action, as they have exactly the same powers as those that you propose. I read your paper with interest, but I think that it is redundant, because powers exist and can be used.

Justine Walker: I assume that you are referring to the annexe paper on alternatives for dealing with drug offenders. That paper was a starter paper, which began by examining the feasibility of drugs courts in Scotland. The current legal system would support them, but the level of use of powers by sheriffs varies. In some areas, sheriffs are proactive and seek a range of options, but that is not the case in other areas. There were sheriffs, solicitors and criminal lawyers on the working group. It was felt that the options were either not available or not being utilised as well as they could be.

Bill Aitken: That is the fault of the individual sheriff.

The Convener: We will pursue some questions, because there are so many things that we have not been able to explore today.

I will ask one final question now. Are you not trying to have it both ways? Your substantial submission states that the problem is all about poverty and social deprivation, and that we need to target resources there. Therefore, that argument should follow for SIPs and local authority allocations. Can we sustain the two-edged sword that you seem to present?

Councillor Thomas: At the risk of oversimplifying the case, I will return to what I said at the start. There is no single drugs problem in Scotland; there is a host of problems, which need different answers. Our submission has shown that the majority of cases of problematic, chaotic, dependent drug use are in socially deprived areas. However, as we all know, that is not the full extent of the drugs problems, which affect a range of communities. We have to keep an eye on both sides of the coin.

The Convener: The debate will go on and on. We thank you for the work that you have done, and we will no doubt be in touch with you—I am sorry to rush you.

I let that part of the meeting overrun because I think that we will have some flexibility on item 4 of the agenda—I do not want to make too many assumptions about that.

I thank the members of the Scottish Drugs Forum, who have given us much information and advice, for once again coming to the committee to give evidence. Thank you for the substantial documentation that you produced. Please introduce yourselves and make a brief opening statement.

11:30

David Liddell (Scottish Drugs Forum): I am the director of the Scottish Drugs Forum and on my left is Alex Meikle, who is our west of Scotland regional manager.

It is appropriate that the Social Inclusion, Housing and the Voluntary Sector Committee is the first Parliament committee to examine the drugs issue closely, because, like COSLA, we believe that drugs is a social problem. There are other consequences, but it is important to view drugs in a social framework.

We need a clearer, shared understanding of the nature of the problem. It is clear that there are about 30,000 problem drug takers in Scotland. The problem is getting worse. In 1994, the ministerial drug task force estimated that there were 20,000 problem drug takers. The problem has widened, but is still strongly linked to poverty and deprivation, even in rural communities. We need to focus on the problem drug takers, because they cause the greatest harm both to themselves and to wider society. The profile of those individuals shows which young people are at greatest risk—primarily young people from our most deprived communities. Even in that context, there are particular high-risk groups, such as looked-after children.

We have a clear understanding of what works, and there is evidence from the national treatment outcome research—a £1.4 million study conducted in England—that treatment and care works. We have further evidence from America on the potential savings that treatment and care services can make. We need to shift resources to target areas where we know we can make a difference. The three key strands where we need to beef up the response are, first, the development of treatment and care services; secondly, the targeting of vulnerable young people; and thirdly, the regeneration of our poorest communities. In recognising the scale of the drug problem, we need to protect those communities more effectively from the harm that drug misuse can cause.

As our submission states, we estimate that £15 million is spent on specialist drugs services in Scotland. About 100 specialist agencies are included in "Where to get help: a directory of specialist helping agencies". If members are not familiar with that directory, I can leave a copy with the committee. We need an extra £30 million to deliver an effective response through specialist treatment and care services. Treatment and care services work best when a full range of services is in place, including needle exchanges, outreach services, drug crisis centres, prescribing services, counselling services, residential rehabilitation, after-care services—including education and training—sheltered employment projects, alternatives to custody programmes and through-care. If only one or two elements are in place, the services cannot provide value for money; we need

a full range of services to make an impact over time.

In England, specific targets are set for increasing client contact—the contact between agencies and people with drug problems. The targets are to increase client contact with agencies by 66 per cent by 2005, and by 100 per cent by 2008. Although it is difficult to measure whether such targets are being achieved, we would welcome the setting of similar targets here. Setting targets shows that there is a clear agenda of trying to increase the amount of agency contact.

Iona Colvin talked about the delay between the onset of a drug problem and people presenting at services. The huge issue of the accessibility of services must be addressed.

Only limited work has been undertaken that has been specific to vulnerable young people. We have evidence that detached youth work is probably the best vehicle for making sustained contact with the most vulnerable young people. Although it is difficult to estimate the figures, that is another area that is extremely poorly resourced.

There might be no hard evidence to prove this, but we feel that it is self-evident that the regeneration of communities and their economies is the best way of making a sustained long-term impact on the fact that we have 30,000 people with drug problems. When programmes are put in place to regenerate communities, it is important to take full account of the scale of the local drug problems—otherwise those problems and other social problems will remain, and efforts at regeneration will be less effective. A number of regeneration programmes have not fully understood the nature of local drug problems and have therefore not been able to address those problems.

We are committed to the effective delivery of the Scottish drugs strategy. I will hand out our annual report, which shows the range of ways in which we are supporting an effective response in many different areas of the strategy. We find it rather frustrating that, despite clear evidence of what works, and a clear acknowledgement from the Executive of what works, there is little evidence of the substantial shift in resources that will be required to make an impact. We are heartened by the clear acknowledgement in the Executive's submission that treatment and care works, but we are keen that that should be delivered in practice.

As an umbrella agency working in the field, we would like to ask policy makers to take a more proactive stance in shaping and influencing public opinion on the measures that will, on the basis of current evidence, make an impact on Scotland's serious drug problem. At the same time, we would like them to make realistic statements on what can be achieved and on the time scale in which it can be achieved.

The Convener: Thank you. There was a lot in that presentation and I am sure that there were a number of points that members will want to pick up on.

I would like to start by asking about your role in trying to broaden understanding of the issue and in delivering services. Before Alex Neil asks whether you are suits, I will ask you.

David Liddell: We are, yes. [*Laughter.*]

The Convener: Can you tell us about the Scottish Drugs Forum—your management structure, your funding and how you operate in the field?

David Liddell: The Scottish Drugs Forum was set up in 1986. At that time, there were about 20 specialist drug services funded with an initial £0.5 million that was made available. We were set up because it was recognised that there should be an umbrella agency to represent the interests of everyone working in the field, to promote best practice and to co-ordinate effective responses.

Our overarching aim is to reduce drug-related harm in Scotland. We do that in various ways, information on which is given in our annual report. We support the whole response infrastructure. A key part of our function is to reduce the gap between those who are in need of our services and those who make decisions on how resources are allocated. We promote best practice and ensure that we put resources where the evidence indicates that they will have the biggest impact.

Recently, we have done work on quality standards for specialist drug services. We are also working on guidance on good practice and on the development of effective outreach work with women drug users.

The Convener: So are you a link between practitioners in the field?

David Liddell: We are a link between policymakers, practitioners and people in need of services.

The Convener: Does that include drug users as well?

David Liddell: Yes. We also link in at different levels through the Scottish advisory committee on drugs misuse, drug action teams, local drug forums and the local agencies on the ground.

We are structured as a membership organisation, with a wide membership from agencies and individuals in the field. Our core funding from the Scottish Executive for the past financial year was £156,000. We are also set up as a charitable organisation with limited status.

The Convener: Who is on your management committee?

David Liddell: The management committee is made up of a range of individuals, primarily people with an interest in the field. A large proportion would be practitioners and policy-makers.

The Convener: Are local groups represented on the management committee?

David Liddell: Yes. We have a democratic structure with elections at the annual general meeting. Our operation is quite transparent.

The Convener: Keith Raffan and I visited the Glasgow family support group, which gave us very moving testimony. That group clearly needs support. Would your organisation have any role in providing such support?

David Liddell: Yes. We have given substantial support to the whole range of agencies working in the field.

The Convener: That particular group is quite different from other agencies.

David Liddell: We have worked specifically with that group. For example, we have supported a project that trains family members to respond to critical incidents.

The Convener: I do not really want the details. My point was more that I thought I saw a gap in your support.

David Liddell: The infrastructure of support for agencies on the ground is a huge area and any support that we can give is largely dependent on our local funding. Although we support the recent focus on measurement of outcome and performance, very small voluntary sector agencies need a lot of practical support to manage their budgets and staff. In recent years, many of those agencies have felt quite undervalued and sometimes almost under attack by some of the pronouncements that have been made. For example, the initial Scotland Against Drugs campaign had a zero tolerance basis and, as a result, the morale of many agencies suffered because they felt that they were not a fully valued part of the response. Their morale continues to suffer; we definitely need to do more for those groups.

The Convener: The most startling comment the Glasgow family support group made was that it does not feel valued by drug treatment agencies. Although I am not saying that I agree with that conclusion, I saw a gap there.

David Liddell: In the past, the Scottish Office funded a training initiative, which we introduced, to bridge the gap between family members and drug workers. Although we have undertaken some work on that issue, we need to do more.

The Convener: Thank you. Those questions were just by way of introduction.

Mr Raffan: As I recall, the family support groups were rather vociferous at the Scottish Drugs Forum AGM.

David Liddell: Well, they are also members of our organisation.

The Convener: I was very pleased to read in your documentation about the distinction you make between community-based treatments and community development strategies. That difference is often not picked up. The challenge is how to get communities to grapple with the problem while allowing them to maintain the quality of life they deserve.

On page 9 of your submission, you say about communities:

"In this regard, they can also seem quite hostile to people with drugs problems"

and

"antagonistic towards . . . services . . . However most of these groups seem to go through a steep learning curve and over time begin to understand the complexities of the problem and that there are no simple solutions."

Is that not a rather patronising statement?

David Liddell: I hope not. The key point is that the drugs problem is so complex.

The Convener: Do you not think that communities understand that already?

David Liddell: As you will recognise, you are going through a steep learning curve on this, so there is a—

The Convener: With all due respect, I think I knew before that the problem is complex.

11:45

David Liddell: Having been involved in the management committee of some of the early community drug projects in Edinburgh, I have seen the learning curve that groups go through. A group may have sprung from a particular concern on the part of parents about their children's drug use, but the services and groups that have sprung up may deal only more generally with the impact of the drug problem of those communities.

The conclusion for the long term is that treatment and care have to be part of the response in overall terms. We need to bridge the gap between the wider community and the specialist drug services—as has been alluded to in relation to parents and drug agencies. There has been some good practice among community groups and community specialist drug services, which have been doing a lot of legwork locally to ensure that there is a partnership.

The Convener: What do drugs workers have to learn from communities?

David Liddell: Drugs services have to learn the day-to-day reality of the drug problem. We need to enmesh the drugs services more closely in communities. That is more relevant to the health provision, which is very detached from some communities. The voluntary sector agencies seem to us to be the most engaged with local communities overall; then come social work and then health services.

Alex Meikle (Scottish Drugs Forum): There is mention on page 9 of our document of the creation of the new horizons drug project in Cranhill, which is in your constituency, convener.

The Convener: We visited it yesterday.

Alex Meikle: That project group started off very hostile to methadone, wanting to hang and flog dealers. Some members of that group probably still want to do that. Over the past year, they have been integrated with the planning process. Iona Colvin will know much more about this than me. They have come round to more of an awareness of the complexity of the problem.

The Convener: That is correct; that project group has moved significantly in terms of its responses. The message that I get is that the group has responded to agencies responding to its needs, and will constantly give evidence that the people who live with and suffer the problem get patronised by agencies—by people who do not live in that community. When good supportive work was done with the members of that group, they saw the possibility of movement, listening and action—but we must be careful; it is not as if all that we change is on their side.

David Liddell: That is right. We have done a lot of other work on consultation with user groups. Alex Meikle in particular has been involved with that. As I said, we consider it a clear part of our role to bridge the gap between the people in need and particular communities.

The Convener: In relation to drugs work, what do you mean by community development strategy? What are the key components?

David Liddell: We have to distinguish the people in the community with a specific interest, because of a drug problem in the family, on whom the problem has impacted more severely. It is easier to engage with and involve those individuals, be they carers or service users, in the planning structures. A good example of that is the Argyll and Clyde drug action team, which now includes a user representative thanks to the work that we have done there. That is the first such case in Britain.

Such engagement is, in a way, far easier than engaging with the wider community. It is far more difficult to do that and maintain a clear idea of what that means in reality. The first step relates much more to raising awareness and to a common understanding of the issues and concerns.

The average person in the community will probably not want to be engaged in all the planning structures for the drug problem; they want action to be taken. We have no clear answers about how to achieve that other than the first step—a consistent drug awareness-raising exercise to engage everybody. That will give everyone a shared understanding of what the problems are and of the best ways to respond to them. That has been a difficulty over the years.

The Convener: So it is a matter of general awareness-raising and of working with users?

David Liddell: Although involving users and carers is the easy bit, it is still complex enough. We also have to consider vulnerable young people and wider provision. When we consider community development, we have to consider whether provision should be drug-specific or much wider.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): In your introduction, David, you spoke about treatment and care; we would all agree with your statement that they can make a big difference. You suggested that more emphasis should be placed on treatment and care. Almost 40 per cent of the budget that is spent on drug issues in Scotland is spent on treatment and care. Our budget is limited; what do you suggest should suffer so that more money can be put into treatment and care?

David Liddell: In our submission we estimate that £15 million is spent on specialist provision and we argue for a trebling of those resources. I think that, according to the Executive, £55 million or so is spent on treatment and care. Our impression over the past 14 or 15 years is that we do not have the range of services in place that we need. For a range of reasons, generic services are not able to respond effectively to the problem. We feel that the specialist drug service has to be a major plank in the strategy; it is under-resourced at present.

In England, it has been estimated that 75 per cent of the drug budget is spent on enforcement. Our impression is that the figure would be similar for Scotland. However, it is difficult to come up with a precise figure. I understand that the Executive estimates that £6.5 million, within the Scottish figure, is spent by the Scottish Prison Service on drug treatment. I think that a lot of people in the field would be surprised that that is the case.

Cathie Craigie: I want to focus on your spending priorities. On page 7 of your submission,

you talk about educational approaches and you question their value. If resources were taken from the educational side, do you feel that it would be of value in dealing with the problem as a whole?

David Liddell: Balance is important. We are making the point that there is a bias towards enforcement at the moment. We feel that there is an important role for educational initiatives as well, but we need to be realistic about what they can achieve. As was said at the beginning, we need to consider these issues in a social context. Educational initiatives are more appropriate if their overall aim is to increase knowledge and awareness among young people, rather than to reduce levels of drug use, because there is scant evidence that that can be achieved.

You asked where the money would come from. We argue that we need to invest money now to save money in the long run. If you like, it would be a kind of bridging finance—investing now on the basis of evidence of what can actually work. It is a Catch-22 situation: if we do not invest now, we will not achieve the long-term results and save money elsewhere. There are 2,000 people in prison because of drug problems and it costs us £50 million to keep them there; we could save a large portion of that if we did more work in the community to help people.

Cathie Craigie: Would you not say that investment in education on HIV and AIDS—education that is on-going—has saved money? Was it not important to use education to get the message across?

David Liddell: Definitely. As I said, educational projects have an important part to play in the overall response. Evidence suggests that we can make an impact in treatment and care. There are 30,000 people with drug problems. The biggest impact that we can make is to reduce the harm they do to themselves, the harm they do to wider society through drug-related crime, and the variety of effects they have on our poorest communities.

Cathie Craigie: On page 6, you make a point about the pilot projects. I recognise that you welcome them and that there is much that we can learn from them, but you say:

"However, as is the case in all too many areas of drugs work, the pilot projects cover a limited geographical area, and funding is usually only for three years".

Is there an alternative approach?

David Liddell: The alternative is more sustained, long-term funding. Yesterday, I spoke to an agency that has been funded for the past 14 years on one-year contracts. Because of delays in payment, it had to get a bank loan to pay the staff, to avoid making them redundant. There are many examples of agencies that have year-to-year funding rather than three-year contracts. That touches on support for the infrastructure. There is a clear need for more sustainable, long-term funding. There are far too many short-term initiatives with one-off funding. The problem for an agency that is funded to the tune of £120,000 a year is that it might spend £20,000 of its resources on chasing funds, which is not a cost-effective way of delivering results.

Cathie Craigie: We will address that issue wearing a different hat.

Your point is that projects must be evaluated much sooner than after 14 years.

David Liddell: For sure.

Cathie Craigie: It could not be a pilot programme if it ran for that length of time.

David Liddell: It was not a pilot programme—

Cathie Craigie: The point about evaluating a pilot is that either it works and funding continues, or the project is mainstreamed, or it does not work and the project is closed.

David Liddell: We have clear evidence that a range of projects can work if the quality of their interventions is supported effectively. Perhaps we should fund a smaller number of pilot projects to test out new ideas. Often, the problem is that projects must reinvent their service, calling it innovative practice, to get the same funding as they had before. That approach is not in anyone's interests.

The Convener: That point has been made by a number of organisations.

Mr Raffan: On community involvement and participation, when I visited the new horizons project and the Glasgow family support group, I got a slightly different impression from that of the convener.

The Convener: That does not surprise me.

Mr Raffan: I was most impressed and moved by the openness of people involved in the projects, who said that they had started off with different attitudes from those that they now hold. That shows how the attitudes of parents and others who may be hostile and who may attach stigma to drug use change the more they are involved in such projects. Is that your experience?

David Liddell: We tried to make that point in our submission. I am sorry if it came across as patronising.

Mr Raffan: Moving on, the minister is to make a statement on drugs strategy tomorrow morning. Were you consulted about that?

David Liddell: I will give the same answer as the Convention of Scottish Local Authorities representatives: not directly.

Mr Raffan: But you hope that your views were fed through?

David Liddell: We hope that we influenced what the minister has to say.

Mr Raffan: You gave the figure of more than 30,000 drug misusers. Is that figure an underestimate, given the figures that Iona Colvin gave—of 12,500 to 15,500 in Glasgow?

David Liddell: The figures come from a study funded by a European monitoring centre and, as with any study, there are confidence intervals. The figures are as good as we are likely to get.

Mr Raffan: Is the Scottish Executive still holding to its 1994 figure of 20,000?

David Liddell: The Executive has not given a current figure, but we have access to the study—I am not sure whether it has been published yet—that shows a figure of 30,000. I alluded to the fact that the figures have increased from the mid-1980s, when the problem was concentrated in Edinburgh, Glasgow and Dundee, but it has now spread out across the country.

Mr Raffan: Your submission is one of the best pieces of written evidence I have ever seen in a committee, either here or at Westminster. One of the most worrying statistics in it is that 25 per cent of new attenders in Fife and Aberdeenshire are in the 15 to 19 age range, whereas in Glasgow and Edinburgh the proportion is only 10 per cent. That is a dramatic measure of the way in which this problem is spreading out.

David Liddell: That statistic is only a snapshot of new attenders. COSLA made the point that the figures give information only on places where the service exists. The figures represent service activity, so where there is no service there are few data to go on. The Glasgow problem is much more entrenched and goes back a lot longer than does the problem in other communities. The age profile shows that.

12:00

Mr Raffan: I would like to ask about funding. COSLA talks about inequalities in service provision; you talk about treatment services being patchy. Last week, the minister gave me some figures: 46 per cent of the drug budget is for enforcement; 39 per cent is for treatment and rehabilitation; 15 per cent is for education. You mentioned a total of £150 million, but you cannot really say how high the figure is. However, you then talked about the current spending on specialist drug services being £15 million. Is it true that those specialist services cover a narrower range than do treatment and rehabilitation? Are you challenging the minister's figures?

David Liddell: No, because we are talking about specialist provision.

Mr Raffan: How would you define specialist provision?

David Liddell: Specialist provision is provided by agencies that are in the directory of helping agencies that has been circulated. The primary function of those agencies is to work with people who have drug problems. The wider figure would also include, for example, funding in the Scottish Prison Service, which spends £6.5 million on treatment and care, and an estimate of the overall expenditure in generic social work, which is clearly a high figure. We have suggested focusing on specialist provision because we can do something with that. The problem with giving extra resources to generic services is that there is a range of other demands as well, which may not represent the greatest need.

Mr Raffan: Is the Scottish Executive aware of the national treatment outcome study, the £1: £3 ratio, and the Rand study? Does the Executive read those things?

The Convener: Keith has told the Executive often enough.

Mr Raffan: Do you draw such information to the Executive's attention? It does not seem to base policy on it.

David Liddell: The Executive has certainly acknowledged in its submission that there is such information. As I said in my introduction, we are slightly frustrated that things have not moved more quickly in shifting the balance of funding.

Alex Meikle: I do not want to dwell too much on outcome measurements, but there are good outcome measurements that show good work and good practice—or the lack of it—in drug treatment agencies. About three or four years ago, the Polkinhorne committee at the Department of Health gave us good outcome indicators that we can use to assess the effectiveness of drug treatment agencies. We do not have to reinvent the wheel. I hope that the new prevalence and prevention units will consider those outcome measurements. An outcome indicators group has been established with ISD. I am on that group, along with a couple of drug development officers from the drug action teams. The group is considering five pilot projects in Scotland to assess the feasibility of measuring outcomes. Robust estimates show—and I think that we in this room know this already—that treatment works. It is very effective.

Mr Raffan: Why were you so worried about the comprehensive audit of all drug treatment services that the Minister for Finance announced on 6 October last year?

Could you define for us what community-based treatment services means?

David Liddell: There was a degree of misunderstanding over that audit. It was simply a look at the way the expenditure added up. A concern with some audits is that the focus tends to be almost totally on treatment and care and, within that, the focus tends to be almost totally on the voluntary sector. We would like all types of response to be considered, including educational issues and enforcement. There should be a level playing field for assessing the impact of all types of response. I cannot remember now, but if I did raise some concerns, it would have been because I was worried that an audit into effectiveness would be quite narrow in its focus.

Mr Raffan: And the second question?

David Liddell: Community-based drug services—for example, the Castlemilk drug project or the Castle project in Craigmillar—operate in distinct communities. The vast majority of such projects operate to a social care agenda that considers problem drug use in the wider context. They do not focus on needle exchange and prescribing services, but on the range of needs people have, such as education and housing benefit. They consider the whole person and consider drug problems as social problems. We are keen that there should be better linking up of all the different parts of the response, because there are huge gaps.

Robert Brown (Glasgow) (LD): I would like to ask about the information base. It is clear that some people do not access services and it is difficult to get data on them, but for those who do access services, does the method of recording—single identifiers, for example—eliminate double counting and repeat visits?

David Liddell: The drug misuse database records new attenders at services. It has an identifier, so double counting is eliminated. The current figure for new attenders is 9,500—but I emphasise that that figure is only for new attenders and is therefore not in any way a measure of the scale of the problem. However, it helps us to map trends in, for example, injecting practice and drug use. There has been an increase in heroin use.

Alex Meikle: There are individual databases. For example, Glasgow has a continuous contact system that records how people move through the system from their initial treatment. That is done individually and there is no double counting between different projects.

Robert Brown: I want to ask about provision by local authorities and provision by voluntary groups. Is there any consensus on the best way of dealing with drug problems? Does voluntary sector involvement help women to overcome the fear of losing their children, which Fiona Hyslop mentioned?

David Liddell: We do not take a purist view, as it were, that the voluntary sector is always better than the local authority. That often depends on how freely the local authorities allow the individual services to operate. In some areas, the voluntary sector is better placed to do the work. There can be political concerns about the way in which some agencies operate. It is horses for courses.

Our primary concern is that services are user friendly, accessible and take full account of clients' needs. In some areas, social work departments are rigid and so are perhaps not best suited to be the front-line agencies. In other areas, they operate independently and their services are more appropriate. For us, the important thing is not whether services come from the voluntary sector or the statutory sector, but whether the services operate well. Some agencies, because they work in an innovative and informed way, seem as though they are in the voluntary sector, but they are in fact in the statutory sector. The distinction is not clear-cut.

Robert Brown: I would also like to ask about the courts and prison systems. We have to consider whether people in prisons want to be helped and how we can help them. Prison is an artificial environment where, as far as one can gather, many, if not most, long-term and medium-term prisoners are using drugs to some extent. Can anything be done to reduce the social exclusion of people in prison to help their drug treatment?

Alex Meikle: The issue is the through-care provision, which Glasgow is thinking about. A good model of that exists in Argyll and Clyde, where Gateside prison has appointed a worker whose job is to liaise with the four feeder projects, Dumbarton drug initiative and Inverclyde community drug team. Her role is to assess someone coming in from Greenock or Paisley sheriff court and to tell Gateside, "This person is coming in on such and such a date. Don't let him rattle for three days. Go in there and try to assess that person." When that person is at liberty, her role is to say, "You live in Dumbarton, right? We can arrange an interview with Dumbarton drug initiative."

Glasgow is a different kettle of fish, because of the sheer size of Barlinnie and the number of projects. It is only through through-care provision that we can stop folk disappearing off the streets. After six months on methadone, suddenly someone is whipped off the streets for an outstanding warrant. He disappears into the prison system and nobody knows where the hell he is. In fact, there is a continuity system whereby a key

worker can latch into the prison system so that people are not left on their own when they are released. The period following release is when people are at their most vulnerable.

Robert Brown: Are the services that can be accessed in prisons informed by the experience outwith prisons?

David Liddell: That is a big issue. We believe that there are a lot of people in prison who should not be there. There is a high turnover of people coming in and out of prison, which can disrupt any sort of community-based treatment that they are receiving. That can be destructive when there is no follow-through treatment.

More people should be dealt with in the community, which would mean that there would be fewer people in prisons. The prisons could then respond more effectively to the prisoners that remained. There must be—to use the buzz words—some continuity of care between what is provided in the community and what is provided in prisons. We have argued that the best way in which to achieve that is through going down the English route of providing specific funds for prisons to contract outside agencies to deliver services. New money would have to be provided for that, and we must build in close links between the community agencies and the prisons.

There have been one or two beacons in the wilderness—instances of excellent through-care work, in which the workers have taken it upon themselves to follow up and work with their clients on release. That initiative has had a high success rate and can clearly be effective, although it is carried out in a piecemeal way.

Robert Brown: Several comments have been made about sheriffs not knowing the system. Is there one issue that we should be concentrating on to increase the courts' use of rehabilitation rather than penal institutions? Is the issue the speed of the process, the assessment or sheriff training?

David Liddell: The main issue continues to be the lack of a full range of alternatives to custody and disposals on the ground. If we had that full range, we could better engage with the judiciary, to encourage them to choose alternative options to custody. The problem is that it is difficult to convince the judiciary to take that route when there is not a full range of services in place. Generally, the courts are not confident of the effectiveness of those services in delivering change.

The Convener: Thank you. I am sorry to keep rushing you, folks, but we are beginning to run out of time. Everybody has spoken, so I ask members to keep questions focused.

Mike Watson: I want to ask about prevention versus cure. Only one of the recommendations in your submission talks about prevention rather than dealing with the problems—not that I underestimate the problems that have to be dealt with. I realise that people have to be assisted to give up drug misuse, but what about prevention?

The pattern of drug misuse is uneven across the country. Either Robert Brown or Keith Raffan referred to the figures from Fife and Aberdeenshire, where more young people are involved. I am concerned that, in 10 years' time, the problem in the worst-affected parts of Scotland will have spread further. In realistic terms, we are talking about the containment rather than the eradication of the problem.

Within that context, first, what resources does the Scottish Drugs Forum commit to prevention aspects of your work? Secondly, how can the problems that you highlighted, such as the increase in heroin smoking, be curtailed to avoid the problems in the worst areas being replicated elsewhere?

12:15

David Liddell: As I highlighted at the beginning, the three planks that we are arguing for are treatment and care, targeting vulnerable young people, and regeneration. Two of those three planks are based on a prevention strategy. The difficulty is that they have to be seen in the wider context—they are not drugs specific. Working with vulnerable people and regeneration are the areas in which we need to invest in the long term to make a difference, although we also need to invest in treatment and care, which is a more short-term response to what is, in many respects, a crisis.

We need to engage with those young people who smoke heroin, and therefore, as I said, we need to invest far more in detached youth workers. I am conscious that the language used in addressing youth often focuses on the drugs war and zero tolerance. We need to move away from some of that.

The other day, I was at a conference on issues relating to detached youth work. It was interesting that the workers in that field said similar things to drug workers. They feel marginalised along with the people they are working with, because of the fears of others that to work with users or young people who may be starting to dabble in drug use is in some way to collude with or to encourage drug use. We have to get to grips with that. Drug use is a problem that is here to stay. We are all working towards reducing it, but we have to recognise that that is the case.

To pick up on Lloyd Quinan's point, there are, as

we say in our submission, communities where the drugs economy has a desperate hold, of which we are all aware. The only way that we can see to get to grips with that in the longer term is to create legitimate economies to undermine the hold of the drugs economy. That is clearly a wider political issue than the one that we are trying to address.

Mike Watson: There are other points on that issue that I would like to pursue, but I will finish with one more question. Do you feel that the Scottish Executive appreciates the need to concentrate on prevention, while balancing that with the needs of those who are involved in drugs already? Is the Executive giving prevention sufficient priority?

David Liddell: The dilemma is that prevention is part of the Executive's much wider agenda for regeneration. To use the jargon, drug use is a difficult cross-cutting issue; there are major problems in how it is joined up. That is the case on the ground and within the Executive, which is not a criticism of any individual—it is just the reality, because the problem is so complex. Seeing the issue in the wider context is crucial, but it makes the response much more complicated. That is the dilemma.

Fiona Hyslop: I am conscious of the time, so I will be brief. You say that your greatest concern is with treatment and care. Can you give some examples of where there is patchy provision? If we recognise the link between deprived communities and drugs misuse, does the provision of treatment and care reflect that? In other words, are the majority of places for treatment and care where they should be, or is the provision of treatment and care haphazardly dependent on where you live?

David Liddell: There is a need for an increase in provision across the country. There are specific areas, such as Forth Valley and Fife and Aberdeenshire, where we are particularly aware of the problem that has arisen in the past four or five years. Services need to be more proactive—this touches on heroin smoking—so we highlighted the need for effective outreach work. There are other huge gaps—for example, in Port Glasgow, which Alex Meikle will tell you about.

Alex Meikle: Two examples of working with drug action teams come to mind from areas that I am familiar with. Inverclyde now has a six-month waiting list for methadone prescribing, which is incredible. It is a disaster to have to say to someone at the beginning of May, "Come back in six months and you will possibly get your methadone." Dumfries and Galloway has one service at Cameron House in Dumfries, an outreach worker, and a community psychiatric unit in Stranraer to cover the entire area. On the other hand, Ayrshire and Arran are fortunate to have extensive backpacking systems in rural areas, and also quite a few drugs projects. Treatment is patchy and depends on your postcode. Glasgow is seen by some areas as a cornucopia for drugs services, but no one in Glasgow would say that.

Fiona Hyslop: To ensure adequate provision, who should decide where services should be?

David Liddell: Drug action teams were set up to do that. Although we are represented on and have supported a large number of the 22 DATs across Scotland, the difficulty has been in translating strategy into the reality of services on the ground. That is a huge issue, which is to do with funding. We have argued that there has to be ring fencing across all the agencies. Accountability comes from funding. Money should be released only following the agreement of the local strategy—you agree a strategy and then have the funds to devote to specific priorities. We believe—we have been involved in planning structures for the past 10 years or more—that that is what we have to do to make things work more effectively.

Fiona Hyslop: You cannot do that if money is distributed via social inclusion partnerships, can you?

David Liddell: That is true, but that is just one example where one cannot always see the clear tie-ups between the local strategic planning structures and additional money. I am sure that there will be tie-ups.

Mr Quinan: I whole-heartedly agree when you say that drug users need to be increasingly involved in service planning. Do you agree that it would be useful for this committee to meet drug users from across the spectrum of drug use? I sometimes feel that when we talk about drug use we are talking in a vacuum, in as much as we have a homogeneous view of drugs. In fact, there are many types of drugs and they produce different reactions in people.

David Liddell: The main group to get a handle on is the 30,000 people with drug problems. Within that, the focus should be on drug use by vulnerable young people. If you extend that focus it becomes unwieldy. However, there needs to be an understanding of the spectrum of drug use, and within that we have to be clear about the most harmful aspects of drug use on which we should be targeting our resources. We have undertaken user involvement work with problem drug users, and we hope to give the committee access to those individuals.

Mr Quinan: In your submission, you estimate that £400 million of retail goods per annum is illegally acquired by problem drug users. If there are only 30,000 of them, that suggests that each one is turning over £139,000 a year. This goes back to the crucial element of economics—not just of service provision, but of what happens when we

take away the drugs economy. More important, how much do you believe is spent on controlled drugs in Scotland weekly or annually? I know that there are no specific figures, but I think that you have estimates.

Alex Meikle: We do not have figures for Scotland, but for Glasgow we estimate that the yearly expenditure on illicit drugs is £194 million, which roughly works out at about £70 to £80 per day per drug user, based on a price of £20 to £30 per quarter gram. Given that 98 per cent of those people are unemployed, there are three ways in which the money can be obtained: acquisitive crime, prostitution or user dealing, or all three combined.

Mr Quinan: A number of years ago, Dr John Marks took an unfashionable approach. He argued that it required a great deal of ingenuity and drive, and a certain amount of entrepreneurial ability, to maintain the lifestyle of a drug abuser. How do we channel those abilities into activities that benefit society?

Alex Meikle: When we take someone from an active, albeit chaotic and tragic, lifestyle on to a stabilised methadone script, that is great for the first couple of months. The problem is that we have nothing to replace that lifestyle with in the long term. We are also dealing with men and women who are, on average, 27 or 28 years of age, but whose state of health is that of a 50-year-old and whose mental state is that of an 18 or 19-year-old. I do not say that to disparage individuals, but the lifestyle they have led is so chaotic that that is what happens. We have to help those people in a range of areas—in acquiring social skills, in relapse management and in anxiety management—before we can even think of getting them into work. Methadone prescribing and the counselling service that is needed on a weekly or fortnightly basis has to be allied with through-care, whether it be group work or anxiety management—something that will get the individual back into a productive lifestyle. That is essential.

Mr Quinan: It has been suggested that the heroin maintenance programme that was used until some years ago was more capable of decomplicating—for want of a better word—the chaotic lifestyle of drug users than the current programme is. A Swiss study suggests that prescribed heroin, rather than methadone, can assist some people more effectively. Do you have a view on that?

David Liddell: A number of alternatives to methadone are being promoted. We have watched with interest the Swiss experiment, which is being extended to Holland. We should learn from other countries regarding good practice. It is important to point out that in the Netherlands, which has a range of provision and a population three times that of Scotland, the number of people with drug problems has remained at 20,000. There are places where drug problems are substantially smaller, and some useful comparisons can be made.

The Convener: Therein lies another story.

Karen Whitefield: You said that there is a waiting list for methadone prescribing in some parts of Scotland. Is that the result of a lack of funding or of how services are administered? If in Lanarkshire there were one central crisis centre prescribing methadone, there would be a waiting list, but because across the board there is an emphasis on prescribing through general practitioners, we do not have a waiting list.

David Liddell: The community addiction team in Motherwell, for example, has a waiting list of nine months. To a degree, you are right—we have to consider how the services are organised. However, waiting lists are a huge problem. In many areas, there is a lack of services, apart from prescribing services, and there is little to move people on to. That means that existing services get blocked by the people who are using them and so become inaccessible. That is an unhelpful position.

Alex Meikle: Uniquely, we set up drug services without an adequate estimate of need or demand. The situation in Inverclyde, where we set up two clinics, was classic. The clinics became a honey pot because, as soon as people hear that methadone is available, thousands of them come out of the woodwork. A couple of GPs and community psychiatric nurses simply cannot cope with that. Something similar is happening in Motherwell.

Karen Whitefield: I do not know that the problem is the same in Motherwell. Throughout Lanarkshire, there is a commitment to ensuring that methadone is prescribed by GPs and that we do not create a honey pot. We would have that problem if GPs refused to prescribe.

On page 23 of your response you refer to the "predominant emphasis on enforcement", and in answer to a question from Cathie Craigie you said that there was a bias towards enforcement. How do you justify that, when three out of the four pillars of the Executive's policy on drugs and drugs funding do not relate to enforcement?

David Liddell: As I said at the beginning, it was estimated that, in England, 75 per cent of resources went towards enforcement. In our view, the Scottish position is broadly similar. Of course, estimates vary depending on what is included, but we believe that at least a couple of thousand of the prison population of 6,000 have a drug problem and would be better dealt with in the

community. I would argue that that amounts to £50 million spent on enforcement. We believe that expenditure needs to be shifted towards more proactive services that can deliver effective outcomes. We need to pump-prime those services, to deliver change in other areas over time.

12:30

Karen Whitefield: So this is a matter of interpretation. [*Laughter.*] On DATs, you say that there is a lack of direction and accountability. What would you replace them with?

David Liddell: We were involved in the ministerial drug task force in 1994 and we pushed for a change from the previous drug liaison committees. The overall aim was that chief officers would bring resources to the table and agree a strategy, which would determine how resources were dispersed. That principle still holds for local planning structures. The difficulty is in tweaking the structures and in allying the funding much more closely with them. In our view, that could be achieved by ring-fencing a percentage of each agency's budget. That would mean that the police, the health service, social work and so on would come to the table with, say, 1 per cent of their budget, decide on a strategy and work out, on the basis of current evidence, where money should be invested to deliver the best results over the next five to 10 years. That is the position at which we need to arrive, but we are a long way from it.

Karen Whitefield: That suggests that there is not a lack of direction and accountability. That is what DATs are there to provide, and they are bringing templates forward. Those templates may not always be right to start with and the service may need to be improved. However, that does not mean that there is a lack of accountability.

David Liddell: As I said, planning is incredibly difficult when dealing with a cross-cutting issue of this sort. There is no doubt that it is a huge challenge to get it right. The point is that we have not got there yet.

Karen Whitefield: My final question relates to the national strategy. What was the SDF's role in drawing up the national strategy? What do you think your role is now that it is being implemented?

David Liddell: We were represented on the working group that drew up the strategy, as a sub-group of the Scottish advisory committee on drug misuse. The easiest way in which to answer your question would be for me to circulate our annual report, which shows some of the areas in which we are working to deliver bits of the strategy.

Karen Whitefield: Do you believe that SDF's role should now be to support the national strategy?

David Liddell: We are signed up to it. Our only concern is that parts of the strategy could be delivered more quickly. I suppose that we feel that way partly because we have been around much longer than other agencies.

The Convener: Thank you. I am going to redefine final and allow John McAllion to ask a question.

Mr McAllion: This is the final question. You said that, when deciding which services for people who abuse drugs are provided by the voluntary sector and which services are provided by the statutory sector, it should be a matter of horses for courses. The criminal justice services in social work departments deal with all kinds of offenders, but they spend a great deal of time dealing with people who have drug problems. It has been rumoured that those services are to be transferred from local authorities to the Scottish Executive. How would you react to that?

David Liddell: That raises huge issues of local accountability. In some areas, drugs cases comprise such a large part of the case load of criminal justice social workers that it is crucial that the services tie in with local planning. On that basis, we would say that they should stay with local government.

The Convener: That was really interesting. I am sure that we will talk to you again during our inquiry and beyond that. Thank you for your paper and for your oral evidence, which was very straightforward. We may write to you to follow up some points. If there are other issues that you would like to bring to our attention, feel free to do so.

Communities Against Poverty

The Convener: I will plough on, as we have one item left on our agenda. I apologise for letting the evidence session overrun, but I thought that it went to the heart of many of the issues with which we are dealing.

The next item is a report on the meeting with Communities Against Poverty that a number of members attended. We made it clear—and the group is well aware of this—that the meeting did not tie us down to consulting only with Communities Against Poverty. Rather, this is a preliminary way of working; we will see how things go and review the situation in future. However, most members who attended found the meeting interesting and innovative. We need to engage with groups, so let us start with this one and see how we get on. The recommendation is that we agree to meet Communities Against Poverty four times a year and afterwards review the situation. Do any of the members who attended the meeting want to comment?

Mr McAllion: I support everything that you have said, convener. This is a positive step forward and a good way of engaging with ordinary people who represent poor communities across Scotland.

Karen Whitefield: One thing that came across at the meeting was that people working in the field are keen to engage in dialogue with the committee. This is a way of starting that dialogue and ensuring that we are accessible.

Robert Brown: We will have to watch the time scales. If we adopt the same approach with a number of groups, the time commitment could be significant. That is my main concern.

The Convener: What is important is the principle of consultation. If we accept the recommendation, that does not mean that we will be excluding other groups or committing ourselves to doing this for evermore. We will simply be moving in the direction of greater consultation. We will review our decision in future. Is that agreed?

Members *indicated agreement.*

The Convener: Well done. I thought that the committee would do that, which is why I let the previous item run on.

Mr Raffan: Will the meetings with Communities Against Poverty be formal meetings of the committee or visits?

The Convener: I should have clarified that. We decided that it would not be appropriate to fit those meetings into the committee's formal programme, but instead have them take place on afternoons. We would agree the topics for discussion with the group—two from them and two from us.

Meeting closed at 12:36.

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