SOCIAL INCLUSION, HOUSING AND VOLUNTARY SECTOR COMMITTEE

Monday 26 June 2000
(*Afternoon*)

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SOCIAL INCLUSION, HOUSING AND VOLUNTARY SECTOR COMMITTEE
24th 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

Dr Charles Lind (Ayrshire and Arran Primary Care NHS Trust)
Chris Spry (Greater Glasgow Drug Action Team)

CLERK TEAM LEADER

Lee Bridges

SENIOR ASSISTANT CLERK

Mary Dinsdale

ASSISTANT CLERK

Rodger Evans

LOCATION

Committee Room 1

Scottish Parliament

Social Inclusion, Housing and Voluntary Sector Committee

Monday 26 June 2000

(*Afternoon*)

[THE CONVENER *opened the meeting at 13:03*]

Housing Stock Transfer (Report)

The Convener (Ms Margaret Curran): I formally open the meeting and thank members for their attendance. The time of the meeting has been brought forward because of our heavy schedule. Before I ask for the committee's approval to consider the draft housing stock transfer report in private on Wednesday, I want to make a statement regarding the events of last week, as it may affect the committee's decision on item 1 on the agenda.

In light of the events of last week, I wish to make the following statement to the committee. Given the very serious nature of the allegations against me, I trust that the committee will allow me to give the facts uninterrupted. I have clarified this approach with the clerks and am advised that I am following proper procedure.

The actions of certain members of the committee were extremely grave and highly regrettable. Their allegations are serious and can be rebutted completely and unequivocally.

First, the inference is that I colluded with the Executive on the amendments to the document. This has not a shred of substance. I am advised that the statements made are defamatory and I am seriously considering legal action against the deputy convener and anyone who repeats them. It is extremely concerning that the deputy convener could make such statements without any attempt to establish the facts. I ask the deputy convener to clarify that she is making no personal allegations that undermine my integrity and to offer me an apology. I thank the remaining members of the committee for their endorsement and note that that involves members of all other parties on the committee.

The deputy convener alleges that evidence was altered. Again, that is a very serious charge, which may also constitute defamation. Evidence to the committee cannot be altered. It is a matter of public record. How that evidence is interpreted is a matter for the committee.

It was agreed at a previous meeting that the report would have to accept some arguments and reject others. It was further agreed that, when we rejected some of the recommendations presented to us, we would have to change the supporting text. Let me make it absolutely and emphatically clear that all members of the committee have the right to propose any change to any document produced in the committee's name.

The deputy convener stated that the report was to be consensual. That contravenes an earlier decision of the committee when it was clearly accepted that consensus could not be reached on the major issues and that the report would reflect the majority view, indicating where disagreement took place. The deputy convener also stated that the draft report was balanced. That is her own view and not the view of the committee. I did not agree that the report was balanced. I raised that point with the writer and the clerks some time ago, which can be confirmed. I was advised that I could propose changes to the text at the appropriate time. I have considered this over some time, and was therefore well prepared for this stage of amendment. The deputy convener also stated that it was agreed that any amendments to the text would be minor. That is categorically not the case. I refer members to the e-mail sent by the clerks on Thursday 15 June, requesting members to submit their general comments on the text by a certain date. I quote:

> "Comments on the deferred recommendations and the general text need to be with . . . by . . ."

I also note the contributions from a number of members indicating their desire to change the text.

I wish to explain the details of the specific circumstances of my own amendments. I appreciate members' earlier comments that there is no necessity to do this, but I am sure that everyone will understand my desire to establish the facts. I had a number of amendments to submit. Karen Whitefield contacted me to say that her computer was down and, as neither of us would be around on Friday, asked how we could deal with the situation. I phoned the clerk to ask whether a researcher could submit amendments for us. The clerk was very clear that that was perfectly appropriate procedure. The researcher also collected Cathie Craigie's amendments and submitted them, informing the Scottish Parliament information centre that the amendments were from a number of Labour members, but that he had authorisation to submit them only in my name. I had no substantial difficulty with the amendments submitted and so let matters proceed. I must say that the most cursory inquiry would have established those facts.

In the context of the above, the statements and behaviour of the members who walked out of the committee, and of the deputy convener in

particular, are extremely reprehensible. It is highly inappropriate that they broke the confidentiality of this committee on such spurious impressions and took the details of their case to a waiting press, rather than allowing the committee to deal with the matter. The committee must assess such irresponsible behaviour and consider our actions so that it is not repeated on a whim.

As convener, I must insist that all members adhere to a minimum standard. I have stressed at all times that our reports are kept confidential. It is highly inappropriate for any member to release information about proceedings prior to publication if discussions are held in private. That contravenes the spirit and the letter of proceedings of this committee to date. I will and I must ensure that we adhere to those rules in all our future work.

I therefore invite the committee to agree that it accepts that there was no leak to the Executive; that it accepts the explanation of the procedures outlined; and that it agrees that we pursue our work as planned and to schedule an extra meeting to ensure publication of the report as soon as possible. Thank you.

If the committee will bear with me a second, I now intend to open the meeting to general discussion and then move on to the decisions to which I have referred.

Fiona Hyslop (Lothians) (SNP): I do not intend to apologise for expressing serious concerns about the source and authorship of the amendments to the third and—at the time—final draft of the report. Those concerns were subsequently confirmed when we learned that some of the amendments in the name of the convener were in fact submitted on behalf of another committee member. In addition—as the latest press reports imply, and as the convener has commented—some kind of group meeting or group activity took place, which could have meant that authorship extended to others. Press speculation is no substitute for an investigation.

I have a number of concerns and have repeatedly said that I am pursuing this issue through the parliamentary procedures available to me. I am doing so and, as a result, would suggest to the committee that this forum is no longer the appropriate place to continue this discussion. As I understand that, because of the volume of amendments, the current housing report has now been delayed into the recess, and as there is much business to get through, I propose that we go to the next item on the agenda.

The Convener: As I said, I am taking general comments first. I will take Robert Brown and then Keith Raffan.

Robert Brown (Glasgow) (LD): I must confess that I find Fiona Hyslop's observations extremely regrettable. I cannot honestly say whether there was some misunderstanding on her part at the beginning; however, it is clear that at the previous committee meeting the deputy convener sprayed unsubstantiated allegations around. The allegations included allegations against committee members generally, and Fiona might recall that, when I asked whether they included me, I received confirmation that they did not—although that was not the original phraseology. The allegations are very serious, and it seems to me that the convener's explanation is perfectly reasonable and acceptable and that the committee should endorse it.

However, the issue raises the question of the deputy convener's conduct in this whole matter. It is one thing to make allegations on the basis of evidence, but it is another thing entirely to make spurious allegations without a shadow of support for them. It seems to me that, although the matter clearly has to go elsewhere in one format or another for a decision, Fiona ought to consider her position on the committee. She must consider whether she feels that she can continue to operate as deputy convener against the observations and serious allegations that have been made. She should also consider the appropriate way forward for her in such circumstances. I must confess that I hoped that I would hear some form of qualification or apology from Fiona about her comments at the previous meeting, as they affected not just the convener but other committee members.

I want to add that any suggestion that amendments suggested by me as a Liberal Democrat member of the committee had any form of involvement with the Executive is entirely without foundation. That was a part of the original allegation. I find myself quite aghast at the proceedings to which we were subjected last time. I have no more to say on the matter, except that I think that we should add a reference to the deputy convener's conduct to any further reference on this matter to the Standards Committee.

The Convener: Thank you very much. I will take Keith Raffan and then Lloyd Quinan.

Mr Keith Raffan (Mid Scotland and Fife) (LD): I also find Fiona Hyslop's behaviour today extremely reprehensible and regrettable. I would have hoped that, after a cooling-off period of a few days, she would have greatly regretted the unsubstantiated allegations that, as Robert Brown said, she sprayed around with such abandon last Wednesday. I would have hoped that she would have come to her senses and withdrawn those extremely serious allegations.

Fiona Hyslop says that she is pursuing this matter through parliamentary procedures; it would be interesting to know which. However, I am not

particularly keen to open that aspect now. Sir David Steel's letter is quite clear and categorical that he is not responsible for what happens at a private meeting.

I think that the matter should be referred to the Standards Committee; it is unparliamentary behaviour, which—I do not say this in any condescending way—might be put down to parliamentary inexperience. However, even allowing for that, I quite frankly think that the deputy convener should consider her position. I personally have no confidence in her any longer as deputy convener and will quite possibly move a motion of no confidence in her at the next meeting. I do not think that we can continue to work until the allegations are withdrawn and an apology is personally made to you, convener.

The Convener: Thank you, Keith. I will take Lloyd Quinan, and then John McAllion and Karen Whitefield.

Mr Lloyd Quinan (West of Scotland) (SNP): I would simply like to say that at no stage have any allegations been made. Concerns have been expressed; those are exactly the words that were used last week and that have been used consistently. We express concern about the source of some amendments. There were no allegations, and the word "Executive" did not pass the lips of any of the three SNP members on this committee. I would suggest that members of this committee have made assumptions about what we actually expressed concerns on. Indeed, such leaping to conclusions has made the situation considerably worse than it actually was.

The Convener: Thank you, Lloyd. I will take John McAllion, then Karen Whitefield and Alex Neil.

13:15

Mr John McAllion (Dundee East) (Lab): I obviously very much regret the atmosphere in the committee today, the reasons for that atmosphere and the fact that the situation seems to be spiralling completely out of control. The fact is that there is not a scrap of evidence to support the allegation that the convener or any other committee member colluded with the Scottish Executive in bringing forward amendments to the housing stock transfer report. Most committee members clearly understood that to be the allegation, and I would have hoped that Fiona Hyslop could have withdrawn it and that we could have started the committee's work of tackling one of the most important subject areas that this Parliament deals with—that is what the committee should be doing instead of dividing against itself. I certainly do not want the matter to carry on beyond this meeting and spiral into the Standards Committee, some further inquiry or motions about removing people from their positions on the committee. That would be most regrettable. At this stage, I make a plea to Fiona to make it clear that there was never any imputation against the integrity of the convener, who is beyond such an imputation.

The Convener: Thank you, John. I will take Karen Whitefield next.

Karen Whitefield (Airdrie and Shotts) (Lab): Like other members of the committee, I must say that I am disappointed that the deputy convener has taken such a course of action, particularly because her concerns—or allegations, as most committee members most certainly interpreted them—were expressed outside the committee. She did not give the committee a proper chance to investigate the concerns, but chose to go immediately to the press. I believe that such conduct is unacceptable and calls into question her conduct as deputy convener, especially as this happened at a private meeting.

I would most certainly say that an apology is required by the deputy convener, as she has made a number of allegations and expressed concerns that cannot be substantiated. I do not believe that it is appropriate for anyone other than members of this committee to investigate this matter. We need proof that she can back up her concerns and allegations but to date we have seen no evidence to substantiate them. She has brought the good name of the committee and all its members into question. As a result, I would ask her to reconsider her position urgently.

In light of press speculation that followed last week's meeting and the comments that were attributed not only to her but to other people who are not members of the committee but might have given evidence to it, I would be particularly keen to know whether the deputy convener chose to show the report to any other member who does not sit on this committee.

The Convener: Fiona, do you want to answer that?

Fiona Hyslop: I have not done that.

Alex Neil (Central Scotland) (SNP): First, I want to emphasise that my clear understanding was that Fiona Hyslop was not making allegations against other committee members. She expressed, in a very focused fashion, her concerns about sources of amendments put down in the name of the convener. I think that, as a matter of record, she actually stated that she was not making allegations against any committee members.

The second point is that Fiona was not making allegations. If we check the record—although

there is no verbatim record, as the meeting was in private—she very deliberately did not use the word "allegations"; she used the word "concerns". It is legitimate for any committee member to raise concerns. As members will know, at the same meeting I raised concerns about amendments that were put down in the name of the convener, because in my view they changed the whole substance of the report at a very late stage. Obviously, the convener is entitled to disagree with that—

The Convener: I would absolutely.

Alex Neil: However, right or wrong, it is a legitimate point of view.

I should point out that today's *The Scotsman* states that Labour members met before the meeting to agree the amendments that they wanted to make to the report. My understanding was that members of this committee and other parliamentary committees were not operating on a caucus basis. If they were, they could not operate in the objective manner in which they are meant to act.

Fiona Hyslop has expressed concerns. Clearly, members who have spoken do not share those concerns, but it is her right to express them. I do not believe that this committee is equipped to take the matter further. Fiona Hyslop has the right to refer it to the Standards Committee or the Procedures Committee, depending on what her concerns are. We should leave it to those committees to decide whether there is a prima facie case for an investigation and, if there is, to conduct that investigation. It is not part of our remit to do that.

To the best of my knowledge, there were no disclosures of the substance of this committee's work on the housing stock transfer report. I certainly saw none reported. All that was discussed was the general principle to which Fiona Hyslop's concerns related. There was no disclosure, oral or otherwise, of the substance or contents of the draft report. That remains the case today, as it has been throughout.

Fiona Hyslop has proposed that we proceed to the next item of business. I second that proposal.

Bill Aitken (Glasgow) (Con): A number of issues arise, but I will deal first with the allegations that have been made and the concerns that have been expressed.

If the convener is telling me that she did not have any dialogue with the Executive on the report, I am perfectly happy to accept that, just as I am perfectly happy to accept Alex Neil's statement that there was no leaking of the report's content. I would like us to operate on the basis of trust. If that trust breaks down, we will face a very serious situation.

Where I would criticise Fiona Hyslop is that my clear recollection of the meeting before last was that any textual amendments would be accepted. I would not have submitted textual amendments had I been under the impression that they would no longer be admitted. I can see how confusion has arisen, and that the manner in which the convener submitted her amendments—by the researcher operating on her behalf—could give rise to concern. However, I am happy to accept that there was no collusion with the Executive.

I would now like to direct our minds to the way forward, as I do not think that what has happened reflects terribly well on either the committee or the Parliament. I am not legally qualified to make a judgment on whether some of the comments that have been made were defamatory, but if this matter ever crossed the threshold of the Court of Session we would be laughed out of court on the ground that the law does not bother with trifles. I think that that is an established legal principle.

I suggest that it is time for us to unruffle our feathers and to get on with things. Housing stock transfer is an important issue. Every member of this committee has spent nine hard months taking a great deal of evidence and making a lot of constructive input. I did not agree with it all, but I respect the way in which it was made, after considerable effort. It is the people of Glasgow who are losing out because of this. What must they think, when they are living in appalling housing conditions and we are spending this much time dealing with a matter that, quite honestly, does not merit any attention? For heaven's sake, let us get on with things. We are not doing anybody any favours.

The Convener: I will draw matters to a close, as we do not want to overload this, but there are proposals that we need to deal with.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): I have a certain amount of sympathy with what Bill Aitken said. The work of this committee has been seriously undermined by the events of last week. Members will recall that at last week's meeting I proposed that we get on with the business and deal with the amendments that had been submitted. That was before the SNP walk-out. Some cynics among us might say—

Alex Neil: On a point of order, convener. It was not an SNP walk-out. That suggests that there was some group decision—[*Laughter.*] You can laugh, Margaret, but—

The Convener: The people who walked out just happened all to be members of the SNP.

Cathie Craigie: Well, I am happy to change—

Alex Neil: I am sorry—this is a point of order.

Unlike the Labour group, we have no pre-meetings. We acted as three individuals.

Cathie Craigie: I am happy to change what I said to "before the SNP members of the committee walked out", if that covers Alex's point.

I think that the conduct of those members and of the deputy convener in particular was childish and immature. We are here to get on with the business of running this committee, which includes the report on the housing stock transfer. That report is important not only to the people of Glasgow but to people throughout Scotland who want improvements in their housing stock. The people who gave evidence to this committee want things to move on quickly so that they know that their housing and the condition of their housing is secure for the future.

We are getting to the stage of playing with words. Clearly, the majority of members who met last week were very offended by the comments made at that meeting, particularly those made by Fiona Hyslop. They were also offended by the action that she took later in going public.

Today, the opportunity is before us for the statements that were made to be withdrawn and for an apology to be made to the convener. When the letter that was sent to the Presiding Officer was read out, members gasped at its contents. What it said was so unlike what we had agreed and unlike our understanding of the previous meeting. I ask Fiona to apologise so that we can move forward.

Alex Neil said that the SNP members of the committee had never had a meeting. I found that quite strange. I am happy to take that point further, but we all remember a previous meeting at which the SNP clearly took a line. I will say no more about that, but I repeat that I find it strange that the SNP members are sitting here today saying that they have never met as a group to discuss the housing stock transfer or any other issue. I find that unbelievable.

Mike Watson (Glasgow Cathcart) (Lab): There is not much to add, but I would like to make some suggestions. It is sad that we are in this position, which, as Bill Aitken said, is not an edifying spectacle for the committee or the Parliament. These things will happen from time to time—the point is how we deal with them and move on.

I have heard what Fiona Hyslop has said. It is clear that she is not going to issue an apology, which I have got to say to Fiona was due. She was wrong on the two basic points last week. The first point relates to the understanding of what we were to do with regard to amendments to the text of the report, as opposed to the recommendations. I think that every other member of the committee—I obviously cannot speak for Alex Neil and Lloyd Quinan—or at least a clear majority of members had no doubt in their minds about the purpose of last Wednesday's meeting.

The second point was that there had been some collusion, with Margaret or others doing the bidding of the Executive in submitting amendments. That is also quite simply wrong. Lloyd can talk about concerns versus allegations, but I was in the room. The way in which the matter was presented—even if only as concerns—very much gave the impression that allegations were being made, as did the content of the letter to Sir David Steel and Fiona's comments to the newspaper the next day. There is no point in going over that again, but what was said was much stronger than a concern. There was great anger in this committee when we heard the contents of Fiona's letter.

I think that we ought to move on. Fiona seemed to be saying that she accepted that Margaret Curran had not taken advice from anybody else, and that, if she had submitted amendments in her name on behalf of other people, that was done in good faith. That is an important point to place on the record. If that is not what Fiona is saying, it is important that she clarify that.

It would also be helpful if Fiona could confirm that she will not go to the Procedures Committee, which would just keep the matter going. I have not discussed this with anybody before the meeting: I say to Margaret, as convener, that if Fiona is clear enough in saying, "As I am not following through the concerns that I had as a result of what you said, convener, you could give an undertaking not to take legal advice," we could perhaps move forward on that basis and get on with the issues in hand. That is for the deputy convener and the convener to decide.

Karen Whitefield: All members of the Scottish National Party who sit on this committee failed to realise that we had to submit textual amendments by the deadline. If it had been one or two Labour members who had got that wrong, that would be fine, but every other committee member understood the requirement. These allegations—

Mr Quinan: What allegations?

The Convener: Lloyd, please let people speak. No interruptions, please—you will get your chance.

Karen Whitefield: The allegations—or concerns—are based on the fundamental point that the textual amendments that were submitted considerably altered the text of the committee's report. It is my understanding that those amendments had not been agreed and that it was for the committee to take a decision that morning on whether those amendments were to be agreed. Instead of being willing to take part in that debate

and to discuss the matters fully, the Scottish National Party members believed that they had lost the political debate and stormed out in a temper. I think that that was unfortunate and undermined the committee's work.

The deputy convener is taking the high moral ground by suggesting that the report has been put on the back burner and slowed down. The only person who has done that is Ms Hyslop, and she should take full responsibility for it.

13:30

The Convener: I call Lloyd Quinan, and I would then like to move to the proposals before us.

Mr Quinan: I again wish to put on record that, last week, when concerns about the source of some of the amendments to the committee report were expressed, that concept was rejected by the convener. At that point, Ms Whitefield intervened to tell us that some of the amendments in the convener's name were hers. I suggest that, if the convener had said at the beginning of the meeting that some of the amendments in her name were submitted on behalf of other members, that would have taken all the heat out of the situation.

I remind the committee that at no stage has any member stated that we believe that there was collusion with the Executive. That is an extrapolation of events by individual members. I make it clear—yet again—that we expressed concerns about the authorship of amendments to the report. Those concerns were confirmed when Karen Whitefield told us about amendments in Margaret Curran's name—that was before the convener told us that she had submitted amendments that she had not prepared herself. The concern was confirmed.

Mike Watson: The concern was about—

The Convener: I am now going to draw matters to a close. I am sure that members will agree that I have the right to make some statement in response to this discussion. I appreciate the climb-down, and the fact that we have moved from talking about allegations to talking about concerns. I notice the change of emphasis.

Mr Quinan: On a point of order, convener. Can someone tell me at what stage during last week's meeting anyone used the word "allegation"?

The Convener: We can go back and check that, Lloyd. Please do not interrupt me; do me the courtesy of letting me pursue this matter.

Mr Quinan: The key point is whether concerns were raised or allegations were made.

The Convener: I have to insist, Lloyd. I refer you to Mike Watson's contribution: this is about emphasis.

I ask members to show some decorum as to how we pursue this. I ask members to ensure that, in this instance and in all further instances, if they have any concerns whatever—be they concerns, allegations, questions or requests for clarification—they come to the committee meeting and stay long enough to ensure that we proceed with the relevant information.

I would never deny any member of the committee the right to raise any question whatever, whether I agreed with it or not. I see it as my duty to demand the right to ensure that all information is processed properly. Such matters have to be brought to the committee; it is not proper for members to express concerns, make allegations or raise question marks but not wait to hear the explanation.

Alex Neil: But this was brought to the committee.

The Convener: You walked out, Alex. Please do not interrupt me. That is not appropriate behaviour. People walked out; if they had stayed, they would have been reassured. There is a world of difference between seeking minor clarification and proceeding in the way that we did.

We have a number of decisions to take, and I wish to begin with my proposal—I am sure that you all appreciate why. A number of points have been clarified. I accept that and I am pleased that the points about what was not being said last week have been clarified.

Does the committee accept that there was no leak to the Executive? Is that agreed?

Members *indicated agreement.*

The Convener: Thank you. I now ask the committee to accept—

Robert Brown: Can we clarify whether that agreement was unanimous? Some people did not indicate one way or the other how they feel.

Fiona Hyslop: On a point of order. I moved a motion that the committee continue with the rest of the agenda. Could the clerks let us know how we can progress with that? That might mean moving a motion without notice to end this debate and proceed to the rest of the agenda. I am pursuing the matter through parliamentary procedures, and it is not appropriate for it to be discussed further in the committee.

I move,

That the committee move on to the next item on the agenda.

The Convener: Members are probably aware that I have been whispering to the clerk throughout the meeting because this procedure is new to us all. I am now advised that we can vote on whether

to move on to the rest of the agenda. Depending on the outcome of that vote, we can move on to my motion.

Let me get the wording of the motion right. It is proposed that we finish discussion of this matter and move on to the next item of business before we reach a decision. Who is in favour of that?

FOR

Hyslop, Fiona (Lothians) (SNP)
Neil, Alex (Central Scotland) (SNP)
Quinan, Mr Lloyd (West of Scotland) (SNP)

AGAINST

Aitken, Bill (Glasgow) (Con)
Brown, Robert (Glasgow) (LD)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
McAllion, Mr John (Dundee East) (Lab)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)

The Convener: The result of the division is: For 3, Against 8, Abstentions 0.

Motion disagreed to.

The Convener: Right. Thank you. The matter is clarified and it helps that it has been put in context.

I ask the committee to accept that there was no leak to the Executive.

Alex Neil: You should ask committee members whether they are for or against the motion, Margaret.

Robert Brown: On a point of order. I am slightly bemused by the fact that there is an issue about the matter being put before the Procedures Committee. Can Fiona Hyslop clarify what she suggests should be reported to the Procedures Committee?

The Convener: Okay. Before we move on, we will clarify that.

Fiona Hyslop: I said that I am using parliamentary procedures. David Steel's reply to me pointed out that I could refer the matter to the Standards Committee. The code of conduct says that we cannot discuss the matter as a committee, and that we must leave it to the process.

I suggest—and I made this quite clear at the beginning of the meeting—that it is not appropriate for the committee to continue discussion of the matter. That is why it would be appropriate to move on. We have a great deal of work to do, including work on the continuing drugs inquiry, and I am keen to get on with it. As I said, I am—I use the present tense—pursuing the matter.

The Convener: It is up to members to decide. That is not a committee view.

Mr Quinan: On a point of order. It would be inappropriate for the committee to vote on something that has simply not arisen in the committee. At no stage did any member say that there was collusion with the Executive. It is entirely inappropriate and out of order for us to vote on something that has not—to my knowledge—been said.

The Convener: I am advised that I can pursue the matter. The general commonsense understanding is that serious inferences and implications were made. I am asking the committee—

Mr Quinan: Can I make it clear, Margaret—

The Convener: No. Bear with me. [*Interruption.*] There is nothing in standing orders to prevent such resolutions being proposed.

Mr Quinan: If anybody voted against that motion, the implication of that action would be defamatory—that there was collusion with the Executive. The matter has neither arisen nor been debated in the committee while I have been present. People can only extrapolate and arrive at their own interpretations of an expression of concern, which at no stage used the words "Executive" or "collusion". How can I vote on that—I would be making a statement on something that I have not said—when there is to be an investigation?

The Convener: You are being very obstructive, Lloyd. It seems to be abundantly clear to the other members of this committee and to the rest of the world what Fiona Hyslop meant when she said on the BBC's "Holyrood Live" programme, "I am very suspicious about the source of these amendments." The headline of that report was "alleged Executive collusion". If you are backing off from what you said, you should have said that to "Holyrood Live". If that was a misinterpretation—

Mr Quinan: We never said that in the first place.

The Convener: I am moving ahead.

Mr Quinan: I am not a reporter for BBC Scotland, Margaret.

The Convener: The implications are very clear. The inference of what was being said was clear. I was named. I ask members to give me their vote of confidence that I absolutely did not collude with any members of the Executive or, indeed, with anybody else outside the committee. I ask the committee for its endorsement of that.

If members believe that that is the case, all that they have to do is vote for that. It means nothing more than that. It does not mean that they were a party to the inference; it just means that today, for the record, they accept that there has been no collusion with the Executive. That is categorical.

We move now to a roll-call vote on whether members accept that there was no leak to the Executive.

FOR

Aitken, Bill (Glasgow) (Con)
Brown, Robert (Glasgow) (LD)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
McAllion, Mr John (Dundee East) (Lab)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)

ABSTENTIONS

Hyslop, Fiona (Lothians) (SNP)
Neil, Alex (Central Scotland) (SNP)
Quinan, Mr Lloyd (West of Scotland) (SNP)

The Convener: The result of the division is: For 8, Against 0, Abstentions 3.

Can the committee accept the explanations of the procedures that have been outlined to clarify the confusion? Are we agreed?

Alex Neil: Could you repeat the detailed proposal, Margaret?

The Convener: The proposal is that the committee accepts that this is an explanation as to why confusion arose over the explanation that I gave in my paper. That is it.

Mr Quinan: That what is an explanation?

The Convener: The text of what I gave.

Bill Aitken: Regarding—

The Convener: Regarding why they tried—

Mr Quinan: Could I have a hard copy of it, please, so that I can read through it properly?

The Convener: Do you want me to read it again?

Mr Quinan: I have heard the statement only once. I request a hard copy of it, so that I can read it in detail.

The Convener: No. I am not deferring the matter. I will read the statement out again, if that is what members want. I think that members are clear about what was said, but I will read it out again. This is ridiculous.

In light of the events of last week, I wish to make the following statement to the committee. Given the very serious nature of the allegations against me, I trust that the committee will allow me to give the facts uninterrupted.

The actions of certain members of the committee were extremely grave and highly regrettable. Their allegations are serious and can be rebutted completely and unequivocally.

I will not repeat the point about collusion with the Executive, as we have dealt with that. The matter is more about the details of the amendments and the procedures of the committee concerning amendments to the text. We need to get on the record that that was what the committee agreed.

The deputy convener alleges that evidence was altered. Again, that is a very serious charge, which might also constitute defamation. Evidence to the committee cannot be altered. It is a matter of public record. How that evidence is interpreted is a matter for the committee.

It was agreed at a previous meeting that the report would have to accept some arguments and reject others. It was further agreed that when we rejected some of the recommendations that were presented to us, we would have to change the supporting text.

If I am going too quickly, slow me down.

Let me make it absolutely and emphatically clear that all members of the committee have the right to propose any change to any document that is produced in the committee's name.

The deputy convener also states that the report was to be consensual. That contravenes an earlier decision of the committee when it was clearly accepted that consensus could not be reached on the major issues and that the report would reflect the majority view, indicating where disagreement took place. The deputy convener also stated that the draft report was balanced. That is her view, not the view of the committee. I did not agree that the report was balanced. I raised that point with the writer and the clerks some time ago, which can be confirmed. I was advised that I could propose changes to the text at the appropriate time. I have considered the matter over some time and was therefore well prepared for this stage of amendment. The deputy convener also stated that it was agreed that any amendments to the text would be minor. That is categorically not the case. I refer members to the e-mail that was sent by the clerks on Thursday 15 June.

I wish to explain the details of the specific circumstances of my amendments. I appreciate members' earlier comments that there is no necessity to do this, but I am sure that everyone will understand my desire to establish the facts. I had a number of amendments to submit. Karen Whitefield contacted me to say that her computer was down and, as neither of us would be around on Friday, asked how we could deal with the situation. I phoned the clerk to ask whether a researcher could submit amendments for us. The clerk was very clear that that was perfectly appropriate procedure. The researcher also collected Cathie Craigie's amendments and lodged them, informing the Scottish Parliament information centre that the amendments were from a number of Labour members, but that he had

authorisation to submit them in my name only. I had no substantial difficulty with the amendments that were being lodged, so I let matters proceed. I must say that the most cursory inquiry would have established those facts.

The rest is commentary.

Fiona Hyslop: Are we being asked to endorse the content of that statement? I suggested textual changes to the report at the last minute, as I knew that we were able to do that. I agree with much of what Margaret has said, but there is much that I disagree with—not least her interpretation of things that I have done or said. I would therefore find it difficult to take a position on the matter.

I do not agree with much of what is in that statement. Are we being asked to vote to endorse the statement? What exactly are we being asked to endorse?

The Convener: I have been getting advice from the clerks, as I genuinely do not want to make things difficult for the committee or to cause any more delay than is necessary. I shall therefore amend my proposal to ask that the committee accept the procedures as I have summarised them, first in terms of the requirements to submit amendments and secondly in terms of our conduct of the report. Can that be agreed?

Alex Neil: No. That is too vague.

13:45

The Convener: Hang on a minute. I want to hear from Robert Brown.

Robert Brown: I have a suggestion. I think that it is probably not helpful to ask us to endorse a long statement that has a lot of things in it.

The Convener: I can see that.

Robert Brown: There are, essentially, two points at issue. You have explained the circumstances in which Karen Whitefield's amendments and your amendments were submitted in your name, convener. That should simply be noted, as that is not the ultimate issue for the committee.

You have also given an explanation that accords, as I understand it, with the recollection of the majority of the committee, about the basis on which textual amendments to the report were submitted. That explanation should be endorsed—it is probably borne out by the clerk's record anyway. I certainly recall making a number of observations about my dissatisfaction with the terms of the original report before it came to committee and before any member had had input into the way in which it was drafted by the committee's advisers and the clerk. I expressly reserved my right to submit detailed textual amendments as, if I remember correctly, one or two other members did.

The essence of the matter is that it was open to members to lodge such amendments following agreement of the recommendations. That is the essential point that we should be agreeing to as far as procedure is concerned.

The Convener: That is helpful. I shall withdraw my amendment in favour of that one. Thank you, Robert.

Mr Quinan: Again I refer to the use of the word allegation. No allegations were made, and Robert Brown, as a lawyer, should know better than to use the word. I do not know what schools you all went to, but an allegation and a concern are radically different.

The Convener: I think that you have made your point, Lloyd.

Alex Neil: I do not think that there was any dispute about the process in terms of being able to submit textual amendments to the draft report. However, the scale and substance of all the amendments that were submitted in Margaret Curran's name changed the substance of the report. I understood that, at that late stage, we would not be changing the substance of the report to such an extent.

The Convener: Here we go, Alex. That is what we have to clarify.

Karen Whitefield: I do not want to prolong the matter any more than is necessary, but we must be careful, because some members of the committee are trying to airbrush history. I clearly remember what was said last Wednesday morning—Fiona Hyslop clearly stated that she did not believe that textual amendments could be lodged at that point. Everybody on the committee confirmed that our clear understanding was that textual amendments had to be submitted before 1 pm on Friday.

Everybody at the committee agreed that, apart from the three SNP members who chose to walk out. They chose not to be mature enough to sit and discuss the matter behind closed doors, but chose instead to take the matter to the press. We must be careful about what we are discussing to ensure that history is not rewritten because, all of a sudden, one party is on the political back burner.

Mr Quinan: Who wrote that for you?

The Convener: Allow me to clarify something for the record. In the text of the letter to the Presiding Officer, the deputy convener said that she understood that only minor alterations to the report would be allowed. I am saying categorically today that that was wrong.

Cathie Craigie: I agree with what the convener

has said. As the meeting is being held in public, let me make it clear that the textual amendments that we were considering before the SNP walk-out last week had not been agreed by the committee, but were there for the committee to agree or disagree to.

The Convener: Thank you, Cathie.

Bill Aitken: The matter can be dealt with quite simply by including in the text of your motion the paragraph that begins,

"As to the specific circumstances",

and ends, "establish the facts." That deals with the problem and gives an explanation of how the amendments were handled, which I am perfectly happy to accept.

The Convener: There is clearly a disagreement about the scale of the amendments. I am trying to get the committee to acknowledge that people were free to submit any amendments that they wanted. There was no limit on the length of amendments—none whatsoever. The committee had not agreed at any time that we would make only minor amendments. That is what I am trying to establish.

I am also trying to establish the fact that we had taken no view that the report was balanced and no view that it should be consensual. That is all that I am trying to get on the record, folks. I appreciate that members may not want to endorse a long and detailed statement, but I propose that that was the view of the committee.

I appreciate that some members have a different understanding of the facts and may not want to agree to that view, but it is my job to ensure that the committee view is established. Let me see those who support that.

Mr Quinan: Support what?

The Convener: Let me make it very clear that I am moving a motion that says that, to date, the committee's view has been that our deliberations on the housing stock transfer and our amendments to the report indicated, first, that we had taken no view that the report was balanced and that amendments, where required, could be of any length. Secondly, the report indicated that we had taken a view that the report need not be consensual where it did not have to be. When the clerk has written down those words, I shall read them back to you. I appreciate that there may be disagreement about that, but I must establish that for the record.

Fiona Hyslop: I submitted textual amendments by the 1 pm deadline—I was quite aware of the process and the deadline. I do not know that we had a discussion to specify an acceptable length for amendments. However, I was aware that we charged individual members of the committee with consideration of specific areas. I considered the areas about which I had raised concerns and I know that other people considered amendments to the bits of the report that they had raised concerns about.

There must be questions about the rules for conducting reports, given the sheer volume, content and nature of the report that the committee should be signing off today. It is clear that the role of the convener is to ensure that there is no division where there need not be any. We should certainly not have only three working days to sign off a report when amendments have been submitted that could change a huge volume of the text. I have not gone through which of the amendments have been agreed to and which have not, but my concerns make me think that we need to consider the matter further—but not in this meeting. The time that we are spending—

The Convener: I think that you have made that point, Fiona.

Fiona Hyslop: I moved my motion. We should be getting on with our agenda instead of having this discussion.

The Convener: You were defeated on that, Fiona. Sometimes you must bear with the majority view of the committee.

It is clear to me that there was no limit. Nobody on the committee is prescribed in terms of how they view a text that is presented to them. As full members of the committee, everybody has the right to comment.

I want to move on and agree procedures and get the matter settled.

Robert Brown: There is a further point that has not emerged so far. The committee had not considered the text. We went expressly to the recommendations and dealt with them first of all. Some of the recommendations had major implications for the text and it was agreed that we would come back to the text once we had agreed the framework as laid down by the recommendations.

To be honest, I am somewhat at a loss to understand what is left of Fiona Hyslop's concerns, allegations or whatever after the way in which our conversation has moved today. I cannot identify anything in all of this that Fiona is still concerned about. I am left in considerable misunderstanding as to what on earth she was going on about when she stormed out of the previous meeting.

The Convener: Thanks to the clerks, I now have a new form of words. I therefore propose that the following is the view of the committee and I move,

"That the committee had taken no view that the report would be balanced; that there was no restriction on the size of the texts of amendments; and that the report need not be consensual."

Does the committee endorse that view? Let me see a show of hands for those who agree that that was how we conducted our proceedings, and then a show of hands for all those who disagree.

FOR

Aitken, Bill (Glasgow) (Con)
Brown, Robert (Glasgow) (LD)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
McAllion, Mr John (Dundee East) (Lab)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)

AGAINST

Hyslop, Fiona (Lothians) (SNP)
Neil, Alex (Central Scotland) (SNP)
Quinan, Mr Lloyd (West of Scotland) (SNP)

The Convener: The result of the division is: For 8, Against 3, Abstentions 0.

Motion agreed to.

The Convener: We now move on to the third motion.

I move,

That the committee agrees that we pursue our work as planned and that we agree to schedule an extra meeting to ensure publication of the report as soon as possible.

Are we all agreed?

Members *indicated agreement.*

The Convener: Can we move on?

Fiona Hyslop: May I ask that the committee agree that a minority report can be produced? My understanding of the information from the clerks is that if there is a majority view—

The Convener: Hang on, is there a point of order?

Cathie Craigie: Before we move on to the next item of business, convener, I want to raise something. The whole process since last Wednesday has brought the committee into disrepute. We wasted an hour last week discussing procedures and we have wasted an hour of valuable time today. Is there a parliamentary procedure to deal with members who negate their responsibility and walk out of a committee?

The Convener: I will refer that to the clerks so that we do not take up time now. I have just had advice from the clerks on Fiona Hyslop's point about minority reports. We will have to defer that to the private session, when we will consider how to take forward the details of the housing stock transfer report.

Mr Raffan: I do not want to prolong the discussion, but I agree with Cathie Craigie that the situation—or the behaviour of one particular member—has brought the committee into disrepute. I would therefore be grateful if the clerk could advise the committee, first, whether the behaviour of that member and the allegations that were made—I believe that they were allegations—can be referred to the Standards Committee and, secondly, whether we can move a motion of no confidence in the deputy convener at the next meeting.

The Convener: That is a matter for you to pursue, Keith. I ask you to speak to the clerks about that separately.

Can we move on? I ask members to agree that the additional meeting be held on Wednesday in private.

Mike Watson: I do not agree, but I am, no doubt, in the minority. I spoke to Mary Dinsdale three weeks ago when no meeting had been scheduled. Based on that discussion, I arranged to attend a school prizegiving in my constituency, which I am not prepared to call off at two days' notice. I am very unhappy, because this means that I will be unable to be present when my amendments to the report are being dealt with. It is not right to organise meetings at two days' notice and expect that members are all hanging around with a free morning to fill.

Alex Neil: May I introduce a note of consensus by agreeing with that? There is a clear need for an additional meeting.

Mike Watson: I agree.

Alex Neil: Indeed, there may be a need for more than one additional meeting. However, given that we have all filled our diaries, it is totally unrealistic to organise the additional meeting for Wednesday morning. The clerks should try to fix a new date, which is acceptable to most members of the committee.

Mike Watson: Can I say—

The Convener: Sorry, Mike. I am taking advice from the clerks.

I will get in touch with members. We always want to ensure maximum attendance. Believe me, the clerks and I go out of our way to do that. I am sure that everyone—no matter what their politics are—agrees that we try genuinely to ensure that everyone gets to the committee's meetings. The behaviour last week has delayed us by one week. It is most regrettable. I am sorry that it has happened, but I am determined that we push ahead with the housing stock transfer report and get it out. Members will have to accept that there will be pressure on their diaries. I ask members to prioritise the report. I appreciate that members

have commitments. My children are most annoyed, because the situation may well mean extra time in my diary—I ask members to bear that in mind. Leave it to the clerks and me. We will do our very best to ensure that members can attend meetings.

Alex Neil: Convener—

The Convener: I want to move on because of the time.

Alex Neil: I want to clarify whether that means that we do not have a meeting on Wednesday morning.

The Convener: No, it does not mean that. It means that we will go round members and see who can attend and what the circumstances are. The circumstances last week were outwith our control. We have to act. It is not right that the committee should be punished for that.

Robert Brown: With great respect, we cannot leave the question of whether or not we are meeting on Wednesday. That is two days hence.

The Convener: Okay. I was trying to see whether there was any possible way that we could meet on that day, if Mike Watson could make it to a later meeting.

Robert Brown: I accept the problem. As it happens, Wednesday would have suited me, but if it does not suit others, it is short notice.

Alex Neil: I think that—

The Convener: Hang on a second. I am getting advice from the clerk.

I wanted to see whether we could negotiate around Mike Watson's commitment, depending on what time it is at. I think that we should always negotiate where possible to suit members of the committee. However, we need another meeting this week.

Mike Watson: Can I say—

The Convener: Mike, I have to say for the record that every member of the Parliament was told that Wednesday would be a full chamber day—that is why our committee is meeting today and not on Wednesday—so your presence in Edinburgh would have been expected. I imagine, therefore, that a number of members have not made too many commitments. That is why we want to programme the additional meeting for then. I appreciate Robert Brown's point about it being short notice, but we are left with a situation that must be dealt with. It is very difficult. If the committee wants to press a decision now, I will propose that we go ahead and meet on Wednesday.

Mike Watson: I accept that I am in a minority position. I just wanted to record the fact that it is very short notice.

The Convener: I apologise to members of the committee.

Mike Watson: Are we allowed to meet at the same time as Parliament?

The Convener: It turns out that the Parliament is not meeting, but the Parliamentary Bureau had blocked the time off in case there was an overspill of business.

We need to agree that Wednesday's meeting will be held in private. Is that agreed?

Members *indicated agreement.*

The Convener: We need to agree to take the items under item 2 on the agenda in private at the meeting on 4 July. I therefore suggest that the agreement of questions to the minister on the inquiry into drug misuse and deprived communities, the committee's general forward work programme, the forward work programme for the inquiry into drug misuse and deprived communities and the committee's annual report be taken in private. Is that agreed?

Members *indicated agreement.*

We now move into private session to consider the Transport (Scotland) Bill.

14:00

Meeting continued in private.

14:15

Meeting resumed in public.

Drugs Inquiry

The Convener: I welcome Chris Spry, chair of the greater Glasgow drug action team. I apologise sincerely for keeping you waiting—we had matters to deal with. Mr Spry and the DAT staff have been very helpful in assisting us with the inquiry and our visits and we much appreciate their co-operation and advice.

Chris Spry (Greater Glasgow Drug Action Team): I am chief executive of Greater Glasgow Health Board and have chaired the greater Glasgow drug action team since February 1997. The drug action team is probably the single most difficult thing that I do, and I spend more of my time on it than on any other issue I deal with—although I do not spend enough time on it.

Drug action teams are difficult entities, but if they did not exist they would have to be invented. Wherever you draw the organisational lines, you have interfaces, overlaps and gaps that must be addressed. If a single agency was trying to provide specialist services, prevention and so on, you would still need to deal with the lines between different agencies—between social work and education, social work and primary care, primary care and mental health, and so on. So I think drug action teams are crucial, but it is difficult to make them work well.

Why is that? As the evidence that the committee has taken over the past few weeks has revealed, this is one of those truly wicked problems. It is complicated and difficult to understand, and every time we think that we are getting somewhere and understanding some dimension of it, we realise that it has changed, or that we have peeled another layer off the onion and it looks rather different. Understanding the scale and the nature of the problems is a major difficulty. At the end of drug action team meetings, I am usually pretty intellectually exhausted by the difficulty of what we have been grappling with. That is partly a result of trying to understand the scale and nature of the problem.

There are huge gaps in our knowledge of what works, especially in education and prevention but also in relation to the effectiveness of detox and rehab regimes. There are big tensions between trying to offer a strategic response to the problem, which is connected in all sorts of ways with other issues of social exclusion and so on, and dealing with the crisis situation that we face today.

Making effective links between agencies is difficult, as they have different budget cycles and different decision-making mechanisms. There is a plethora of initiatives and programmes, and we are bedevilled by short-term funding. The fact that money comes forward in dribs and drabs and in unco-ordinated ways makes it difficult to put together a long-range plan that we can be confident of unfolding over a particular time scale. Instead, things happen in bursts—when a bit of money comes into the system, everyone is galvanised into trying to use it, but because the funding is often short term, we are nervous about doing things that will fall about our ears in three years' time. There are also different degrees of corporate and top-level commitment from the agencies involved. It is difficult to make effective links between agencies, because different agencies have different cultures.

It is necessary to sustain energy in peeling away the layers of the onion. We never get to the point of thinking that we are on top of the problem and that all we have to do is carry on as we are. We have to keep at it, and not feel that it is all just too much and racing away from us.

Two years ago, when I had been chairing the greater Glasgow DAT for a year, we were still preoccupied with working through the complexities of a DAT on which the health board, the police and several local authorities were represented. We were trying to work out how to get the balance right between different local authorities, how to make effective links with councillors and so on. We had the option of going down the path that has been gone down in several other parts of Scotland and setting up separate drug action teams for each local authority area. We were also grappling with the rather sterile politics of harm reduction versus abstinence, which was absorbing a lot of the energy of DAT members.

Now our preoccupation is training and employment, which is a massive issue. It is clear to us that rehabilitation will be difficult to achieve as long as finding training and employment opportunities for users is so difficult. We are also grappling with the tension between long-term and short-term approaches.

We are beginning to address issues of equity of access to services. We want to create synergies with social inclusion partnerships and encourage through-care with prisons. Issues remain about security of funding: too many of our services are reliant on short-term funding and are uneasily aware that, when that funding drops out, either the health board or the council will have a problem about how to sustain services. We are dealing with a much bigger set of issues than seemed to be the case two years ago. The DAT is much more sophisticated than it was and deals with more interlocking issues. Collectively, we are more conscious of how difficult the challenges are.

The Convener: Thank you; that was interesting.

We are getting a lot of evidence—from your organisation and from our visits—that shows that the scale of the problem is changing. I want to explore the impact of the increased use of heroin. We have an interest in deprivation issues and are examining the effect of heroin use on social inclusion issues.

What is happening in communities? What is the scale of the problem?

Chris Spry: I am not an expert on patterns of drug usage. My contribution to the DAT is in driving forward the group of agencies as one. I do not sit in the chair pretending to be the world's greatest expert on drugs. I might not give you a reliable answer.

The Convener: I am asking about the DAT's view as much as about the detail. Is heroin the major problem?

Chris Spry: Undoubtedly. Heroin is the major problem by a mile. It is usually used in conjunction with drugs such as temazepam and diazepam, and is implicated in the most serious of drug problems. The DAT is focused on heroin, in terms of treatment. We are not conscious yet of having to deal with problems arising from cocaine. Cannabis gets dealt with on the educational side—we try to encourage young children not to get into addictive behaviour.

We are aware that many communities feel that enough is enough and that they want to take action, but are not sure what action to take. We know that they are frustrated with the system and doubt the ability of the criminal justice system, social work, primary care and so on to respond appropriately. The DAT has put a lot of work into building links with local communities.

The Convener: I want to pursue that point. There seems to be a mismatch between the expectations of the communities and the expectations of the services as to how the issues can be resolved. There have been debates around the location of needle exchanges and so on. How does the DAT communicate with communities that are struggling, and gain an understanding of what they are experiencing? How can we develop services in the face of community opposition?

Chris Spry: We have tended to work through local drugs forums, but—because of Glasgow's size—there are a lot of them. Some issues need additional support—from me, or from a senior person in the police. For example, we did a lot of work on that recent problem in Cranhill. We have had meetings in the Gorbals recently to deal with people's concerns about drug users congregating around chemists shops and so on.

We are conscious that there is a growing cohort of drug users—people are coming on to drugs and having a drug problem much faster than we can get them off. The natural history of addiction is measured in decades rather than years. That growing cohort means that it is difficult to deal with people where they live in ways that are socially unobtrusive, if you know what I mean.

The Convener: Yes.

Chris Spry: That is a problem for us, and we are not sure that we know quite how to handle it. We are worried about the burden on chemists shops and the impact on shopping areas. We will have to think of different ways of handling that.

14:30

The Convener: I understand that the methadone programme in Glasgow has attracted praise and is regarded throughout the country as successful. Some people strongly support the methadone programme, but some general practitioners are quite resistant. How big is the resistance, and how do you deal with it?

Chris Spry: I am not sure that it is resistance; it is more a reluctance to get involved.

The Convener: Do GPs have that privilege these days?

Chris Spry: Yes, they do. Taking part in the methadone programme imposes certain duties on GPs in terms of record keeping, providing us with data, and working with social work services to provide additional counselling support for the drug users. GPs are specially remunerated for their participation in the methadone programme, so it is not seen as part of their normal contract. But do not get me on to GP contracts, or we will be here all afternoon.

Participation in methadone programmes is voluntary. Many GPs regard dealing with difficult users as burdensome—some even find it threatening—and therefore choose not to take part. That is another problem that we face.

The Convener: What can you do about that problem? What are your options?

Chris Spry: One option is to continue with local encouragement. Another is to work with local health care co-operatives—we may be able to develop a plan with a co-op, whereas we may not be able to do so with a particular practice. Another option is to review the remuneration package for GPs. Those are the sorts of levers that we have, but options are limited.

We have been strengthening mental health services for drug users. GPs often have problems with the turbulent drug user who is very difficult to deal with. Sometimes, there is an undercurrent of violence, which can be associated with a mental

illness. By strengthening mental illness services for drug users, we may be able to help to ease some of the burden that GPs feel when they are one-to-one with a turbulent drug user in their surgery.

Karen Whitefield: We have had similar problems with getting GPs involved in Lanarkshire. How do you support GPs? Having spoken to some of them, I get the impression that they sometimes feel that they are isolated and lack support. Does the DAT have a role in supporting, training and providing back-up for GPs who are working on the methadone programme?

Chris Spry: I have mentioned some of the back-up that GPs find helpful—for example, the quality of the mental health services that focus on people with addictions. It is also important to ensure that the pharmacies provide good support in the dispensing of methadone. It is not just a case of the user going in, swallowing the stuff, and then going off: a high-quality pharmacy service will provide rather more support than that to the user.

Counselling support through the social work services is also important, but it is an area of weakness. That is not in any way a criticism of social work services, but such counselling is very resource intensive, and departments find it difficult to stretch their resources to provide a level of counselling support to GPs that is commensurate with the number of users that they might have on their books. That is a stress area, and we want to improve the counselling support that is available to people who are on the methadone programme.

Alex Neil: We have heard contradictory evidence about the scale of the problem in Glasgow. The Scottish Executive estimated that the drug problem in Glasgow probably affected about 12,500 to 13,000 drug misusers. However, when the Glasgow Association for Family Support Groups gave evidence, it put the figure at nearer 20,000, which is much higher. Does the DAT have a view on the scale of the problem in Glasgow? Is the figure nearer 20,000 or 12,000?

Chris Spry: The figure that you were quoted by the Glasgow Association for Family Support Groups is based on work done by Glasgow City Council, which is part of the DAT. As you probably know, the council added together a variety of data sources, asking, "What is this telling us?" It came up with a range of between 12,500 and 15,000 injecting drug users. The two sets of figures are probably not inconsistent, as I suspect that the council's figures, which were based on people who accessed services such as needle exchanges and so on, missed drug users who do not inject.

I suspect that the figure for problematic drug users is rather greater than 15,000, which was the council's estimate. You must remember that the last time that prevalence was measured in Glasgow, the figure was 5,000 to 8,000. Therefore, we revised our estimates upwards, and it is likely that those figures will continue to rise for some time.

Alex Neil: When we visited Aberdeen to take evidence, nearly everyone we met said that the drugs problem in Aberdeen is now of crisis proportions. At the other end of the spectrum, we went to Cumnock, where one estimate was that up to 30 per cent of the population of Cumnock, which is a fairly small town in comparison with Glasgow, were involved in some form of drug misuse. Proportionally, how does Glasgow compare to that? Is Glasgow in crisis like Aberdeen? Is the proportion of drug misusers anything like 25 or 30 per cent?

Chris Spry: I hesitate to get involved in measuring the problem in numbers that are a bit squishy and soft. However, I think that there is a crisis. There is plenty of evidence that whole communities are being torn apart by the drug problem, that quite a large number of young people are experimenting with drugs and that people from the most deprived areas get into terrible problems with drugs.

Members will have seen the data that shows that there is a thirtyfold difference in hospital admissions related to drug misuse associated with people from deprivation category 7 compared with people from deprivation category 1. The problem is of major proportions. Over the past year or so, the DAT has felt that the problem is in danger of running away from us.

Alex Neil: What needs to be done? If there is a crisis, are the resources that are available to DATs and the plethora, as you described them, of agencies anything like on the scale that would be required to deal with that crisis?

Chris Spry: No; not at all.

Alex Neil: You mentioned both the availability of resources and the multitude of funding programmes, many of which are short term, which makes it difficult to plan ahead and so on. Given the numbers, if we accept that there is a crisis, what needs to be done as a matter of urgency to address the scale of funding available and to make that funding more effective?

Chris Spry: It is hard to size it. For example, last year, the Scottish Executive put an additional £500,000 in drug treatment services. In Glasgow, the health board and the local authorities agreed an additional, matched funding supplement. Ultimately, we were able to commission £1 million-worth of additional services.

Alex Neil: Is that a drop in the ocean if the problem is running away from you?

Chris Spry: Yes. You have probably heard the details from other witnesses. Included in that £1 million was money for our first go at a comprehensive service to be based in Easterhouse. That service is expensive; I cannot remember the precise figure, but it is more than £300,000. Services such as that are needed in Drumchapel, in the Gorbals, in Pollok, and so on. That £300,000 will have to be multiplied several times to get a range of services going. In the meantime, there is the exponential cost of the methadone programme.

Alex Neil: Are we losing the drugs war?

Chris Spry: We ain't doing too well. I do not believe one should talk of having lost it, because that would be the counsel of despair, but we ain't doing well. However, we are trying very hard.

There is a tension between short-term and long-term aims. Most of the things that I have talked about relate to the short term, and there is a danger that we chase our tail in the short term and therefore do not do enough about long-term prevention. If we get certain things right—the social inclusion partnerships, the community schools, and the Starting Well project for children, for example—that will start to pay dividends, but it will take 10 or 12 years to see the evidence of that. We have to have the courage to stick with those things. Unfortunately, we still have today's casualties, and they are difficult to deal with. When I say that I think things are running away from us, I am thinking about today's casualties and feeling pretty desperate about them. I am rather more hopeful about the longer term, because there are a lot of resources for tackling the strategic issues. Art will be required to weave the short-term and long-term projects together to make them all effective.

Alex Neil: With the establishment of the Scottish Drug Enforcement Agency, additional funding of between £10 million and £13 million is being made available on the enforcement side. Do you think that that is money well spent; or would it have been better spent on prevention, education and treatment?

Chris Spry: I do not know. The jury is out on the effectiveness of the DEA because it has been set up only recently. There is no doubt that, for the public, the supply of drugs and the way in which the criminal justice system deals with suppliers are major issues. If the DEA can help us all to make progress on those issues, the public will regard that as a great benefit.

The Convener: Keith Raffan is champing at the bit, but we will hear John McAllion first.

Mr McAllion: The submission from Greater Glasgow Health Board indicated that the methadone programme was introduced in 1994, and that between 1995 and 1997 there was a fall in deaths related to drug misuse. Recorded property crime related to drug misuse also fell steadily throughout that period. However, post-1997 there was a sudden upsurge in drug-related deaths, which reached its peak in 1999. Did a new phenomenon take place post-1997—apart from your taking over as the chairman of the DAT? Did something happen on the ground? Did heroin become cheaper? What happened to turn the figures around?

Chris Spry: With the benefit of hindsight, we can see that the fall in drug-related deaths in 1997 was almost certainly due to a shortage in the supply of temazepam. Prior to 1997, it was available in gel form, but the regulations were changed. That meant that it was no longer available in gel form and, as a result, much more difficult for users to access. The black market has now resumed that supply. A lot of drug deaths are from heroin but are related to temazepam.

Mr McAllion: So, the methadone programme itself is not necessarily cutting the number of deaths from drug misuse?

Chris Spry: I think that it probably is, because it means that there are many fewer chaotic drug users. The people who are most susceptible to drug-related deaths are the chaotic drug users and those who have been on drugs for so long that they have hit rock bottom; at that point, the despair of their predicament becomes overwhelming. Those are two distinct groups. In the natural cycle of drug addiction, it can take 10 to 12 years for someone to reach rock bottom. At that point, there is a tendency for addicts to commit suicide. The other group—the chaotic drug users—is younger and comprises people whose habit is out of control.

14:45

Mr McAllion: I was interested in your comments about the gaps in knowledge of what works in prevention—detox, rehab and so on. That is something else that we have picked up in our visits throughout the country. Do you agree with others who have given evidence to the committee that there is insufficient research into what works and that more of the drugs budget should be spent on research to find out what is effective instead of on fighting forest fires all the time?

Chris Spry: Absolutely. Part of our DAT strategy, before the latest national initiative was launched to improve the level of national research, was to create a research programme to fill those gaps in knowledge. We felt that, in the absence of that research, we should set up our own research programme. We estimated that if we could create a recurrent fund of about £100,000 a year, our

DAT would be able to sustain a reasonable research programme.

It is interesting that although the health board decided to put money on the table to help get that going, other local authorities put no money or very small amounts on the table. The police also were unable to put any money on the table. The argument was either that they did not have the money or, more important for the purposes of this discussion, that priority had to be given to treatment—the crisis of today—rather than to research. That encapsulates the situation.

Mr McAllion: Has the Scottish Executive said whether it is prepared to help fund that research?

Chris Spry: Yes. The national research programme has recently been enhanced.

Mr McAllion: What about research by local DATs?

Chris Spry: No. Not that I am aware of.

The Convener: We must move on.

Mr Raffan: In the submission from Greater Glasgow Health Board, the main indicator of improvement is recorded property crime. Dr Laurence Gruer said that in Glasgow alone, shoplifting and burglary to finance people's drug habits costs the community £190 million a year. Do you agree with that figure?

Chris Spry: Yes, but that figure was based on the lower level of prevalence that we were working on until fairly recently. It was an extrapolation from a survey of a cohort of users. If the number of people in Glasgow who have a drug problem is greater than we originally thought, the crime levels are, accordingly, likely to be higher.

Mr Raffan: You replied very tactfully and diplomatically to Alex Neil when he asked you about the DEA and the emphasis on enforcement. It must be pretty galling for you that the Greater Glasgow Health Board's submission states:

"Ring-fenced Scottish Executive drug misuse funding has not been linked to inflation resulting in drug misuse services effectively getting an annual cut in funding."

The problem is getting worse and you are facing an annual cut in funding, yet the Scottish Executive managed to find £10.5 million to set up the Scottish Drug Enforcement Agency.

Chris Spry: I recall from my conversations with the police that some of that money came from the existing envelope of police resourcing and was not wholly new money.

Mr Raffan: The Executive would not agree.

Chris Spry: I am not an expert on that.

Bill Aitken: Astonishing.

The Convener: Let us not interrupt the witness. It is bad enough when we interrupt one another.

Chris Spry: There seems to be a growing realisation in the Executive that more money needs to be provided and that the funding streams need to be more robust in the future. It seems to have a problem connecting appraisal of the situation with what comes out of the allocation process. I suspect that that will get better and that this is part of a learning exercise within the Scottish Executive.

You mentioned the lack of inflation uplift, which is galling because there is neither rhyme nor reason for its being cut out of the normal funding conventions that apply.

Mr Raffan: In *The Economist* last Friday, there was an interesting piece about cocaine. What it said applies to heroin, as Colombia produces much more heroin because it is more profitable. There is such a huge dividend for those who are engaged in the drug trade that it is difficult to cut supply, taking into consideration the cost of heroin in Colombia, the cost when it reaches the Caribbean and the street prices in New York or here. More emphasis should be placed on cutting demand.

You agreed that current funding is a drop in the ocean and that we do not have sufficient facilities. Margaret Curran and I went to the Glasgow Drug Crisis Centre, where the number of beds is utterly inadequate. There is insufficient provision of residential rehabilitation services, aftercare, through-care or halfway houses. As you said, we are trying to put out an inferno with only one hose.

Chris Spry: Yes, sometimes it feels like that.

The Convener: I will move on, as we have a lot of questions.

Cathie Craigie: I agree with Chris Spry that enforcement and supply are major issues for communities, and for poorer communities in particular. It seems that people who live in the area know the dealers and people who work to support addicts know who the dealers are. The only people who cannot do anything—either because they do not know who the dealers are or because they do not have the powers to act—are the police. Perhaps we should give more powers to the police or change the law. Do you have any suggestions that would allow the enforcement agencies to tackle the suppliers?

Chris Spry: When I joined the DAT and got involved in this for the first time, I was struck at just how positive, active and co-operative the police were. The more I hear about the problem, the more it seems to be a product of that intrinsic dilemma in our criminal justice system that one is innocent until proven guilty. The process of people

coming to court takes time and if people who have been sentenced go back into the community, too often they revert to dealing. That is a huge frustration for local residents.

The police will lift a dealer, but before they know where they are the dealer is back on the streets because they have no powers to detain the dealer indefinitely. The result is that the dealer carries on supplying. Even when dealers are sentenced, they may not be imprisoned for very long before they are back on the streets—or at all. That is coupled with the intractable problem of housing policy for people who are known to be dealers. Those issues are overlaid by the fact that many local dealers are also users who deal to sustain their own habits. The situation is muddled, muddied and mixed up.

My heart always lifts when I read about the really big importers being lifted. We must concentrate on the efforts of the police and HM Customs and Excise to intercept the supply at the more macro level. I understand that that is one of the main functions of the DEA, with which I wish it well.

Mike Watson: Those of us who are active in Glasgow would bear out your comments on what appears to be the growing tide of the effects of drug misuse, which is very depressing.

I want to ask you about the figures. It is hard for you to be precise, obviously, but I wondered how the 12,000 to 15,000 figure that was mentioned in your response compares with some of the figures in the health board's earlier response to us. There was mention of the drug misuse clinic scheme with about 2,800 patients receiving methadone on prescription, which is a fairly small proportion of the needle-using population. What can be done to increase the number of people on that scheme? Do you know what proportion of drug users are receiving treatment through this programme or others, including needle exchanges? That would allow you to see how effectively resources are being used.

Chris Spry: The proportion varies in different parts of the city and there are inequities—

Mike Watson: Inequities in the deprived parts of the city that you have identified?

Chris Spry: Between different parts of the city. Service use in some parts of the city is lower than it should be. A rough estimate would be that our services connect with perhaps only 20 to 25 per cent of users. That is probably a fair guess, but it is crude and not well-informed.

The problem is that a lot of users drift in and out of contact with the services and, especially if they go into prison, lose contact entirely. As you know, an enormous number of people are admitted to Barlinnie prison every month and a huge percentage of them are drug users. Unfortunately, once they lose contact with drug services, it is extremely difficult to re-establish contact. We are not reaching a vast reservoir of people.

Mike Watson: What can be done about that? Is it possible to reach more of them using existing resources or could that be done only by increasing the resources available to the DAT?

Chris Spry: More can always be done with the existing resources.

Mike Watson: I meant in terms of making contact with the drug users.

Chris Spry: To improve uptake, we have to make services more responsive to users; we have to provide users with more support and we have to show that being in contact with the services can have a good result. That is where my point about training and employment comes in.

The committee has talked to users and will be aware that many of them have an incredibly profound sense of hopelessness. That has to be broken. One way of doing it is by giving them support, allowing them to succeed and so on. That is time intensive and it would be hard to do it without a substantial increase in resources. As I say that, however, I am aware that that is what public servants always say. Even so, I cannot see how we can greatly increase our effectiveness without a step change in the shape and responsiveness of the services we offer.

Mike Watson: You mentioned Barlinnie. I was part of a group of members of this committee who went there a month ago and saw a lot of the good work that is being done. We were told that the treatment drug users receive in the prison is limited by the length of their sentence and that they often do not reconnect with the facilities that are available in the community. What you are saying seems to be the mirror image of that: you said that people who are involved in the services that you provide before they go into prison are not reconnecting with the service when they are released. There is a clear need to marry the elements. Obviously, you work with Barlinnie, but people seem to fall out of the system at both ends. How can that gap be bridged to ensure that there is more continuity?

Chris Spry: We have had several discussions with senior officers at Barlinnie prison about that. We all recognise that it is a major problem. It is difficult to achieve because the number of prisoners is so huge: the length of stay at Barlinnie is usually short, so the number of prisoners churning through the system is pretty huge.

The situation is exacerbated by all sorts of things. Many of the people in Barlinnie do not

know their postcode or address, which makes the record linkages, which are key, quite difficult. We have talked to senior staff at Barlinnie about whether some strengthening of criminal justice social work support, for example, would improve the connections. We have discussed record linkages to improve information sharing with the world of primary care. That would mean being in contact with the prisoner before they go in and subsequently when they leave.

15:00

We also need to concentrate on some of the other, longer-stay prisons, where we have a better chance of improving continuity among prisoners. If we can achieve that, we will learn about what works and start to apply it to the churning of people through the system at Barlinnie, which I have already mentioned. At the moment, the number of prisoners at Barlinnie is so great that it is very difficult to know how to tackle the problem effectively.

Mike Watson: Cathie Craigie referred to the 10 bullet points in Greater Glasgow Health Board's written response, headed "Key Issues In Greater Glasgow". I can see that they are not ranked in order of importance. One of them covers prisoner through-care and aftercare.

From memory, about £3 million a year is spent in Barlinnie prison on treatment for drug users. Are you satisfied that there are close enough links between the funding that Barlinnie prison gets and the money the drug action teams have to deal with what is effectively part of the same problem? Are the connections being made to the best possible level?

Chris Spry: I do not think that that problem is necessarily one of money; I think it is one of how to devise systems of tracking individuals and sustaining their treatments at key points of change in their lives. If we knew how to achieve that, I do not think that the money would be a problem. The health board and, I would hope, criminal justice social work, would be able to work effectively with the Scottish Prison Service to put in place an effective support system.

The difficulty is with the churning of a large number of prisoners. There are break points in the person's experience. The night they spend in the police cells is a crucial break: they can go through a great crisis in the space of a few hours. When they get admitted to prison, there is also the time it takes to assess them and to get them on to the appropriate regime.

It is only a few hours, but it can be a crisis for the individual. They then come out early in the morning. They are free, they go off, all sorts of things happen to them and turbulence then sets in again. The problem is how to handle those crisis points in their experience.

The Convener: I am very sorry, but we are running out of time. We have agreed a line of questioning. I will take Cathie Craigie for one question, then Robert Brown, Keith Raffan and Fiona Hyslop. Any other members should please indicate.

Cathie Craigie: Chris, much effort has focused—appropriately—on the treatment and provision of care for drug users. How much importance do you place on prevention, including the prevention of drug misuse and of a transition from experimental use to misuse? What are your action priorities and plans?

Chris Spry: The knowledge of what works is perhaps skimpiest in this area. As a drug action team, we have found it harder to get into education than into treatment and care. The situation is now a whole lot better. At the drug action team meeting last week, we had a really good discussion with the director of education of Glasgow City Council, examining how issues of health and addiction in particular were being played into the syllabus all the way through children's school experience. That and the community schools initiative offer some encouraging prospects for working together with education services.

As I said, we have been slow in getting our acts together effectively. Culture comes into that—the world of education has all sorts of preoccupations and problems of its own and has not found it easy to make connections with the world inhabited by drug action teams. However, we are beginning to get there.

Cathie Craigie: Do different drug action teams share information about their experiences? The Lanarkshire drug action team has produced an excellent information pack for schools that is based on research from around the world. Do you think that that kind of information should be shared; or should each DAT invent, or reinvent, its own material?

Chris Spry: A fair bit of sharing takes place, but material usually has to be tailored to local circumstances. Our health promotion people work closely with people in education on printed and audiovisual materials. When I said that it was not easy to get into the world of education, I was really asking how the work schools are doing can be connected with some of the other environments in which messages about drugs should be got across. Connectivity has been difficult to pursue.

Robert Brown: I was struck by some of the figures on drugs and alcohol that we were given in the papers from the Ayrshire and Arran Primary Care NHS Trust. There have been 227 drug-

related deaths and 33,000 alcohol-related deaths. The latter arguably represents the real crisis, although I know that the figures have to be considered over the long term.

On page 5 of your submission, you say that the Castle Craig study showed that the proportion of recovering drug addicts who achieve abstinence in the medium term is lower than the proportion of alcoholics who achieve it—in other words, that the recovery rate for drug addicts is lower. You spoke about the problems of helping people to move on, wondering what happened to them after they had been put on to methadone. What would you like to happen? Should we provide specific training and employment opportunities? Should we provide drug regimes and health counselling? What would be the best way of moving people past methadone?

Chris Spry: Because people on methadone often feel that they have a lack of prospects, it is difficult for them to contemplate coming off. I do not think that there is a quick fix to that. The world of employment and training has, in the past, been slightly disconnected from the world of health services and sometimes even from the world of social work. They are now beginning to come together. Those of us who are working on trying to make those connections are finding it incredibly complicated.

Bringing the user to the point of being capable of working, or bringing the employer to the point of thinking that employing the user is a worthwhile proposition, is extremely difficult. Making the move from detoxing to sustaining somebody in a stable state—perhaps on methadone—and then to getting him or her into a job or training feels like the new frontier. We have to crack that; if we cannot, we will see the number of people who are just sustained on methadone growing year by year. They will not have the incentive or the encouragement to come off, and will therefore have no prospect of coming off.

Robert Brown: Is that where the lack of finance bites deepest? You have talked about worthwhile aftercare projects, counselling and crisis points. Is the problem a lack of knowledge or is it a lack of finance to implement the knowledge?

Chris Spry: It is partly a learning curve issue. How, in a relatively short time, can we make up for an individual's lack of education and self-confidence? We are talking about people who have been incredibly damaged and who lack self-confidence. Trying to repair that through a training and education programme is incredibly difficult, but if we cannot do that how will we ever reach the point at which employers will decide that those individuals are worth taking a chance on? That is the new frontier.

There are quite a lot of resources out there—in all sorts of different pockets. One would have to be Henry the Navigator to get the most out of what is out there, because there is so much of it.

Robert Brown: To go back to the alcohol-drug problem, to what extent is an overlap of facilities a good thing, or do you deal with alcohol and drugs in totally separate pockets? What is more important, the fact of addiction or the separate nature of the two addictions?

Chris Spry: We have separate drug and alcohol action teams in Glasgow, although they are inter-agency teams. We take that approach because the issues are so huge for each addiction that trying to handle them through a high-level inter-agency team would be unworkable. However, the detailed planning and an increasing proportion of the services are delivered jointly by health and social work. We are trying to bring them together. Eventually, we may well end up with a combined drug and alcohol action team, but it was all too big and difficult to start from that point.

Mr Raffan: Greater Glasgow Primary Care NHS Trust has an alcohol and drug directorate. Our next witness is from Ayrshire and Arran Primary Care NHS Trust, which has an alcohol and drug action team. Forth Valley has a substance abuse team. Because of the prevalence of cross-addiction and the early use of alcohol being seen as a gateway to other drugs, it would seem sensible for the action teams to become addiction action teams.

Chris Spry: In principle, I agree with that, but the drug and alcohol situation is so huge that we had to find some way to divide up the deliberations in a workable way. There is quite a bit of common membership—people go to the drug action team and the same people can be found sitting around the table talking about alcohol. Although the teams operate through different channels, in terms of brain power, there is quite a bit of convergence.

Mr Raffan: Robert Brown gave the statistics on alcohol use in Ayrshire. In the written evidence, Charles Lind says that

"Alcohol presents the greater problem".

There is some concern that the high profile of drug misuse and the attention that is given to it by the UK Government and the Scottish Executive overshadows a much more severe health problem for the population at large.

Chris Spry: Part of what we have to do involves giving communities a sense that they can make a contribution to tackling the problem. Most communities feel fairly united about tackling the drug problem, but if we tell them that we are going to tackle the alcohol problem, lots of ambivalent feelings start to emerge.

Mr Raffan: One of the phrases used by ministers about the 22 or 23 DATs throughout Scotland is their variability—a rather diplomatic term. Your DAT is often referred to as the success story and as being the model for many of the other teams. Why? Is it because you have managed to integrate your approach and have encouraged the different bodies to work together?

Chris Spry: There is a fair bit of high-quality expertise round the table. Moreover, a number of people around the table genuinely invest a lot of personal commitment in making the DAT work. It comes down to individuals' determination to address the issue successfully. As I said at the outset, the chair has to be very strongly committed to make it work.

Mr Raffan: In Fife, the DAT is chaired by an assistant chief constable. You are chief executive of the health board. Is that the right emphasis? Should the DATs be more treatment and prevention-led rather than enforcement-led?

15:15

Chris Spry: On the whole, that approach would be more appropriate, although I can see that the emphasis might differ from place to place. In some senses, it is not necessarily ideal for the DATs to be health-led. Because of the range of their responsibilities, local authorities really need to feel that they own the problem, and there is no better way of owning the problem than being responsible for chairing the DAT.

Our difficulty is that, as you know, Greater Glasgow Health Board works with six different local authorities. We consciously decided to keep the greater Glasgow DAT because we felt that benefited more from the expertise and commitment of the people around the table than we would have if we had split into separate DATs, which might become overstretched and have a bit less expertise. However, keeping the DAT together has made it very difficult for any one authority to chair it, for reasons that I am sure you will understand.

Mr Raffan: One of the reasons why the DATs were formed was the hope that the different component bodies would bring resources to the table. However, in many cases, that has not happened. I am not being critical—the pressures on their own budgets have probably forced them to draw up certain strategies. Should the money be channelled through the DATs? The committee has heard concerns, particularly when we visited Ayrshire, about a lack of co-ordination: money has been going directly to a social inclusion partnership and the DAT has not been aware of what the money is being used for. I have taken the matter up with ministers, as there is always a danger of duplication and waste in such situations.

Chris Spry: We would get into pretty murky waters. Many of the services are provided by local authorities, and I do not see how local authority money can be channelled through a DAT without getting into huge difficulties with local authority budget setting processes.

Mr Raffan: So how do you co-ordinate funding to ensure that that does not happen?

Chris Spry: That is a difficulty that we have to grapple with. What is more important is transparency about how resources are used. Good progress will likely come from transparency and a commitment to a clear strategy or practical plans, and you do not necessarily need a single channel through which all the money flows.

That said, there is no doubt that if a health board is committed to a DAT's work, is transparent and is not salting money away in different ways, channelling the money through health usually provides more flexibility than other sources. The area is incredibly complicated, and there is no one-bullet answer about the right approach to it.

Mr Raffan: I have one final question on the reports. I had a letter from the clerk that I have managed to lose already; however, from memory, it says that the Scottish Executive has not been keen for DAT reports to be published. They have been described as a management tool, and, as such, the issue of confidentiality arises. Obviously, confidentiality is paramount in individual cases, but in terms of the general strategy, do you think that the reports that you make to the Executive should be published?

Chris Spry: Do you mean the template?

Mr Raffan: Yes.

Chris Spry: I have no difficulty with publishing the template. However, we found the template a particularly cumbersome and not very useful document. The strategy document that we developed was set out in a format that we could actively use in our discussions with the people with whom we work. The template was a fairly predictable product of what happens when you ask a Government department to gather information. It gathers information, but does not necessarily present it in an understandable or user-friendly form.

Fiona Hyslop: I will be brief to let others in. I will ask about the money that goes through SIPs. How can the drug action team be accountable for the drug action plan if the money goes through another agency over which it has no control?

I understand that social work has a strong lead in Glasgow. How does it interact with health board provision and the voluntary sector? The health

board submission says that there will be redirection and reshaping of services. Could you explain more about that?

Chris Spry: The fact that the money goes directly to SIPs highlights the fact that the responsibility for the DAT is partly to persuade other agencies and bodies to contribute to an overall strategy that will be effective. Therefore, my accountability for working with SIPs relates not so much to how they use the money as to the success of our relationship with them: it is about whether they understand what the DAT strategy is trying to achieve and whether they use the money in a way that is supportive and takes the strategy forward. I am happy to be measured by that test. It matters less whether we are able to influence how £10,000 is used here and £5,000 there. I am reasonably relaxed about that.

On the shift of emphasis on services, we have been trying to encourage more local authority specific approaches to planning drug treatment services in the Glasgow area. The pattern was very uneven. A lot was concentrated in the city, but there were very patchy services in other local authority areas. Under the umbrella of the DAT, we have tried to pursue local authority specific approaches. In the city, there is an elaborate planning mechanism to examine a whole range of aspects of developing drug treatment services. That is basically a joint effort by the local authority, the health board and various providers in the voluntary sector. Those bodies work under the umbrella of the DAT strategy.

Fiona Hyslop: What does Glasgow social work department bring to the table?

Chris Spry: It brings a huge amount of planning effort and increasing transparency in the way in which money is used. I am encouraged by how that is going.

Mr Quinan: You said earlier that you only touch around 25 per cent of the chaotic drug abusers in Glasgow. It has been estimated that there are 4,000 individuals who have taken part at some point in the methadone programme. If we accept that there are potentially between 15,000 and 18,000 chaotic drug users, what plans do you have to meet the shortfall in methadone provision?

Chris Spry: An additional allocation of money for treatment has just been announced. The drug action team considered that last week. Our view was that the top priority was to strengthen shared care services—stronger support for counselling and other services associated with the methadone programme. In effect, we will want to use the next tranche of available money to strengthen support for the methadone programme.

Mr Quinan: You are saying that you support the 4,000 chaotic drug users whom you currently reach, but that you have no plans to extend the methadone programme to cover the 11,000 people whom you are not reaching.

Chris Spry: I do not think that we contemplate making such a jump. We do not think that the programme could be extended so far in one step. Huge issues would arise from doing that, as such a large number of users would flood the current pattern of service, so there would have to be an entirely different service model. We are thinking about different service models, but we have not reached a conclusion.

Mr Quinan: I have heard concerns from service users about how methadone is dispensed. In particular, concerns revolve around the lack of confidentiality at pharmacies. Even where health information booths have been set up, they have rapidly become known as the junkie booths and there has been no improvement in protecting people's confidentiality. What is the drug action team doing to find alternative ways of dispensing methadone, for instance, through the community-based drug services?

Chris Spry: It is important to take into account that health advice points are used for other health problems and are not just for people swallowing methadone. The more that is understood, the more that image of those facilities will be broken down. We are steadily spending more money to provide more pharmacies with advice points, where people can be dealt with in private without being seen or overheard.

On your question about other models, complications arise when one considers dispensing drugs through channels other than pharmacies. There are regulations about how drugs can be dispensed in a community setting outside the bounds of a pharmacy. The planning group has to grapple with such issues.

Mr Quinan: Are you saying that you are examining the concept of using community-based drug services for the delivery of methadone, or that that model of delivery is so complicated that you will not adopt it?

Chris Spry: We are examining that model, but in arriving at a different model one starts tripping over such things as the pharmacy regulations.

Mr Quinan: Clearly, much of what you have said relates to our ability to take people from chaotic drug use to controlled drug use, and then to reintegration into the community. Do you accept that it may be worth while to look at the studies in Switzerland and Holland and to consider seriously the prescription of heroin to stabilise, but more important to decriminalise, people and undermine the organised crime that runs the drugs industry and other elements of the drug abuse problem in Glasgow?

Chris Spry: The drug action team has not discussed that. Your question highlights one of the huge difficulties in this field, which is that thinking aloud about radically different models—

Mr Quinan: There is nothing new or radical about this, as it was the situation in the United Kingdom from 1908 until 1968.

Chris Spry: We have had huge problems with local public opinion about our giving methadone to people who are addicted on opiates.

Mr Quinan: But you are doing it.

Chris Spry: I know we are. However, the rhetoric that surrounds the issue—the abstinence versus harm reduction debate—makes it feel like shark-infested waters. I remember that I came to Glasgow just after Mary Hartnoll, who was then director of social work, remarked that more harm was done by alcohol than was done by ecstasy. I recollect that she was crucified for saying that. It is difficult for drug action teams to talk publicly about such choices. Our experience is that the environment of public debate is pretty intolerant and unforgiving. This country struggles with that major difficulty.

Mr Quinan: Are you discussing that concept behind closed doors?

Chris Spry: No.

Mr Quinan: When you examine methods that are used in other countries, is your first priority to decide whether you will get a bad headline, or is it to find appropriate methods to reduce chaotic drug abuse in Scotland?

Chris Spry: We have to operate in the environment in which we exist. The debate about whether you should consider heroin prescribing is beginning to take off in this country. You can be assured that we would find ways of exploring the evidence and getting it into the system in an effective way. That sounds a rather arch comment, but DAT does not see itself as a lobbying entity; it sees itself as learning from research, observing what is going on in the development of national policy—

Mr Quinan: On that point—

15:30

The Convener: Lloyd, we have to draw to a close now. You have one last question.

Mr Quinan: You have just said that you are prepared to look but not to talk. I am asking you straightforwardly, would the drug action team consider taking action against chaotic drug abuse? Within your DAT area, would you consider prescribing pharmaceutical heroin to appropriate individuals as a stabilisation measure?

Chris Spry: You would have to be satisfied that you could do it in a sustainable way, and that you did not get leakage of the drug into the wider environment. There are many practical issues. First, you would have to look at the evidence for its effectiveness, so you would examine the effectiveness of the Swiss experience. You would then have to ask how you would set up a system that would work effectively in the turbulent environment in which we operate.

The Convener: We have to draw matters to a close. That was an interesting discussion, which I am sure will continue. Chris, thank you for your evidence today. It has been extremely useful to the committee in our inquiry. As ever, we may contact the DAT if we want more information. As usual, we are well over time. We will have to move on swiftly, so I am afraid that your departure will be abrupt.

I welcome Charles Lind, associate medical director and lead consultant in addiction from Ayrshire and Arran Primary Care NHS Trust. Thank you for coming today. We are grateful for the information that you provided. You gave us an informal briefing some time ago, the contents of which have stayed with a number of members. Could you give a brief introduction, because you will appreciate that we are running over time.

Dr Charles Lind (Ayrshire and Arran Primary Care NHS Trust): Thank you for inviting me. We are moving away from the concept of a DAT in Ayrshire. As Mr Raffan mentioned, we have never had anything that was specifically designed to deal with the drug abuse problem. Historically, there was a mandate from the Scottish Office in 1989 to produce alcohol misuse co-ordinating committees. We used that to bring together all the addiction agencies under one banner. The DAT emerged—almost organically, in 1995 or whenever it was—from an alcohol and drug action team, not a drug action team. That reflects the way in which we have worked.

We have worked in a way that is characterised by unusually high levels of cross-agency co-operation. That is true at the level of inter-agency working, although perhaps less so at managerial level. It has enabled us to maximise scarce resources and has allowed us to move about within each other's professional confines. For example, I will do clinics out of voluntary agencies, and voluntary workers will come and work within health service provision. That allows for a useful and interesting flux of personnel such that they can move through the various parts of our addiction services.

I caught the tail-end of what Chris Spry said. I was interested in that, because we are beginning to move away from seeing drugs, or indeed alcohol, in isolation. The last time I was here I

referred to the fact that there is a vast political backdrop to this issue, which encompasses not just alcohol and drugs but all sorts of other issues, such as mental health, physical health and general well-being, all of which are almost indivisible and come within the remit of social inclusion and exclusion.

It becomes increasingly difficult for me to understand where I should draw lines and why I should draw lines in certain ways. Our service reflects that difficulty. For example, we have a flourishing dual diagnosis service, which I think is the first of its kind in Scotland. It is certainly the first residential one in Scotland. It is turning over something like 500 new referrals a year in its second year of operation.

Probably the most important part of our operation is the teaching, research and development arm, which is flourishing. It tries to ensure that, in their normal day-to-day work, generic workers maintain an understanding of the difficulties that are associated with drug and alcohol use. Those workers include community midwives, general practitioners, the police, prison workers, social workers and those from voluntary agencies.

I am aware that I am rambling a bit, so it might be easier if I took questions.

The Convener: Thank you. We have a range of questions and issues that we wish to raise. We want to encourage a dialogue.

I appreciate the holistic picture that you are painting. That is the direction in which we are heading, but I wish to focus on one aspect that concerns us, which is the pattern of heroin use. I am probably guilty of focusing on heroin use myself, because I represent an urban area of massive deprivation and I have my own views on the pattern of drug use and issues surrounding it. But it must be different for you. How different is it? Is too much of this debate dominated by urban centres? What are the issues across Scotland, and how do we understand them?

Dr Lind: The issue is what was deprivation, what is exclusion, and what is now inclusion?

The Convener: Why is that?

Dr Lind: Because deprivation is not monopolised by inner-city urban areas; it happens in many different contexts. It can happen in postcode areas that apparently are affluent. It can happen in the house on the corner, where someone who is deprived and is excluded moves in. More broadly, in Ayrshire we have a hinterland of what is now absent heavy industry. We have Cumnock and the Doon Valley, which has the highest level of unemployment in Scotland.

Unemployment is not an inner-city phenomenon. When I moved to Ayrshire it was as much of a surprise to me as it may have been to you recently. I was expecting the bulk of my custom to come from Kilmarnock and Ayr, but it did not; it came from small ex-coalmining villages, where unemployment in the 25 to 35-year-old age bracket among males was in the region of 85 to 90 per cent. That is vast. Huge swaths were decimated. There were no jobs and no chances of jobs. The talented people in those types of communities either leave or beat their heads against a brick wall of gradually declining community awareness. That is one of the things that is often overlooked in areas of rural deprivation. At least in inner cities you can usually find a platform. In areas like Cumnock and the Doon Valley or Kelty it is difficult to find a platform to be heard. People must understand not only that there are difficulties of exclusion and deprivation, but that Stagecoach is not the most magnanimous company in the world.

The Convener: That is on the record.

Dr Lind: If someone has two children and needs to take four bus rides to get to the nearest service that they want to access, whether it be leisure or health facilities or signing on, it can be very difficult indeed, as they must devote a day to doing that. Child care is much more difficult to access in rural areas. There is a notion of the extended families and an agrarian idyll, but that no longer exists.

The Convener: I accept that point, which you have expressed well. How does that link into the problem of drug abuse? What is happening in your part of the world?

Dr Lind: What has happened in our part of the world is pretty much a mirror image of the emerging drug use patterns in Glasgow. There is not a substantial difference. When I arrived in the area, I quickly became aware of a substantial problem with the use of Temgesic and temazepam, which is exactly what Glasgow was experiencing at the time. I became aware that at least two of our smaller villages were being used as staging posts between Manchester and Glasgow for heroin transport.

If there is a difference in rural areas, it is that, before supply lines get properly established, there is a tendency towards inventiveness. For example, we had a vast amount of bathtub amphetamines being produced, and for some time that was the bulk of the drug abuse in the Cumnock area. In other areas, the problem progressed in parallel with the rest of the west of Scotland.

The Convener: That is interesting. What are the implications for service development? Do services have to be different, or do we have to deliver or resource them differently?

Dr Lind: That is a difficult question to answer.

The comparison is not one that I particularly want to make. However, if one is serious about delivering a service to an excluded group, one must take that service to it. It makes no difference whether that excluded group lives in the middle of the city or in a small housing scheme with no social infrastructure in the middle of nowhere—one must still deliver the service.

The Stimson studies on the original needle exchanges in Glasgow showed that people would not travel more than a mile and a half to get there. That problem is not peculiar to rural areas, but the scale of it is perhaps peculiar, because one has to get services out there in some way or another. Our needle exchange backpacking exercises have huge levels of uptake, much bigger than for our original static sites. That is largely done by word of mouth, village by village and visit by visit, and involves taking injecting equipment to individuals.

Fiona Hyslop: I understand that the service delivery mechanisms in Ayrshire are quite distinct, but how does the system work? John McAllion and I visited Fife, where there are also small communities that need delivery to the doorstep, or nearer than some of the centralised facilities. You mentioned the backpacking needle exchange. Exactly how do you deliver those services to small communities?

Dr Lind: We started off with a little white van but, like most little white vans, it rapidly became known for what it was. In my village, the little white van is the vodka supplier. Among the other villagers, it rapidly became known that it was the needle exchange service. Our workers now use their own cars. They have Crown indemnity by way of insurance and carry a large amount of injecting equipment in their car boots. They make appointments at prearranged places with pre-arranged people, so that they are aware of roughly what the routine will be.

They also provide other services. We are beginning to provide services specifically for women and for disabled people on the back of that service. Once the infrastructure is established, those more specialised services can be provided in addition. We now have a cohort of something in the region of a dozen workers providing that service. We ran into a small difficulty with one of our local authorities, which did not want us to perform that kind of operation out of its housing stock, but that was resolved quite rapidly. I cannot say much more about it than that. It is pragmatic; we simply take a service where it is needed.

Fiona Hyslop: That is a medical model for needle exchange, but it integrates with other services. There are concerns that it is difficult to connect with women and encourage them to use the services that are available. Are there other services that are not just about health, but which connect with the work that you do?

Dr Lind: I am not sure that I would describe the needle exchange workers as health workers per se; they see themselves as addiction workers. One of the joys of working in our model is that we do not divide things up into social work, voluntary work and health work. We are addiction workers and we work within that conglomerate.

15:45

Fiona Hyslop: How effective is your work with GPs and your shared care model? In Edinburgh, there are efforts to ensure that support and information services are available at the time when people see GPs. However, there must be agreement with GPs to share their facilities to provide that information and see patients. What are your views on that?

Dr Lind: We do not use primary care premises very much. We have a different form of shared care. In fact, I suspect that calling it shared care might be stretching it slightly, and we have been criticised in some quarters for what we have done. Our local general practitioners made it quite clear very early on in the proceedings that they did not want to be part of the substitute prescribing programme, and I have some sympathy with that view. It does not fall within what is generally recognised as general medical services and it requires a level of expertise that can be quite difficult to sustain, unless substantial specific support is provided, as happens in Glasgow.

We have employed GPs on a sessional basis at strategic points around the area, so that they work for one session a week in each of the drug agencies to provide substitute prescribing facilities. Other services may well be provided from community centres or from other community facilities, but rarely are they provided from primary care facilities.

Mr Raffan: The convener touched something that, although I do not want to labour it, I think is an important point—[*Interruption.*]

The Convener: That is Dr Lind's pager going off. I usually have to warn members to switch off their pagers.

Mr Raffan: Yes, it is usually our pagers that interrupt the meeting.

You said that there are no adequate indices for measuring deprivation in rural areas, and you mentioned Carstairs and Townsend. Do you think that that leads to distortion in resource allocation, given that overall resources in Scotland are inadequate?

Dr Lind: I have absolutely no doubt that there are substantial schisms and skews in resource

allocation. The way in which the Arbuthnott report was constructed reflects that. Ayrshire came out reasonably well from the Arbuthnott review, but only because we have a large aging population. It had nothing to do with the fact that we have the highest level of unemployment in Scotland in one of our areas.

The appendix to the Arbuthnott report, which is as close to impenetrable as any I have ever seen, shows that the report's compilers have followed the Carstairs and Townsend logic to the limit. That includes such issues as car ownership. If one has a car, one cannot, by definition, be deprived. Given the lack of public transport in most rural parts of Scotland, it is quite impossible to live in a rural community without a car. The car may not be MOT'd or insured and the driver may not have a licence, so it may not be entirely legal, but one must have a car none the less.

Mr Raffan: In chapter 2 of your written submission, you make a point very forcefully about the variability and lack of recording of alcohol and drug information across general services, making analysis difficult. You say that at present each local authority uses different recording systems. That makes it very difficult to estimate the true levels of need for service and the extent of the problem. Do you think that the Scottish Executive should bring uniformity to the recording of crucial information?

Dr Lind: That would be an ideal to work towards. To begin with, we must decide what constitutes crucial information. However, in my view, this is crucial information. We have rectified the problem to some extent by using something called the common database, which extends information and statistics division data and has been signed up to by all local authorities. None the less, it is difficult to work out, for example, how much contact the police have with people who may be drunk or intoxicated. We can guess, they can guess and we can agree on an estimate. However, it is still no better than a guess. The same applies to children in care—we do not know about that, because it is not routinely recorded.

There is a cultural problem that people are not used to including alcohol-related issues in their data. As Chris Spry said earlier, they record drug-related information much more readily. Drugs are something solid, coherent and tangible that communities tend to latch on to. Alcohol issues are more amorphous, ambivalent and difficult to grasp. The culture must change and people must confront the ambivalence that surrounds alcohol and, to a lesser extent, drugs. Frankly, in many of our cultures drug taking is regarded as normal. It is what people in huge sectors of the population do.

Mr Raffan: Ayrshire and Arran's services are held up as a model for other health board areas. As you know, I represent Fife, where the services are nowhere near as good, but which is not dissimilar from Ayrshire and Arran demographically and topographically. I know that you can only answer this question subjectively, but why do you think that Ayrshire and Arran has been so successful? Is it because the services are consultant led?

Dr Lind: Not entirely. It is because we are lucky enough to have a group of people who are genuinely interested and motivated, and who do not really care what professional grouping they belong to. The key thing is that they are interested in trying to provide an answer to a problem. Having a consultant to champion services is a great strength. It is more of a strength—which is unfortunate, and perhaps should not be the case—than having a social worker or a junior doctor in that position. It carries some cachet.

Mr Raffan: We went to the Bentinck centre, and the total commitment of the people there is very impressive. How do we replicate that commitment? Do you think that there is enough sharing of best practice and of the methods that you have used to motivate people?

Dr Lind: There is not nearly enough sharing across Scotland. There are many areas of practice in which we could learn from other places. I regularly have conversations with Brian Kydd, my counterpart in Forth Valley Health Board, about setting up joint training programmes and ways of evaluating what does and does not work. Until we are able to foster commitment and interest at all levels, it is difficult to produce anything other than a disjointed service.

Mr Quinan: There is something very interesting about the area that you come from. I know some parts of it very well, as I lived in Cumnock and Auchinleck during the 1984-85 strike. We refer to the area as rural, but I would suggest that it is home to some post-industrial villages, which have a radically different mindset from the genuinely rural villages in Ayrshire. Cumnock, Auchinleck, Mauchline, Bellsbank and Drongan operate in an entirely different way from genuinely rural villages. As you said—and as I know from experience—bathtub amphetamines were the drug of choice for young people in the mining communities in the run-up to, during and after the strike. I am led to believe that villages such as Ochiltree and Sorn do not have as endemic a chaotic drug use problem as the post-industrial villages have.

Dr Lind: That is a valid point, although I suspect that there is a great deal of overlap. There are two categories of rural community. One is the post-industrial community, which is common across the central belt of Scotland, and the other is the more traditional rural agrarian community. However, if

we take that argument too far, there is a danger of buying into the myth that the more agrarian communities have a tradition of sustainability and self-propulsion that post-industrial communities lack. I remain enormously impressed by the power of the community in small villages such as Drongan. Despite the difficulties under which they labour, people remain optimistic about regeneration.

Agrarian communities are suffering along with post-industrial ones. Although Lloyd Quinan is probably right to say that drug use is not yet as intense there as it is in places such as Drongan and Cumnock, it is getting to be. Agriculture-related employment is on the wane; the more intensive agriculture becomes, the more jobs in that sector dry up. What was previously a sustained and intensive employment opportunity is vanishing. That is common throughout Scotland, and there is nothing new in it.

When people have limited choice in what they can do with their lives, they are more likely to cross the boundary from experimental drug use into problematic drug use. That is the critical point. I am concerned less with whether people decide to use drugs in the first place than with what propels them into problematic drug use. Those are different issues. The crossover point reflects the extent to which people have choice in their lives. That is where the issue ties in with the inclusion-exclusion agenda. If people live in a fundamentally excluded community—no matter where it is—it is much more likely that problematic drug use will be regarded as normal. It is much more likely that their choices will be limited to the point where they do not have the same variety of options as my children might have.

Conversely, we need to ask why someone lives in Drongan and does not use drugs, or why someone lives in Easterhouse and does not use drugs. Those are fascinating questions. Why do people live in those horrendous environments and not become depressed and use drugs? If we turned the usual questions on their head, that might produce more interesting answers than the ones that we are looking for at the moment.

Mr Quinan: You were here when I asked this question earlier, so I will trim it down. Should anything be counted out, or should everything be counted in that could lead to the stabilising of people's lives and decriminalisation? Do you consider that returning to the pre-1968 situation would give us more freedom, end the classification of large numbers of people as criminals and—more important—hit harder at the criminal organisations that are running the drugs business in Scotland? Do you think that the ability to prescribe heroin pharmaceutically on an individual basis—to some degree, at the individual's request—would be a means of bringing stabilisation into lives and communities?

Dr Lind: I take it that, by 1968, you are referring to the second Brain report.

Mr Quinan: Yes.

16:00

Dr Lind: The second Brain report was a series of recommendations, not a series of mandates. It is within the clinical remit of every physician in this country—if they apply for a licence—to prescribe heroin. I have not applied for a licence, for some of the reasons that Chris Spry gave. I would rather comment on that practice with the comfort of some statistics behind me, rather than off the top of my head, and I hope that I could do that in private.

The Convener: This meeting is not private. This is on the public record.

Dr Lind: Okay. I will not say anything that I have not said before in public.

I would count nothing out. We have a series of examples, both historical and from other countries, which suggest potential ways forward. Simply saying that something works in Holland or in Switzerland does not mean that it will work here. Drug use has changed historically and geographically. For instance, in this city in the 1960s, drug use was the preserve of the political middle-class youth, but it is that no longer.

My concern about simply going ahead and prescribing heroin revolves around the kind of argument that Chris Spry made. There is a huge volume of public opinion to be taken into account, although public opinion tends to be shaped by a few slightly idiosyncratic people.

The Convener: We will not ask for their names for the *Official Report*.

Dr Lind: No. I would not name them on the public record.

None the less, those are powerful people who are able to push buttons. I was enormously impressed by the job that Laurence Gruer was able to do in Glasgow, in switching round the debate on methadone in the way that he did, from an environment that was profoundly antipathetic towards any kind of substitute prescribing—and I include my psychiatric colleagues in that, as having almost set the tone for that act—to one in which, for the most part, such prescribing is regarded as a good thing.

I also admire the fact that Laurence went public with his feeling that heroin should be available on prescription. I would echo that. There are groups of people in my practice who clearly are not benefiting as much as they should from the

prescription of methadone in any way, shape or form—including the prescription of injectable methadone. Several of my colleagues in England, as a matter of course, prescribe heroin in a variety of forms.

At the beginning of the methadone debate, one of the difficulties in Glasgow, where the problem was most virulent, was the issue of leakage. In the west of Scotland, unless reassurance could be provided—which is much more difficult to provide for heroin than for methadone—that some control could be taken over leakage, the debate would be long, drawn out and unpleasant. One of my colleagues from England, who now works in New Zealand, invented the heroin reefer somewhere outside Manchester. Those reefers regularly turned up on our doorstep, so there was evidence of substantial leakage. However, the public must grasp the nettle by recognising that whatever is being prescribed will leak at some point, and that sometimes leakage is not, by definition, a bad thing.

In the west of Scotland, one of the things that characterised drug users up until the past seven or eight years was their preference for pharmaceutically pure drugs, in the form of Temgesic and temazepam. It is only in the past five or six years, as the availability of those drugs has diminished, that they have begun to use cut substances, with the results that we have seen over the past two or three months.

Bill Aitken: The number of drug abusers is nebulous—we do not know their precise number, and differing opinions were expressed earlier. That being the case, the percentage of users who utilise the service that you provide in your health board area cannot be calculated. Clearly, however, that percentage is not as high as we would like. What steps could be taken to ensure that more drug abusers use the service? You made the point that you have to take the service to them; what other steps are necessary?

Dr Lind: That is a critical issue. Our home detoxification team started out as a venture that was designed to deal with alcohol detoxification at home, as an alternative to using up psychiatric in-patient beds. Around 30 per cent of its users are now on a course of heroin detoxification.

Normally, the male to female ratio across service uptake is about 65:35, and sometimes 70:30. However, in the take-up of our home detoxification programme—which is much more private and anonymous—the gender ratio is roughly 50:50. If we are serious about tackling the addiction problem among women and people with mental health problems, the issue of taking the service to people is critical. Such a service is very resource-intensive.

Bill Aitken: That might be a case of taking the horse to water. What percentage of drug abusers would you estimate have no intention of kicking the habit?

Dr Lind: That varies from moment to moment, from day to day, and from week to week. People move through cycles. I do not think that, as they move through their cycle of drug use, an injecting, chaotic heroin user is particularly different from you or me, concerning the reasons for which, and the methods whereby, they make decisions for change. I make decisions for change on a balance of the pros and cons of what is going on at a specific point in time. A heroin user will do the same. Some days, they will say that having a habit is a wonderful thing and that they really enjoy it—it is exciting. On other days—usually after they have just been busted or developed an abscess—the habit becomes less heroic and exciting, and they require the service.

I would guess that there is a hard core of between 25 and 30 per cent of drug users, in the area that I deal with, who are not interested in accessing the services that I can offer. If heroin were to be offered in some shape or form, around 15 per cent would still not be interested in accessing any service because they like it the way they are. No matter how strange it may seem to us, sitting round this table, there is a group of people who enjoy that lifestyle.

Bill Aitken: Yes. That must be generally recognised.

I will now ask you the $64,000 question, and I would like you to relate your answer to resourcing, as it is the crux of the matter. What steps are necessary to increase the number of drug users who become drug free and who take a course of treatment?

Dr Lind: Drug free or drug stable?

Bill Aitken: Drug free.

Dr Lind: Outwith methadone programmes?

Bill Aitken: Yes.

Dr Lind: Having successfully graduated?

Bill Aitken: Yes.

Dr Lind: The first step is to recognise that successful graduation from a methadone programme, with adequate counselling and support facilities, will take 10 or 12 years from the moment a person enters the programme to the moment that they leave it. I have been providing the service in Ayrshire for 12 years, and it is only in the past couple of years that people have begun to leave the programme with some success. Patience is needed, as well as the understanding that such programmes are long-term events. All the international studies from America,

Switzerland, Holland, Europe and Australia support that view.

Secondly, there has been a cultural shift in people's understanding. We have to understand that drug use is a normative event, that it has always been so, that—although the drugs that people use and the ways in which they use them vary and shift over time—drugs have always been there and will probably always cause problems in one way or another. There needs to be an understanding that a substantial subsection of society is moving away from the traditional drugs that we have been used to in the past 50 years—alcohol and tobacco—and towards other drugs. We must understand that the days of drug stratification—going to one dealer for amphetamines, another for cannabis and another for heroin—are gone and that there are big dealers who deal in everything, which means that the notion of gateway drugs is redundant. There are no gateway drugs; there is a gateway where all drugs are available.

Along with those cultural shifts in understanding, there must be an adequate needs assessment, which has never been done in Scotland. We have no idea of the true scale of the problem. Worse, we have no idea of the true scale of the need. The only way in which we can measure need is by the number of people who contact the support services. We need to have some way of knowing what the people involved want to happen.

We need more money.

The Convener: That is the answer to the $64,000 question.

Dr Lind: I have a background in mental health, so I know that we should not simply throw money at problems. The reason why I prefaced the request for more money with my other comments is that there needs to be a better understanding of what the services should be tailored towards. At the moment, we are juggling balls in the air without knowing which way they will come down.

Bill Aitken: There is an argument that the easiest way to stop people taking drugs is to deny them access to drugs. That is the enforcement argument. By the shaking of your head, I can tell that you are opposed to the idea. What is your chief opposition? Do you think that it is simplistic?

Dr Lind: Yes. It has been tried for a long time. The Americans have made an industry out of it and have failed miserably. The kind of people about whom I was just talking—the ones who do not want services—enjoy the situation. Some people enjoy being Rimbaud; they like keeping to the shadows and they enjoy the thrill of the chase. People go to Oxford, get degrees, become cannabis smugglers and get rich writing books about their lives. There is a piratical thrill involved and enforcement simply magnifies that.

We need an understanding that humans have always used drugs in one form or another. Opiates go back for centuries.

Bill Aitken: But the scale of the problem does not.

Dr Lind: The scale of the problem is such that the Houses of Parliament in Westminster were built with drug money.

The Convener: This could be a fascinating discussion, but I must move us on.

Karen Whitefield: I will return to what Dr Lind said about heroin and methadone prescribing. In Ayrshire, you met with difficulties in getting GPs to agree to prescribe methadone. Do you agree that many people not only in the community but in the medical profession would have to be convinced of the merits of prescribing heroin?

Dr Lind: Yes. Heroin prescribing needs to be a specialist area. None of my colleagues would think that GPs should become involved in it. It would be contentious if they were.

Karen Whitefield: In Ayrshire and Arran, methadone is prescribed centrally. When we visited the area, we were told that that arrangement works well but that there can be problems when the limit is reached and the programme cannot take any more people. That is why Lanarkshire, a part of which I represent, has been reluctant to go down that road. Have you encountered such problems?

16:15

Dr Lind: That potential problem has always been one of the drawbacks of the model. Set against that is the fact that, whenever we have neared the limit, we have been able to increase it. There has never been much difficulty in persuading people that there is a need for that.

Another thing in the model's favour is quality control. With the best will in the world, it is difficult to guarantee quality prescribing through primary care; GPs would probably agree with that. We make it a condition of prescribing that the individual must come for counselling, no matter how unwillingly. All the evidence shows that, although methadone on its own makes some difference, a good outcome is much more likely to be produced with methadone plus good quality counselling plus a range of other activities.

The primary care-based prescribing systems often struggle to be more than a methadone-dispensing service. Daily, I become more convinced that a good quality addiction service is about much more than simply dispensing methadone. It is about making sure that good

detox is available, that women's issues are addressed, that child care issues are addressed and that ethnic minorities have their needs addressed. I mean no disrespect to primary care, but those issues can be lost in that sector.

With the advent of primary health care trusts and local health care co-operatives, I hope that the financial issue is no longer as much of a problem; we are all working from the same budget these days and should be making co-operative decisions about how the money should be spent.

Karen Whitefield: Has Ayrshire and Arran Primary Care NHS Trust taken any specific action to ensure that the services that it provides meet the needs of drug users and their carers?

Dr Lind: That is difficult to do. In 1983, I invited one of our more stable drug users to what was then the addiction strategy committee, which was the forerunner of the drug action team. I have never forgiven myself for that. Without any training or preparation, that poor man was exposed to a degree of unpleasantness and patronisation that no one should have to be exposed to. Our reaction to that experiment was to set up a series of events aimed at ensuring that users and carers could use the forums that are available rather than being taken into inappropriate situations and asked for their opinions.

Having said that, I admire Argyll and Clyde for getting a drug user on its drug action team. I would be interested to see how that works out. I am glad that I am not that drug user, as he or she is in a difficult situation. I hope that he or she is properly supported.

Karen Whitefield: Do you agree that it is important that drug users' carers influence the DAT strategy and how it operates? You have made some good points about how that can be problematic, but do you feel it is important that they have a voice? Do you have any suggestions, based on your experience of the difficulties that can exist in making that possible? We are all saying that this is a great idea, but we are not considering how we enable those communities and those drug users to have that voice.

Dr Lind: The problem is that drug users are an unpopular group of people in any community outwith the drug-using one. Communities do not necessarily want to listen to drug users. They will listen to families and to the fallout that drug use has in the community, but drug users are often the last people who are listened to in the process.

There are a couple of honourable exceptions. The smaller the community, the more likely it is to be supportive of its drug users, because they are less anonymous and less able to hide behind other people. On your original point about empowerment and facilitation, the issue is that people need to be trained. I do not know how much training you have had in sitting on committees and in chairmanship and so on.

The Convener: That is a sore point.

Mike Watson: Not enough.

The Convener: Not enough, certainly.

Dr Lind: I have had little such training and have had to dig myself out of some deep holes as a result. I do not like putting other people in that position. Our action plan includes a specific section about providing training, education and resources for users and carers, to enable them to become fully involved in the debate. The milestone for that is March next year, by which time we hope that all the carers groups and users groups will feel able to sit in a committee that can get quite fierce sometimes and put their point across effectively, without taking the hump if things do not go their way.

Mr McAllion: As I listen to and read the evidence, I am becoming aware that certain strategies exist. They may be the wrong ones, but at least they exist. For example, we have a strategy for enforcement in locking up drug users. We also have a strategy that is aimed at moving from chaotic and problematic use to stability under methadone or heroin, or whatever. What is the strategy for the next phase, which is moving from stability to reintegration into the community?

Chris Spry thinks that how we get someone stable on methadone and into education and training is the new frontier. Do people have to be drug-free to make that jump back into the community, or are you suggesting that people who are still taking methadone can go back into education and training, hold down a job and cope with life as part of the community?

Dr Lind: The latest employment figures from our methadone maintenance programme show that about 30 per cent are in employment—proper employment, not made-up jobs.

Mr McAllion: You made the point about society having to learn to live with drugs as a reality. It is a myth that we can be a drug-free society. We should stop trying to attain that and concentrate instead on what we can do practically to get people with a drugs problem back into the community.

Dr Lind: Principled responses are probably not the way forward. I used to have principled responses to such matters; I am now a pragmatist. The way it works is that we respond to a situation in the way that makes things easier for people and gives them a good result.

Conversations such as this always come back to methadone, which is an emotive word. First, it is a

minor part of what we do. Secondly, it is only a tool to try to introduce stability into somebody's life. Because methadone has a longer half-life than heroin, it has to be taken only once a day, as opposed to three or four times a day, so all it does is replace the need for someone to go out and buy heroin. Unless someone wants to use on top of that and continue to be intoxicated, the methadone replaces heroin until such time as the person is willing to come off it. Methadone sits in the system and does nothing—it does not intoxicate people. We are trying to get that thin line between intoxication on the one hand and withdrawal on the other.

The body produces drugs all the time; they are simply being replaced. What happens in heroin addiction is that the body depletes itself of its natural opiates. A person has to take more heroin to make up for that. When they stop taking heroin, the body takes ten days or so to get that opiate factory moving again to the point where it works properly. The difficulty is that that ten-day period is extremely painful; that is where methadone comes in.

Methadone should not be used as a tool to judge people by, any more than insulin is a tool to judge diabetics by. It is simply there. It is a medication. It is helpful in certain circumstances with certain people. People are quite capable of gainful employment while they are on methadone.

Mr Raffan: Ayrshire and Arran cover three local authority areas. To what extent is there a variation in the response of the local authorities? At the bridge project in Ayr, which is in South Ayrshire, there is a drop-in needle exchange, but there are no similar projects in Cumnock and Kilmarnock in East Ayrshire. Why is that?

Dr Lind: There has been a drop in the number of people taking up the service at the bridge project in Ayr. I am not sure why. Perhaps we are curing the problem in South Ayrshire, but I find that impossible to believe.

Mr Raffan: Perhaps I will be more direct. Is East Ayrshire not too keen on needle exchanges taking place?

Dr Lind: At one point, East Ayrshire was not too keen on needle exchanges taking place on its property, including its housing stock. We have resolved that problem now. For example, there are two bridge projects in East Ayrshire—in Cumnock and Kilmarnock—and we are expecting to start needle exchanges in the near future.

Mr Raffan: That is one of your difficulties—bringing all those disparate councils, organisations and bodies together.

Dr Lind: It has some practical difficulties. We resolved both those issues by using backpacking exchanges. That is why backpacking is over-represented in East Ayrshire. We compensated by using that way round the problem, until East Ayrshire decided to change its mind. Some of those decisions feel capricious from time to time.

Mr Raffan: It is a measure of the amount of education that is needed, even for those who hold public office.

Dr Lind: Even those—the most difficult people I have talked to are local councillors. They are sometimes difficult to move from their fairly entrenched positions. I find them more difficult than general practitioners, which is saying something.

The Convener: I remind you that you are on the record.

Mr Raffan: On the hepatitis issue—as the two issues are related—how serious is the hepatitis situation in your health board area?

Dr Lind: I hate to think.

Mr Raffan: We do not have any figures on that either. There is a little footnote below the Scottish figures from the Scottish Centre for Infection and Environmental Health to say that those figures could be an underestimate by severalfold.

16:30

Dr Lind: The rumour doing the rounds of drug agencies in the west of Scotland is that 70 to 75 per cent of intravenous drug users are coming across the threshold. I am cagey about that, because we had the same kind of debate when HIV was first around.

What has become clear is that the way we did needle exchange to begin with was probably not terribly effective with hep C, although it was with HIV. We have re-examined that fairly substantially and made some changes to the advice that needle exchange workers offer. I have been loth to test people for hep C, because I am loth to test people for something for which there is no apparent intervention.

Mr Raffan: What about interferon?

Dr Lind: That is out to some debate at the moment. There is a fairly substantial argument about its effectiveness. It seems likely that it is a delay rather than a cure, per se.

The Convener: I am sorry, but I need to push things on. Keith, have you finished your questions?

Mr Raffan: There is one final one, but—

The Convener: I am sorry, but we must finish. We may well come back to you, Dr Lind, especially on the details and for information. Many

of the issues you have talked about have been extremely interesting. You have given us many quotes for our report.

Dr Lind: As long as they do not get back to the health board.

The Convener: We will do our best to protect you—we know how it feels. Thank you for all the work you have done for us. It will very much help us with our report, of which you will receive a copy.

Meeting closed at 16:31.

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