

Home Affairs Committee

Oral evidence: [Drugs, HC 198](#)

Wednesday 25 May 2022

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[Watch the meeting](#)

Members present: Dame Diana Johnson (Chair); Ms Diane Abbott; Simon Fell; Carolyn Harris; Adam Holloway; Tim Loughton; Stuart C. McDonald.

Questions 118-193

Witnesses

[I](#): Councillor Joanne Harding, Local Government Association, Maggie Boreham, City and Hackney Public Health Team, Hackney Council, and Professor Jim McManus, President of the Association of Directors of Public Health and Director of Public Health, Hertfordshire County Council.

[II](#): Professor Dame Carol Black, independent adviser to the Government on drugs.

Written evidence from witnesses:

[Local Government Association](#)

Examination of witnesses

Witnesses: Councillor Joanne Harding, Maggie Boreham and Professor Jim McManus.

Q118 **Chair:** Good morning. Welcome to the third session of our inquiry into drugs. I will ask our witnesses to introduce themselves. Perhaps we could start with Professor McManus, who is joining us by Zoom.

Professor Jim McManus: Good morning, Chair and members. Thank you for the invitation and for allowing me to participate remotely. My name is Jim McManus. I am president of the Association of Directors of Public Health, which has drug and alcohol treatment commissioning responsibilities and prevention responsibilities. My day job is director of public health for Hertfordshire. I have been a drug and alcohol commissioner, or involved in commissioning, for around 30 years.

Chair: Thank you very much. Maggie, would you like to introduce yourself?

Maggie Boreham: I am Maggie Boreham, principal public health specialist. I have 20 years of experience working in community frontline services in the homeless and drug and alcohol sector.

Chair: Thank you. Councillor Harding.

Councillor Joanne Harding: I am Councillor Joanne Harding, from Trafford, Greater Manchester, representing the LGA as its substance misuse lead. I am also a former drug and alcohol worker, and manager of several substance misuse services.

Q119 **Chair:** Thank you very much for joining us this morning. The focus of today's hearing is the 10-year drugs strategy, which we want to look at in depth. Perhaps I could start off by asking each of you in turn, starting with Maggie Boreham, to say what you think about the strategy and whether there are any gaps in it.

Maggie Boreham: It is really important to start by thinking about a public health approach, which is an evidence-based approach. It is about making sure that we can get the right information to people: for instance, understanding the difference between addiction and dependency as opposed to occasional use. It is about understanding the drivers of that, such as adverse childhood events and trauma, which affect anybody from any part of society, and poverty, structural inequalities and racism. That is the way to understand addiction: as a symptom of those things.

In terms of the drugs strategy, the cross-departmental commitment to reducing drug-related harms is particularly welcome, because that has not necessarily been achieved with previous strategies. The sustained investment in treatment and in rebuilding and developing the workforce is very welcome. The focus on diversion away from the criminal justice system is absolutely necessary, and also very welcome. The focus on the



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most harmful and violent aspects of the criminal and illicit drugs market, and the safeguarding of more young people, is also particularly welcome.

Some of the tensions that will arise in trying to implement the strategy will be in the prioritisation of crime reduction and increased prohibition. If you look at decades of research from around the world, the evidence shows you that prohibition will generally, at best, achieve temporal, marginal and localised disruptions to drug production and supply. It ends up displacing criminal activity, and generally means that you have more people being criminalised and imprisoned. The other issue is that, because you have economic processes, you have an illicit trade that will seek to develop more potent and much more profitable drugs. The other unintended consequence of prohibition is that the people who generally bear the brunt are the most marginalised and vulnerable. That is one aspect that will cause tensions in terms of implementation.

There are other interesting areas. For instance, there is a particular approach that looks at new digital therapeutics and technologies—sobriety tags, for instance. The evidence base is not really supportive of that. A further aspect is that those could actually be provided instead of treatment. If we are seeking to create meaningful change and help people understand what underlies their substance use, we need to make sure that treatment is included.

We need to think about how the focus on recreational drug use will be implemented, the reason being that 61% of recreational drug users are under the age of 30. The strategy is very clear that it will look to criminalise possession for individual and personal use. That makes me concerned that we may end up criminalising more younger people. The other thing that is very clear in the Dame Carol Black report, but not necessarily as clear in the drugs strategy, is that there are different levels of risk and danger in how drugs are sourced. Over half of recreational drugs users source through social supply, which is a less dangerous way of obtaining drugs. If we continue to criminalise people for possession for personal use, that creates further barriers to having honest discussions about drug use.

Q120 Chair: Sorry, could you explain social supply? A friend giving you something rather than you going out and finding a drug dealer—is that what you are saying?

Maggie Boreham: No, it is just meant generally. The Dame Carol Black report was very clear that over half of people who are recreational, occasional users will source their drugs from somebody within their social network. Another 10% will source their drugs from an acquaintance or a relative.

Q121 Chair: Thank you. We will have further questions about a number of the points you have raised. Councillor Harding, would you like to comment on your views on the 10-year drugs strategy and any gaps?

Councillor Joanne Harding: Certainly. From an LGA perspective, we welcome the 10-year drugs strategy, the extra investment that goes with



the strategy and the opportunity to rebuild some of the work around drug prevention and treatment. Councils are absolutely committed to the 10-year drugs strategy. It is fundamental that drug users should be able to get the right treatment at the right time and in the right place.

One of the things that we want to happen as a result of the strategy is to remove some of those borders. We all know that drugs know no class and no borders. We want those open-access services so that people get the treatment that they need, when they need it. Doing that—reducing some of those borders—helps to reduce stigma as well. It should not be that it is just about a health-based model. We need services in the community—those wraparound services—for example, when people come out of a detox. An in-patient detox is only one aspect to treatment. When people come out, and they are coming out to the same environment, they need to know that all those wraparound services are going to be there for families, children and the drug user themselves.

The drugs strategy is a chance to rebuild. We welcome the money that has been invested, but we know that it is not going to all local authorities. Some of the local authorities that have not got that extra money are going to be playing catch-up as we try to achieve the outcomes of the strategy.

I have serious concerns about sustainability. We know that local authorities have had significant cuts to their funding, and it is okay to invest extra money into drugs, but we need to look at those wider determinants and the reasons why people use drugs. Maggie mentioned trauma—those adverse childhood experiences—so we need investments in those wider services. How do we support better housing, better tenancies, more investment around parenting, physical health and mental health? While we welcome the strategy, we recognise that we need long-term sustainable funding to those other services.

A key aspect to being able to deliver that is workforce. I know, as the cabinet member for social care, that we are all—to coin an expression—fishing out of the same pond when it comes to looking for workers across health and care. We are losing skills in drug and alcohol treatment services. If we do not have those skills, we are simply not going to be able to deliver the right support at the right time and in the right place. The strategy is welcomed, but we know there are significant gaps around some of that longer-term funding and workforce.

Q122 Chair: Thank you, that is very helpful. Do you think the Home Office is the right Department to lead on this? You have talked a lot about the health issues around drugs.

Councillor Joanne Harding: I think that it has to be that cross-Department working. That is the way I feel about council portfolios. We should not see drugs, and I have to say alcohol—it is about time we started talking about drugs and alcohol—in silos. We need to start working cross-Department, and the LGA has made reference in its written submission that we would like to see a sponsored Minister to help us navigate across those Departments to really start embedding the strategy.



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Professor Jim McManus: I won't repeat what colleagues have said for the sake of time. There are huge elements in the strategy to welcome, particularly the investment, because we need to rebuild drug and alcohol services after the effect of the significant cuts to local authority services.

There is a good focus on harm reduction, but it doesn't go far enough. Areas that I think the strategy misses are cross-Government co-ordination. It is right that we take a public health approach to drugs. That means we need elements of policing where those are needed, but we also need elements of treatment and care. A key thing for me that is missing is how we get people back into jobs, employment and education after successfully resolving drug and alcohol problems. There is another issue for me, which is that when people have mental health problems, a drug and alcohol problem and/or a learning disability or autism, I think that that is still lacking. The focus on the wider determinants needs a bit more work, as does the focus on different communities and different populations and how they are affected by drugs and alcohol—the socioeconomic and diversity variables.

There is a lot to welcome, but I think there is an awful lot more that needs to be done. We really need sustained investment in treatment and care, but I particularly welcome the fact that Dame Carol Black recognised that local authorities can be trusted with drug and alcohol treatment and care commissioning. We need to work together in partnership, because that is the only way we will reduce the harms to our country from drugs and alcohol. I give it one and a half out of three.

Chair: One and a half out of three—okay, thank you. I am going to come to Diane Abbott next.

Q123 **Ms Abbott:** Thank you very much, Chair. I want to put this in context. In your understanding, has the overall drug-taking population risen over time in relation to the population as a whole? Do you know? You are looking blank.

Councillor Joanne Harding: I think reference is made in some of the LGA work about drug use in the population. Professor McManus may know the answer to that one, but we have made reference to the drug-using population in our work.

Ms Abbott: It wasn't meant to be a trick question!

Councillor Joanne Harding: No, I am not taking it as a trick question.

Q124 **Ms Abbott:** I am just interested in whether it is a rising problem.

Councillor Joanne Harding: We have definitely seen an increase in young people's drug use, for sure. That is again about the prevention aspect, and how we work with young people but do not necessarily criminalise them. That was certainly referenced at the Home Office summit on the 10-year drugs strategy.

Q125 **Ms Abbott:** Professor McManus, has the overall drug-taking population



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risen in relation to the population as whole. Do you know?

Professor Jim McManus: The short answer is nobody is really sure, Ms Abbott. It depends on which drugs you are looking at. If you are looking at stimulants, then there is some evidence that their use has risen. If you are looking at opiates, it looks like the more synthetic opiate use has risen. I can go away and find the answer for you, but I think one of the problems is a lot of the research actually looks at different using populations.

What we can say is the use of alcohol, stimulants and legal highs has risen. We can also say that the use of opiates is very variable in its patterns; I can already feel a number of researchers disagreeing with me from their particular part of it. The reason why your question is an exceptionally good one is because it is so difficult—it is such a moving feast to get a handle on.

In more deprived communities, the burden of illicit drugs has risen in terms of its impact on people, not just because of the changing patterns of drug use, but because of the other consequences and harms that come along with it. I am sorry I cannot give you a crystal-clear answer, but I hope that made some sense.

Q126 **Ms Abbott:** Yes, it did. I have another question, and it isn't meant to be a trick question. Has the type and pattern of drug use altered over time? Are people taking different types of drugs than they would have taken 10 or 20 years ago?

Professor Jim McManus: Do you want me to try and have an inadequate stab at that again?

Ms Abbott: Yes.

Professor Jim McManus: The short answer is yes. You will see, for example, dance drugs being used a lot by younger people—my colleague referred to the use by younger people under 30. Heroin and opiates will be used by other types of populations, but synthetic opioids are coming into use as well. There are different patterns by age, class and socioeconomic strata, and by different ethnicities in different parts of the country.

One of the strengths of the strategy, which I might have been a little too hard on earlier, is getting local partnerships together to understand their local drugs dynamics. The pattern of drug use in somewhere like Hackney is different from the pattern of drug use in somewhere like Liverpool, although there are overlaps. What you do not have is one pattern of drug use across England; you have multiple patterns, a bit like a mosaic.

Q127 **Ms Abbott:** All right. My final question, which is not meant to be a trick question, is: will the 10-year strategy disproportionately affect black communities?

Chair: Who wants to have a go at that?

Councillor Joanne Harding: Can I pick up on something Professor McManus said about that? I think that's about how we need to get the



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messaging right in communities and ensure that we engage properly with different communities, because the messaging will be different. For example, in Trafford, where I am a councillor, we have a big south Asian community in some parts of the borough, and I am using the example of covid when I think of the messaging that went out. It wasn't always right to direct certain communities—

Q128 Ms Abbott: I understand about the messaging. My question was: will the 10-year strategy disproportionately affect black and minority ethnic communities?

Maggie Boreham: The focus on possession for personal use, which is very much around the recreational drug use angle of the strategy, will need to be implemented very carefully in the sense that we would need to ensure we're having full diversionary pathways. People that are coming into contact with the criminal justice system should be diverted away straight away into harm reduction, education and prevention programmes, and that should be a no-sanction model. For us to be able implement this in a way that actually has the intended consequences of reducing the harms of drug use, we would need good diversionary pathways for those communities that we know have already been disproportionately impacted by that part of the legislation, which is the possession of drugs for personal use.

Q129 Ms Abbott: So you are saying that it does not necessarily disproportionately affect black and minority ethnic communities.

Maggie Boreham: No, I am not saying that. I think we know stop and search has a disproportionate impact on black and Asian communities. What I am saying is, I think, in terms of where this drug strategy is going, and the particular focus that it has on recreational drug use, the implementation of that will need to include very strong diversionary schemes.

Ms Abbott: Thank you, Chair.

Chair: Professor McManus, did you want to come in on that question?

Professor Jim McManus: Briefly. The first thing to say is that I think Ms Abbott's questions are clearly not trick questions; they are the kind of perceptive questions that every local partnership should be soul searching over on a regular basis. They are crucial to understanding our local dynamics.

The second thing is that I think it is too early to say whether this strategy will disproportionately affect black, Asian and minority ethnic populations, and I will give a couple of acid tests that we need to meet in order to make sure it does not.

The first, as my colleague has said, is that we must do everything we can to avoid unnecessary criminalisation. Secondly, access should be culturally sensitive, appropriate and non-stigmatising for young black people, for example. The third thing is how we support them to move from



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problematic drug use into employment and thriving, and next is how we deal with the wider determinants.

Those are four acid tests for me of whether the strategy really will do what it needs to do for our black citizens and residents, rather than disproportionately affect them.

Q130 Tim Loughton: Can I come back to an earlier question, professor, in terms of whether drug usage has increased? You may not be able to give those figures, but have the number of people presenting with health problems and fatalities increased as a result of drug taking? Is that a more accessible figure?

Professor Jim McManus: Yes, Mr Loughton. There are several figures. First, the number of people presenting for treatment and care has increased. If we exclude the proportion of the population who have dependence on prescription drugs, which I think is a separate problem, that has also increased massively. There seems to be no doubt that the number of people who are needing help because they have got into problems has increased, because it is affecting their work, their lives or their health.

The second thing that we have is an ageing population who, in their drug-using careers, have been using drugs that have given them significant health problems such as immunosuppression. That means they are much more at risk of drug-related death. That population seems to have increased in its needs and its complexity.

The third thing is that, despite great efforts being made, drug-related deaths have increased. We are doing everything we can to keep them down, and the roll-out of naloxone has helped, but if you look at the health impact and the economic impact of drug and alcohol abuse, and the impact on people's lives, they have worsened over the past five to 10 years. Our strategy rightly recognises that we need to address that.

Q131 Tim Loughton: Okay. Briefly, because it wasn't the main question that I wanted to ask, is the increased presentation of people with drug-related problems—setting aside those who present with other problems such that their drug dependency has impacted on immunosuppression and everything else—an indication in itself that a higher proportion of the population is taking drugs, or is it more a reflection of there being more people taking more powerful drugs over which they have less control, as well as greater accessibility of prescription drugs—high-powered prescription opiates being used and people becoming addicted to them? Is it more down to traditional non-prescription drugs or is it down to greater use of and dependency on prescription drugs causing those dreadful problems?

Professor Jim McManus: I would have to say that this is a bit like looking at a rainbow in that all those make up the totality of the problem we are facing. For example, the use of drugs alongside sexual scenes has grown, and more and more people have got into difficulties because of that. More and more people have got into needs. I would say that this is a



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bit of a growing river into which a number of tributaries that you have mentioned are flowing, if that makes any sense at all.

Q132 Tim Loughton: There are a lot of metaphors in that answer, professor, but thank you. I think it is a complex situation.

Can I come to local government with Councillor Harding? Could you comment generally? Do you think the move to local authorities being responsible for public health policy over the past eight or nine years—whatever it is—has been a success?

Councillor Joanne Harding: Yes, I do, and we are committed as local authorities to continue with that public health work, the commissioning. We know our communities. Again, I will use the example of covid. We knew what was going on in our communities. We knew where to target resources. We are absolutely committed to achieving better health outcomes for people in our communities, so completely, it has been a success. I have to caveat that with the fact that we have had significant cuts to our funding, and that funding would have allowed us to do other things around housing, mental health and physical health.

We are best placed to address what our communities need, and again, throughout covid, we have been creative and innovative. We have developed partnerships, we have collaborated, we have improved things for people, and we want to continue doing that, but as I mentioned in my first response, in order to do it, we need that longer-term, sustainable funding. Whenever we have one-year funding or three-year funding, that does not allow us the opportunity to develop those strong, robust plans. We have pilots, but we need more than pilots. We need that sustainable funding to continue it.

Q133 Tim Loughton: I completely understand that and acknowledge the funding challenges, but to take another example, since local authorities took over responsibility for health visitors, for example, the numbers have halved. That is disproportionate with respect to other aspects of public health that are now the responsibility of local authorities. Because that funding is not ringfenced, they have been seen as low-hanging fruit for local authorities to make savings. Why won't the same happen to taking over drug treatment policy?

Councillor Joanne Harding: Again, I refer to my original point that we have to make difficult decisions in local authorities when we do budget setting. I am not saying that we should pick low-hanging fruit because, clearly, health visitors are an important and integral part of any drug strategy too. You would want health visitors to be around parental drug misuse. You would want to ensure that parents got access to that early intervention and treatments. I don't think it is great that health visitors have been reduced. I refer to my original point that it is about funding, but it is also about workforce. We need to look at some of those significant reductions we have seen across the health and social care workforce.

Q134 Tim Loughton: Again, I do not disagree, and I am not trying to underplay the challenges of funding in local government. It is a question



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of where the priorities lay. You said that you think that moving public health policy to local authorities has been a big success. Why? What has been done differently from if it had remained with central Government?

Councillor Joanne Harding: I made the point about local authorities collaborating and working together. Let's not forget that we are now looking at another restructure of health, with integrated care systems, so that duty to collaborate should be even stronger; we should bring some public health, health and social care together. That is what is happening, and that is what we all have to do—to develop those partnerships. Local authorities will want to strengthen those partnerships across public health, health and social care.

Q135 **Tim Loughton:** What has changed on the commissioning of drug treatment services going to local authorities in 2013?

Councillor Joanne Harding: I am going to ask Maggie, as a specialist commissioner, to respond to that.

Maggie Boreham: The point that Councillor Harding is making around the level of collaboration that can be achieved through local authorities with our local populations is incredibly important. Professor McManus also noted that we know our local populations, which has become much clearer during the pandemic.

Drug treatment systems include different stakeholders, such as smaller charities within the local authority, culturally sensitive services and NHS trusts. All those different aspects of the system need to come together and need to be able to respond to the individual and community needs within your local authority. That is something that local authorities can do a lot better than central Government.

Q136 **Tim Loughton:** They can in theory, but are they in practice? Ignore the fact that you have Councillor Harding next to you, though she might like to comment on this. I am slightly playing devil's advocate. Do you think, in the scrutiny of the specialist services that you and colleagues deliver, that local councillors have the capacity to know what they are scrutinising, to put it frankly?

Maggie Boreham: I would say yes, we do, but there is more work to be done. The drugs strategy mentions things like a national outcomes framework and a local outcomes framework. Those things are welcome, as long as they follow the Black report, which looks at ensuring that our treatment systems are improving quality of life, as well as having numerical metrics on how many people are into treatment.

We have seen a 59% increase in the number of people coming into our local treatment systems since 2020. That essentially is through doing a number of things with our treatment system. One is ensuring that we have a lot more outreach. We have more people on the streets, going into temporary accommodation and hostels, working with smaller community services, delivering harm reduction and distributing naloxone.



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That has been possible because we have had this additional investment. I would say that, yes, we have responded, but I do totally hear your point. Do there need to be additional layers of scrutiny? Do we need that? I would say we probably always need that.

Q137 Tim Loughton: I am not denying the increase you have seen in your outreach or whatever. What I am not hearing is why that has been absolutely a consequence of the switch of responsibility to the local authority, rather than to a dedicated central Government Department, team or whatever.

I have more experience with early years services, and I am concerned that there is a lack of expertise and capacity on political scrutiny of some of those services on a local basis. An even more technical area, such as drugs, is perhaps making even greater demands on voluntary local councillors sitting on scrutiny committees, as to what the local public health priorities should be.

Maggie Boreham: Essentially, the delivery plans for the ADDER programme of work were developed by me and colleagues in public health. We were the only ones who could develop those, because we are the ones who have the local population data. We understand where the blockages in the system are and where the pathways are not that strong. That is not something that someone in central Government could do. We have those relationships, and we have that data. It is our job to make sure that we have that data and understand where the vulnerabilities in our local system are.

Tim Loughton: We will come to you, Professor McManus, and then go to Councillor Harding to finish off.

Professor Jim McManus: There are a couple of points, I think. First, the Health and Social Care Committee heard evidence from Public Health England that, despite 25% cuts in funding to local government, 85% of the outcomes that local government was responsible for in public health had held up or improved. Secondly, we have increased the number of people accessing drug treatment, and we have held up outcomes—the data shows that quite clearly—since the transfer of responsibility in 2013.

Thirdly, there is a national quality framework, developed by public health specialists with drug and alcohol commissioning expertise in public health, which is applied by officers. The scrutiny is not just down to local authority elected members; it is also down to experts in public health. We have more scrutiny of drug treatment and commissioning than we had when it was in the NHS—I was a commissioner when it was in the NHS. I think that it is better scrutiny because you have democratic scrutiny working with expert officer scrutiny. Other countries have looked at that and said that we are doing quite well.

The key point on health visitors is that the Department of Health and Social Care is responsible for recruiting them, not the local authorities. I take your point about the cuts in funding, but we were given a 25% net



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cut in funding to local authority budgets over three or four years, and the money that was supposed to be there for the previous Prime Minister's target for the number of health visitors recruited was not there when we started. In any case, there were not enough training places in the country.

We do need health visitors—I would also say that we really need school nurses, because they are every bit as vital—but I do not think that is a good example of how the local authority system has worked to keep up outcomes. I would say that drug commissioning and some other services are a good example of how local authorities can be trusted with both the outcomes for their community and delivering high-quality services, despite year-on-year cuts. Again, there has been a real-terms cut this year to the public health grant, which has not helped.

Councillor Joanne Harding: Just to echo some of the points that Professor McManus made, as a former chair of health scrutiny, I can tell you that local councillors take incredibly seriously the scrutiny function. Scrutiny is a really important part of the work we do. The reason it works in that way is that councillors are committed to wanting to get the best for their communities. They are genuinely interested in the impacts of harm on their communities. Subjects like drugs and alcohol are regular features on any scrutiny committee. As Professor McManus referenced, we have specialist commissioners in our public health team, we have NHS providers, we have all of those charities, and we have specialist and expertise officer support. I think that the scrutiny function at a local authority level is an incredibly useful and very thorough tool. To your point, scrutiny absolutely does work around things like drug and alcohol strategies.

Tim Loughton: Thank you.

Q138 **Carolyn Harris:** Joanne, Project ADDER started November 2020 and has operated in 13 locations across England and Wales, including in my own city. What do you think of the project?

Councillor Joanne Harding: I think Project ADDER is a brilliant initiative. Reminiscing back in time to my days as a drug worker, I was involved in the first mandatory drug testing in custody suites and was part of the DTTO scheme. I have to say that the work that we did around diversion, and getting people access to treatment for their physical and mental health, absolutely worked. We used to have intravenous drug users who were injecting into their groin, who would have leg ulcers and then end up with amputations, but we started a very complex, multi-agency system, with police, health, local authorities, probation, housing and mental health services being brought together. It would take us time to build relationships with those people, because if you are homeless and have a lifestyle that is based around illicit drug use and offending, that is potentially the lifestyle that you know—I am not going to say you choose it—and you feel safe around the people who you know. It takes a lot of relationship building, it takes building trust, and it takes agencies being committed to want the best.



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I worked really hard to change the culture in the police. Clearly, they had victim empathy, and I had to flick the switch so that they understood that people using drugs were potentially victims too—victims of their own traumatic lifestyle. It is about changing the cultures within organisations. It is a brilliant initiative, and anything that looks to reduce drug-related deaths and to improve people's lives is good by me.

At the LGA, what we are saying is that we want to see the evidence from the pilots before we have further roll-outs, but if the evidence tells us that things are working, we also need to be clear that different areas have different demographics. It is not going to be one size fits all. As Diane Abbott said about different communities, we know that we need to make different offers to different communities, but any multi-agency, multi-team approach that improves people's lives is the right way to go, if the evidence tells us that.

Q139 Carolyn Harris: I am delighted to hear you say that. In Swansea, the organisation Dyfodol is running what it calls a RAPS programme. It works with a section of the community who are very dear to my heart and, I know, to the Chair's heart: victims of prostitution—mostly, but not always, women. These women are double victims: they are victims of prostitution, and they are also the victims of pimps and drug dealers. It is perpetual, and county lines has no doubt fed into that and created an awful situation.

What I like about RAPS—I would be interested to hear if this is the same right across all these projects—is that, previously, victims of prostitution were able to access a script to get on to methadone or Buvidal only if they had committed an offence, and the easiest way was to go through the criminal justice system. It would appear that RAPS is able to short-circuit that. Is that replicated across the country?

Councillor Joanne Harding: I am going bring in Maggie on that, because she has referenced the work that she has done with ADDER, so I think she would be best placed to answer.

Maggie Boreham: That is very much the aim. We really want to reduce the involvement in the criminal justice system as much as possible. The work that we have been doing with ADDER has been creating stronger pathways between criminal justice and community treatment, so that people are essentially being signposted into community treatment. What we do not want is people to be going round and round the criminal justice system, as you are talking about, and there should be no gatekeeping of treatment because somebody has committed a crime or been charged with a crime. We talked about the kind of people who are involved in sex work—a lot of them are women, but there are also an awful lot of men—and we know that the underlying drivers of that will include early childhood adversity. There will be an awful lot of trauma. Injecting drug use is traumatic. Homelessness is traumatic. Essentially, what we want to be doing is making sure that people are getting the full range of services, which includes opiate agonist therapy, Buvidal and making sure that people have access to heroin-assisted treatment. In some parts of Europe,

and as a study in Glasgow found, it could also involve overdose prevention sites. All these things will reduce drug-related harms. They will definitely support the pathways and make sure that people are getting treatment in a much more timely way.

Carolyn Harris: Thank you—that is all I wanted to know.

Q140 **Adam Holloway:** Take the gloves off: if it were up to you, how would you deal with this problem? Given a blank sheet of paper, on victims and the criminal justice system, what would you do?

Maggie Boreham: First, I would reframe the issue as a health issue and an issue that often relates to trauma, early childhood adversity, structural inequalities and, as we know, deprivation—there is a very strong evidence base for that. I would make sure that we had a full range of evidence-based treatments available. As we have already said, that includes opiate agonist therapy, heroin-assisted treatment and a whole range of harm reduction interventions, as well as abstinence-based interventions.

I would continue with the investment. Essentially, we need as much investment in treatment as possible—and investment in the treatment system. That includes NHS colleagues, and it includes working with culturally sensitive local organisations and charities, which we have done in Hackney, to make sure that there is no wrong door. If you go back to “Models of care”, which came out in 2002, that created a four-tier treatment system that meant that wherever you went, you were always going to be able to access treatment. Tier 1 was actually not treatment systems, but other types of organisations that could signpost effectively and make sure that people could access treatment. We know that treatment works, and we know that additional support for housing and employment, and wider social care support, also helps.

Q141 **Stuart C. McDonald:** I thank our witnesses for their evidence this morning. Maggie, you said that you would like to reframe this as a health issue, which takes us back to something that other witnesses have said to us during this inquiry. Do you think there is still too much of a focus on criminal justice and penalties? If so, what problems does that cause?

Maggie Boreham: A narrative that is very much about criminalising drug use creates a huge amount of tension. Obviously, our enforcement agencies need to be able to follow and deliver that approach through the legislation, but if you are working in health that becomes very difficult. If I am trying to have an honest discussion with someone about their drug use, that becomes very difficult, because essentially that person will be unable to fully explain or talk to me about what they are doing.

We do manage that within the treatment services, obviously, but the pathway to treatment services is more difficult, because people will fear that there will be some form of criminal response to their drug use. If we are talking about areas of deprivation, as Professor McManus has, and we think about the disproportionate impact of illicit drug use on those areas, then how we support those communities to come forward and trust in

treatment is more difficult if we have an overarching crime-reduction narrative.

Q142 Stuart C. McDonald: Councillor Harding, I see you nodding. Is there anything you want to add?

Councillor Joanne Harding: I have just written “trust” on my page, because I think that is imperative for reducing stigma. I want to focus specifically on younger people. Picking up Adam’s point about what we would do if we had a blank canvas, for me some of that investment in young people is critical, so that we can do the work on early intervention and prevention.

It is also important to get the messages right. I was at the Home Office summit last week, and one of the speakers referenced young people not wanting to talk to FRANK. So whatever our messages are around public health, we have to get it right. There was also a speaker talking about students and the university population. What is the messaging to young people? I would want to do some work about young people, building trust, reducing stigma and getting messages right.

I have worked in a women’s prison estate, and I have seen women criminalised and sentenced to short sentences because they have had an addiction. Their lives have invariably been destroyed, children have been removed or they have lost their tenancy. They then end up in that revolving door of systems.

We have to think about sentences that are proportionate or about community orders that genuinely support somebody to rebuild their life if they are blighted by addiction. Let us be clear, I know the impact of addiction on families. We know that it blights families’ lives. We have to make sure that we don’t just get someone stuck in the criminal justice system. Treatment needs to be proportionate and right for where that person is at in their life.

Q143 Stuart C. McDonald: Professor McManus, do you have anything to add? Is there a case for drugs policy to be driven by the Department of Health and Social Care, rather than by the Home Office?

Professor Jim McManus: I think there is a strong case for that, yes. If you read closely the Dame Carol Black review, the Government’s 10-year strategy and what my colleagues have said, there is consistent theme running through this that treatment is the catalyst to the way out of drug-related harms and you need to be able to access it, and that we need to reframe drugs as a health problem, not just a crime problem.

There is a really important place for policing, and Project ADDER should be welcomed because it is systematically funding the investigation of what the police role is in drug-related harm, so that we stop criminalising people. We need to realise that all the evidence shows that just criminalising drug use actually creates more harm than treating it as a cross-Government, cross-society health issue to be tackled. The evidence



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for that is overwhelming. Dame Carol Black recognises that, as does the sign of hope in the treatment strategy.

Q144 Stuart C. McDonald: I will follow up on Adam Holloway's question, this time starting with you, Professor McManus. In the evidence we have been presented with so far, there are examples of local authority initiatives, including the centralised warning systems in Southampton, the roll-out of naloxone in Newcastle, and the Wirral recovery village. Are there examples of good local authority practice that you would like to see rolled out nationally? Are there other things, such as overdose prevention facilities, that you would like local authorities to be able to explore?

Professor Jim McManus: I have to say that the Local Government Association, the English Substance Misuse Commissioners' Group, and Collective Voice—a coalition of voluntary sector providers—have been fantastic in creating case studies, of which I am an inveterate consumer.

If I were blowing my own trumpet, I would say that there is a social enterprise in my county that takes people out of drug and alcohol treatment services and trains them through employment. That is fantastic and it does amazing work. The way we have rolled out naloxone locally has lessons for others. The consistent support of our police in joining together with us strategically has been brilliant, in my experience.

I could point you to examples right across the country. I do not think it is just a case of either rehabilitation or other treatment, or assisted heroin treatment, but a case of both/and. We need to create a patchwork of the right services for people. There are examples right across the country that we could look at and build an excellent treatment system. The sticking point will be whether we see the sustainable funding needed to deliver our ambitions to reduce harms to our citizens. Harms are hampering our economy and the levelling-up agenda.

Q145 Stuart C. McDonald: What is your view of overdose prevention facilities, in particular? Do you think we should explore that initiative?

Professor Jim McManus: You need a number of things from overdose prevention. You need really good basic and well-funded treatment services; you need mental health services to have the right level of treatment, and A&Es to have the right level of support to deliver their bit; you need good naloxone; and then you need the overdose prevention facilities to slot in beside that. But they are so expensive that if you just wanted to provide them on existing funding, you would wipe out the funding for much of the rest of the drug treatment system. They are a "great to have" on top of all the other things that are "must have", but you need the funding.

Q146 Stuart C. McDonald: Thank you. May I ask for specific examples of harm reduction and of local initiatives to tackle offending? Examples given to us in evidence include a violence and vulnerability steering group in Southend, and a CCE partnership board at North East Lincolnshire Council. Are there other examples of good practice that we should look at?



Maggie Boreham: Through the ADDER work that we have been doing, we have a lived-experience forum that is extremely helpful in thinking about how we build partnerships with the police. We are also looking at developing a peer-led needle exchange. Professor McManus noted how it is really important that we start to co-create the response with people who have experiences of drug use and with our communities. That is where we end up getting a reduction in violence because we are bringing people into the system and understanding what would work better for them.

We did a lot of that during covid, and it is the sort of work that we should be doing, because it is one of the ways in which we can start to reduce health inequalities and understand the barriers to people accessing treatment and engaging in the support that they need. A strong aspect of our approach to ADDER has been working with the police by bringing them in to think about how there definitely needs to be wider roll-out of naloxone. It would be great if all police forces had those pockets of brilliant practice.

Bringing in people with lived experience and looking at how to develop services better is one of the ways to do that. We have done that with the peer-led needle exchange, and we are doing it with other work too.

Councillor Joanne Harding: As Professor McManus referenced, the LGA has a whole suite of case studies that we can provide on some brilliant areas of innovation. Clearly, naloxone is imperative in reducing drug-related deaths and preventing overdoses. As Maggie said, we should probably take some learning from some of the peer-led groups. We talk about co-production all the time in health, across social care and in local authorities, but how often do we genuinely do it? Some genuine co-production from some of these pilots would be really useful. If it works, carry on. If it doesn't work, we might need to tweak it and do it differently. We don't throw the baby out with the bathwater.

We have learned a lot from covid. We had to make sure that interventions were still there for people during covid. If you have dependent drinkers who need to access alcohol, because otherwise they will die, you have to make sure you get services to people, and we had to do that during covid. We have to move away from this system of thinking that we should expect people to come to us for treatment. The services that are out in the community include outreach services, which are responsive to local need, and one-stop collaboration shops, which mean that people aren't having to go here for housing, here for mental health and here for substance misuse. How do we bring people together? I think that genuine co-production should help us build some of those future models.

Stuart C. McDonald: Thank you. We will definitely have a look at the case studies.

Q147 **Simon Fell:** To follow on from Stuart McDonald's point, I have a fantastic treatment and rehabilitation centre in my constituency, which operates in Cumbria and north Lancashire, called The Well Communities. It is great, but it is very locally focused. I would be interested to hear your views,



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based on the wealth of evidence and case studies that you have, on whether there could be a one-size-fits-all solution, properly funded, or whether you think it is better that these things grow organically in the communities they serve.

Councillor Joanne Harding: As I said in an earlier response, I don't ever think there is a one-size-fits-all. In Cumbria, you have huge rural communities, so your access to treatment is going to be different. The transport links for people to get to treatment are different. Your demographics may be different, although I know there are huge areas of deprivation and poverty in Cumbria. I am not talking about a one-size-fits-all; I think we should adapt and grow some of those very old-fashioned, traditional systems that we had around drug treatment services way back when. They are not the services that we want now. We want services to be more flexible and responsive to people's needs, so I think communities should develop and grow them with some co-production. How do you bring people together? We should not be prescriptive and tell people what they should have; we should develop it with them so that we get the right fit for that particular community.

Q148 **Simon Fell:** I am minded to agree. Do any of the other witnesses have a view?

Maggie Boreham: The Black report, which is incredibly helpful, talks about a recovery-oriented system of care. It is made up of a number of different things; it is both voluntary and statutory. It needs to be co-created with peers—people with lived experience. For instance, we are looking at recovery housing at the minute, and some of it is likely to be delivered by local organisations that have an interest in working in particular communities. We know that particular communities—for instance, older black men—are not being seen in our treatment systems. For some reason, there is a barrier to that. We now have an organisation that delivers a pathway into treatment, which is looking at developing recovery houses. You need a number of different options that very much relate to your local population.

Q149 **Simon Fell:** Professor McManus, do you have anything to add?

Professor Jim McManus: I echo what my colleagues said. We know that one-size-fits-all approaches work for very few things. I am a trustee of a hospice outside work, and it doesn't work in palliative care. If you take the Black report's thread of recovery-oriented treatment, which Maggie mentioned, the best thing to do is to get local partnerships to fulfil their statutory duty of assessing and understanding the needs of their population and building a plan based on that need. It will be different in Cumbria from somewhere like Brighton, because of geography for one thing, and the local partnerships should really respond to that. The acid test is whether they are really understanding and co-producing with their community a footprint of services that work for that community. I would suggest that outcomes, not portfolios of services, are the crucial acid test.

Q150 **Simon Fell:** Thank you, that is really helpful. In the Scottish Parliament, a Bill was introduced that tried to enshrine a right of recovery for



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individuals who are dependent on drugs. It effectively gives them the right to request a range of treatments. Would you support such a Bill?

Maggie Boreham: Yes, definitely. UK citizens who are usually resident within the UK already have rights to medical treatment under the Human Rights Act and the public sector equality duty. However, I do think that the Scottish Parliament is quite right to take that forward, further develop it and make sure that there is a right to treatment, which includes access to a range of evidence-based treatments that do not interfere with the relationship and clinical decisions that are being made between the clinician and the patient or service user. Those clinical decisions should be respected. I think we probably should have a UK-wide adoption of the Scottish Drug Deaths Taskforce's minimum standards for medication-assisted treatment.

Q151 **Simon Fell:** Thank you. It has been suggested that some of the existing powers in law already provide this right. To your mind, what is the uplift you would get from this, or what clarity would be given?

Maggie Boreham: I am certainly not an expert on this, but I would say the difference is that we are able to make sure that it allows a full range of evidence-based treatments—for example, different harm reductions including heroin-assisted treatment. It also ensures that the law does not interfere in the relationship and the clinical decision making that takes place between the person in treatment and the clinicians and recovery workers who are collaborating with them.

Q152 **Simon Fell:** Thank you. Councillor Harding, do you have anything to add?

Councillor Joanne Harding: From an LGA point of view, we are obviously committed to the 10-year drugs strategy and to ensuring that people are getting the right treatment in the right place at the right time. In so far as enshrining it in law is concerned, we know that wait times for treatment have actually reduced. People are getting the treatment that they need. They are not waiting a long time to access treatments. More importantly, it is about the wrap-around treatments that people need—those other community treatments. The LGA stance is that we would really need to see more evidence that enshrining something in law genuinely does improve outcomes for people.

Q153 **Simon Fell:** Thank you. Professor McManus?

Professor Jim McManus: I agree with my colleagues. I think the key thing about the Carol Black review was that it was a wake-up call for central Government, because local authorities have known since we took over the commissioning of drug and alcohol treatment how important it was, but there has not been the funding. A wake-up call in the form of a right enshrined in law would be good, because the rights in the NHS constitution do not go far enough—in England, anyway—to safeguard people's rights to drug and alcohol treatments. A justiciable right in statute should be welcomed, provided there is sustainable funding to deliver a really good treatment service. If the money is there, a right works. If the money isn't there, a right might fail people.



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Q154 **Simon Fell:** Thank you. You have led me to my next question. If this did become law, what would the impact be for you, delivering it at the frontline?

Professor Jim McManus: I guess that if the money was there, the impact would be that we could have a system that enables people who have problems with drugs to absolutely thrive and contribute to a society and economy in the way they want to and to live the lives they want to. That is the vision that Dame Carol Black quotes to us: "recovery-focused treatment". The worst-case scenario is that you have a whole load of people who cannot get access to drugs because the money isn't there to fund them. Because the Secretary of State and local authorities are being sued, money that should go into treatment is going to paying lawyers.

Q155 **Simon Fell:** For the avoidance of doubt, that money is not there at the moment, so without it being enshrined in law you could not deliver on it as it stands.

Professor Jim McManus: Yes. There is no money—we would welcome more money, but there isn't enough money to deliver heroin-assisted treatment and there isn't enough money for the overdose centres. We need sustained and more investment, because the money we have got does not make up for the money that was cut significantly over several years from the public health grant and the drug and alcohol treatment centres. It is wonderful, but it does not make up for what we have lost.

Q156 **Chair:** Thank you. That is very helpful. On the funding issue, is the money that has been allocated so far just for three years, even though this is a 10-year drugs strategy? We know that the funding is £780 million for three years. We have also heard that workforce is a big issue. Is there anything else that we need to be very mindful of to make this strategy work? Obviously funding and workforce, but do we need to focus on anything else?

Councillor Joanne Harding: I would say something about education and working with young people. That is critical, that early intervention education and having conversations with young people. I don't think that "Just Say No" works, but there has to be a way that we get messages across to young people, so that they build trust with other people whom they feel confident to explore with, particularly if adverse situations are happening at home or they have parental drug use. How do we explore some of those conversations so that they do not become the adult service user of tomorrow?

Q157 **Chair:** Thank you. Maggie Boreham, is there anything particular that you want to say to us about where we should focus?

Maggie Boreham: Yes. The recent ACMD report on vulnerability to drug use is really helpful, because essentially it says that there are not individual vulnerabilities, but a collection of behaviours. We have to understand drug use within a social context. The same factors that increase childhood risk of drug use also increase the risk of alcohol and tobacco use. What we need is a much stronger prevention system, which



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we do not actually have. Again, it comes back to funding. The public health grant, as Professor McManus said, has been reduced by 24%, so if we are to look at the wider determinants of health, we need sustained investment.

Q158 **Chair:** Professor McManus?

Professor Jim McManus: Chair, you and my colleagues have neatly identified some additional watchwords. I would add merely three: first, we must remain focused on what Dame Carol Black said about recovery going into treatment, and recovery into employment and education; secondly, we must resist the attempt to tinker with the system and to start restructuring, reorganising and shifting responsibilities, because that wastes money and energy while people suffer; and, thirdly, we must recognise that this is a cross-Government issue, which requires us all to work together, and is not an either a Home Office or a Health issue, but a “both and, and” issue. Those would be my three watchwords.

Chair: Thank you. That is incredibly helpful. Thank you for your time this morning, and we will look at your written submissions and again at what you said today to inform our questioning for other panels in the future. Thank you very much.

Examination of witness

Witness: Professor Dame Carol Black.

Q159 **Chair:** Our second panel is Dame Carol Black. Good morning. Dame Carol, we are very pleased that you are with us today. Your report has been important reading for us on this inquiry. May we start with your reflections on the 10-year drugs strategy that the Government have produced? Do you feel that it has incorporated all the key recommendations and issues that you recognised in your report?

Professor Dame Carol Black: Part 2 of the drugs strategy is my report, really. So, yes, they have acknowledged and accepted the report and I think are doing their best to roll out and develop what I said.

I think the drugs strategy is more than my report, as it should be. You will have noticed that in my report I could not really do much about—I hate the word, but I will use it—“recreational” drugs, because the evidence was not there, whereas in the rest of my report I could find good evidence, so there is a lot of work to be done on reducing the amount of drugs that are taken in the population. There is a section on that. And, of course, the supply of drugs is important. You can never stop drug addiction through just supply, but, in part 1 of my review, I found that there was a lot more that needed to be done on supply, and so you see in the 10-year strategy a part that is really relevant mainly to the Home Office. Part 2, the middle bit, is my report. Part 3 is recreational drugs.

Q160 **Chair:** Thank you. Can I just ask you about funding, which seems to have been an issue with our previous panel, and about securing sufficient funding? We know there have been cuts to drug treatment services. The



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plan is for 10 years, but the funding is just for three years. As we have heard already, it is not enough to do everything that we would like to do. What is your understanding about the funding and how important that is?

Professor Dame Carol Black: As you can imagine, it was very difficult to get funding at this time. I think the fact that we got any funding, considering where the Government is and the economic situation, is very much to be welcomed. It is for three years, but I think the Treasury made it quite clear—I do not have a problem with this—that future funding should depend on whether we can show that we can begin to turn the tanker round. Can we show a change in the figures? You will see in the 10-year strategy that there are outcomes that are hoped for or intended. Well, how close can we get to them? I think it is difficult—they are very stretched targets—but we have to be able to use that money wisely. I would say, if we cannot, do we deserve any more funding?

Q161 **Chair:** As I understand it, the national outcomes framework and the local outcomes frameworks have not been published yet.

Professor Dame Carol Black: No.

Q162 **Chair:** We are still waiting for those. Have you any idea when they might be with us?

Professor Dame Carol Black: I believe June or July, but of course I don't know. They are very near to completion, as far as I know.

Q163 **Ms Abbott:** I wanted to ask you whether the amount of drug taking in the population has risen over time compared with the population as a whole?

Professor Dame Carol Black: I wonder if I should leave you the evidence pack to part 1 of my review, which would give you all the figures.

Q164 **Ms Abbott:** I am just asking, has it risen over time?

Professor Dame Carol Black: Yes, it has.

Q165 **Ms Abbott:** Thank you. Has the type of drugs that people are taking changed over time? Overall, are people taking different drugs now than they would have taken 10 or 20 years ago?

Professor Dame Carol Black: They are taking more powder cocaine—that is a very definite increase. You see far more usage of things like fentanyl, MDMA. Nitrous oxide has been introduced. They are not at the same volume. Cannabis has increased. One of the reasons I believe that they commissioned the review was because of the very shocking figures that were emerging.

Q166 **Ms Abbott:** In your opinion, will the 10-year strategy bear down more heavily on black and minority ethnic communities? If so, what could be done about that?

Professor Dame Carol Black: I would hope not. If I just take my part of what I wrote in my review, I very much hope that the diversion schemes that should come into place, working with the Justice Department, would ensure that far fewer people go down the criminal route. In taking



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evidence for my review, I did talk to many groups—vulnerable groups, black and ethnic groups—that told me that their needs were not met, that there were not enough suitable workers, and their culture was not recognised. I made it quite clear in my review that we need to really improve both the quantity and quality of treatment that would, I hope, do some of the things that I am sure you would like to see. I think the whole intention is for it to be positive, but the proof of the pudding is when we roll it out.

Q167 Ms Abbott: Is there any prospect of types of treatment and the type of workers employed changing in such a way as would stop the 10-year strategy bearing down more heavily on black and minority ethnic communities?

Professor Dame Carol Black: As we do the work with the workforce, that ought to make a really big difference, because one of the great lacks in treatment in this country at the moment is the period of recovery. In that recovery period, you really need peer workers. You need peer workers who have been addicted and who have come through, and there, you could have a much more genuinely diverse mix of people. We have got to get people working in the system who are much more diverse and who understand different groups. People with neurodiversity talked to me and said their needs are not met, so there are quite a lot of vulnerable groups who go into the treatment system for which we have made, really, no provision.

Q168 Stuart C. McDonald: Pretty much all our witnesses so far in this inquiry have welcomed large chunks of the strategy, but a concern has been expressed on a number of occasions that there is still too much focus on the criminal justice side of things, as opposed to the public health side of things. Indeed, you will have heard the previous panel talking about having to reframe this as a health issue, and the barriers that can be put up because of this sort of atmosphere of criminalisation and punishment. Do you think we have got that balance right yet?

Professor Dame Carol Black: I tried very hard in my review to make it a health issue. Drug dependency is a chronic disease. It is a bit like diabetes or rheumatoid arthritis: you have relapses, you have remissions. It is simply that we do not treat it like that. We treat people who have a drug dependency as a stigmatised population who get a very inferior service from both the health service and, in fact, the treatment and recovery service. There is nothing but ourselves to stop us treating these people as if they have a health condition. Of course, we need the Home Office and the Department of Health, but I made it very clear in my review that you need six Departments of State at the centre with their feet held to the fire, otherwise we will fail.

Q169 Stuart C. McDonald: Thank you for that. Do you think there is a case for Government policy and strategy in this area being led by the Department of Health, rather than the Home Office? If you were starting from a blank sheet of paper, is that where you would place responsibility?



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Professor Dame Carol Black: I would like to see them more visible. Drug dependency is such a complex problem that I do not want to make any one Department so important that the other five that we need decide that this is very peripheral, and they will not do much about it. I would say, as I found in my review, that the Department of Health were not visible enough. They did not take enough of a major interest in it; they were there, but not to the level that I would have liked to have seen them.

Q170 **Stuart C. McDonald:** The other issue I wanted to broach with you, if I may, is about certain harm reduction measures. You will have heard, again in the previous panel, some support—cautious, in the case of Professor McManus—for overdose prevention facilities, for example. I think I read an interview with you somewhere where you described it as not being a silver bullet. Nobody is saying that it would be, but what is the role for harm reduction measures such as overdose prevention facilities here?

Professor Dame Carol Black: Are you thinking about drug consumption rooms?

Stuart C. McDonald: Yes.

Professor Dame Carol Black: I would be in favour of a pilot—a good, well-designed pilot. As you know, there are drug consumption rooms in countries around the world, and there is evidence from those countries. We have no evidence that is United Kingdom-based.

You would have to design it extremely carefully. It would have to be an area of high-density drug taking, because I don't know how long someone about to inject heroin would travel or wait to inject. It would be of greatest relevance in areas of high density, where there are the visible signs of drug taking.

Q171 **Stuart C. McDonald:** Somewhere like Glasgow.

Professor Dame Carol Black: Somewhere like Glasgow. You would have to ask yourself: is it value for money and value in terms of life? Because you have only so much of a budget, and you have got to spend that budget across the treatment and recovery community. I personally would like to know where it sits in our basket of offers. I don't know and we will never know in this country.

Q172 **Stuart C. McDonald:** Until we have a pilot.

Professor Dame Carol Black: That pilot—if we could do it—would need to be so very well conducted, so that we can really get some decent answers. It has been a discussion that has gone on for a long time. It might be something; it might not be. We cannot answer the question at the moment.

Q173 **Simon Fell:** Dame Carol, I am going to quote from the Government's foreword to the 10-year drugs strategy, so I will try not to butcher it. "Decriminalisation is often suggested as a simple solution to many of the problems caused by illegal drugs. This is not the case. It would leave



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organised criminals in control while risking an increase in drug use.” Do you share that view?

Professor Dame Carol Black: As you know, I was not permitted or asked to look at legalisation or decriminalisation in my review, so I have not studied the Act. I have not looked at this in great detail, but I have one or two personal remarks, not based on evidence and certainly not based on knowledge.

We already have two legal drugs: alcohol and tobacco. All I see at the moment, is more trouble for individuals with alcohol. We have not got a system in which the harms from alcohol have been reduced. Of the known population of alcohol-dependent individuals, only 13% are in treatment. If we legalised—I don’t know—heroin, which I hope we wouldn’t, or cannabis or cocaine, would we have 50% in treatment, or 70%? If you take alcohol as an example, we have only 13%.

I heard from your previous people giving evidence that Portugal is talked about a lot. Of course, Portugal, when it decriminalised drugs, put in a massive investment of money and services. Nobody really knows whether the great improvement in what happened in Portugal is due to the really important investment, the improvement and availability of services, or what percentage was due to a change in the law.

It is wrong to think that in Portugal there is not a legal route. There is indeed still a legal route, and personal possession is limited to a certain amount. If you are above that, or if you keep reoffending, you go down the criminal route. As I say, I did not study it in detail, but I do reflect on what we already have, and whether it has been successful.

Q174 **Simon Fell:** I appreciate you sharing your personal views. If the Government came back and asked you to look at it and at the legal framework, would you be interested in doing that?

Professor Dame Carol Black: I have just spent over two years of my life doing this review. I think the biggest service I can give to society is to make sure that what is in the 10-year strategy is rolled out. I would say that that is where I want my efforts to be, because I think I can make a difference there now. I know what I think needs to be done. I think there is a willing population out there, of people wanting it to be different, wanting to make it better. I don’t know; I think perhaps my talents would be better served there.

Q175 **Simon Fell:** You didn’t quite say no, but I think we got your intention.

Moving on to the strategy, it talks about an intention to publish a White Paper, which will look at a series of escalating sanctions on drug users, such as curfews and the removal of identity documentation and the ability to travel. I am interested to know your views on that approach and what impact you think it might have.

Professor Dame Carol Black: As I said, one of the sadnesses in doing the review was that I could not find, nationally or internationally, good evidence of what would make a difference to reduce, if you like, general



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drug taking. There is just not an evidence base. The only thing we really know from the international literature is that if you have a campaign telling people to stop—that sort of messaging—it doesn't work at all.

I suggested that the Government should have an innovation fund and call for ideas about how we could change people's attitude to recreational drugs. Most people, when they take their cocaine on a Friday and Saturday night, do not think it will harm them. They probably do not think of the harm it does through the chain of supply—through South America, through the Albanian gangs, into this country, into county lines and into young and vulnerable people. It earns £4 billion a year for the drug dealers.

There is a problem, and the Government are right to identify the problem. Cocaine usage has increased most among our 16 to 24-year-olds, and then among 24 to 29-year-olds. I understand, although of course I am not party to the White Paper as it is being prepared, that they will have different suggestions of sanctions, which they will consult on before they go any further. That is my understanding.

I think the Government have looked at the work in America of Professor Keith Humphreys, who was on my advisory group. He talks about immediate and quick sanctioning through the tagging of people who have a problem with alcohol. The tag will tell the police, for example, whether you have taken alcohol that day. If you take alcohol, the immediate sanction is a night in a cell. There is a very quick sanction. Apparently, that has been very successful in reducing alcohol consumption in the USA. I think it is those sorts of ideas that the Government are thinking about. I have no idea whether they would make a difference, but that is where they are.

I would like to see some really innovative ideas about how we move behaviour. There is one good research endeavour at the moment at Universities UK. There is a research study going on with the universities to try to assess the size of the problem in UK universities and to see what approach there might be to it. That piece of work is being done with students and with the universities. That sort of thing seems to me to be a sensible approach, because we believe that county lines has infiltrated some of our universities. That might account for some of the increase in cocaine.

Q176 Simon Fell: You have partially answered my last question, which is about what will help deliver the strategy best. We have the plan and there is money assigned to it, although perhaps not as much as people would like, as we have heard. To your mind, what are the risks in delivery? What do we need to be aware of? How should the Government's feet be held to the fire to make sure that we deliver on the strategy?

Professor Dame Carol Black: If I may, I will tell you what needs to be done to keep the treatment, recovery and prevention part on the rails. What we have recommended is a central unit, which we now have, with six Departments of State in it, and a Minister reporting annually to



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Parliament. That job should be to keep those six Departments in there doing their part and committed to this whole agenda. If you have not got that cross-Government, really active, collaborative work, that is a real risk. You need very good collaboration between the centre and the local. In my review I said the system was broken. It is broken at a local level. I could go into that in much greater detail if you wanted, but we have to have real, collaborative working at a local level between all the agencies that are needed to deliver this, and there has to be accountability.

When I did my review, I used to go round asking who I could speak to who could tell me what the situation was in any local area. Quite frankly, I was pushed from pillar to post. Public Health England would say, "Carol, it's the local authorities," and the local authorities would send me back to the directors of public health, who would send me on to the NHS. You need a local system that is truly accountable, where I would only have maybe eight or nine measures that I was going to look at to see whether we were moving this tanker.

We have ringfenced the money, so you need to keep a very definite eye on that ringfencing. And is it really additional? I would hate to think that any local authority would think that this is extra money, so we will just use less of our public health grant on drugs, because then we are back to square one. I think there should be a single responsible officer in a local area that would be the person you or anyone could go to to say, "So what is it like at the moment?" We don't have that.

There are many pitfalls. I asked a lot about needs assessment. You have just been talking about geographical differences, and there are many. Any area of the country should have done a proper needs assessment: how much of a heroin problem have you got? How much with other drugs? How many psychologists and drug workers do you need? How much housing? And then do it all together. But when I have asked about needs assessment, in some areas there has not been a needs assessment done for four or five years.

There are critical stages, and if they are not watched extremely carefully, I fear this money will not be well spent. Quite frankly, you cannot do more of the same. It is not more money just to put more people through treatment. The treatment, because of the austerity, has never been fully developed. What we had was money given to clinical treatment, but local authorities had no resources to make sure there was mental health trauma-informed care, proper recovery programmes, housing, and the ability to get towards the world of work. There has just not been that in place. If you do not have that, I fear it will be as it was when I started my review.

Simon Fell: Thank you. That is very helpful.

Q177 Chair: I think you have been appointed as the ongoing independent adviser on drugs. When do you think you will produce a review of how things are going?



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Professor Dame Carol Black: It is actually not in my contract to do that. I see my role as keeping people's feet to the fire, really inquiring about what is going on locally, and making sure that things do not go off the rail. Of course, I do report back what I see to both the Home Office and the Department of Health, and I go to meetings, but I have not been asked by anyone yet to produce a formal report. I see myself as, if you like, the eyes and ears of what is going to ensure that we do not just do more of the same. It is such an easy tendency to say, "We've got more money. We just need to send another 1,000 or 2,000 people through the system and all will be well." Well, it won't.

Q178 Adam Holloway: Dame Carol, you talk about recreational drug use and the harm that that does within the supply chain. I would guess that the vast majority of illegal drug use is so-called recreational drug use. I would imagine that a substantial percentage of the people in this room, including myself, have in the past taken so-called recreational drugs—class A drugs even.

I would guess that the vast majority of people who take recreational drugs have had no adverse health effects, unlike many people in my constituency who don't have jobs to go to on a Monday morning, and that the harm you refer to within the supply chain is because this is an illegal market. These drugs aren't being provided by Diageo.

The fact is, therefore, that the Misuse of Drugs Act has failed completely, because drug use only continues to rise and, with that, the substantial number of people—none the less it is a minority—for whom it does a great deal of harm continues to rise.

Overall, what do you do when you have basically a parallel market which is doing harm at one end, but is probably not doing harm for the vast majority of users? How do we get ourselves out of this?

Professor Dame Carol Black: I think the drugs you are referring to—I accept that a lot of people after the age of 30 are not taking these drugs. I have not studied this in great detail, but when I talk to people like Professor Robin Murray and Professor John Strang, who I would consider really know about these things, they would point you to the increasing harm that is being seen in this country, even now, from powder cocaine, from cannabis, particularly of the THC variety and, of course, from nitrous oxide. They would—

Q179 Ms Abbott: What is the THC variety?

Professor Dame Carol Black: THC is a stronger form of cannabis, and there is a stronger form of powder cocaine. As you probably know, often these drugs are mixed with other fillers. As we had an increased supply of cocaine coming into this country, they have been able to sell it pure. Of course, the purer it is, the quicker and higher your kick, because it is a stimulant.



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I don't think they would take such a view that you have: that this is not something that we should worry about. They would absolutely think that these are dangerous drugs in the main.

Q180 Adam Holloway: Forgive me—I agree with you that these are dangerous drugs, but there is a reality on the ground that is not being changed by how things are today.

Professor Dame Carol Black: In countries where drugs are legalised, what I do not think you have been told yet—in fact, you may have been told the opposite—is that you do not get rid of the black market. In fact, you have a black market that often is selling a worse form of the drug.

In a country, let us say, where there is a regulated Government supply, that will have been produced to a certain standard and usually to what would be considered to be, shall we say, a less harmful standard. However, the black market still flourishes and usually sells the much worse forms. There is nowhere where you have legalised drugs that you have got rid of that—you have a two-tier system, and the black market still flourishes.

On the idea that there is some wonderful nirvana where this can happen, I don't think that is so. In a recent review called "High societies"—sorry, I have forgotten by whom—

Stuart C. McDonald: The Social Market Foundation.

Professor Dame Carol Black: They give you the emerging picture. Personally, I would like to see what the emerging picture looks like a few years on.

Q181 Tim Loughton: Professor, has there ever been a golden age for the way we treat drugs in this country?

Professor Dame Carol Black: No. I was not involved in the topic at the time, but in 2003, once there was a—when did the national treatment agency start? I'm sorry, I can't remember. But once more money was put in and there was a national treatment agency, there was the beginning of a much better system and better outcomes. We saw drug dependency go down, we saw more people going into and staying in treatment, we saw crime go down, we saw homicide go down, and fewer people went to prison. The problem was that they first did what I would call the clinical part of drug treatment, and because it was closed down they never had the opportunity to go on and do all the things that I tried to put in my review, which are around the recovery elements. Sadly, many years ago we had the beginnings of a good system.

Q182 Tim Loughton: What was it doing right? What had an impact?

Professor Dame Carol Black: It got good, well-supported, well-funded treatment across the country. The national treatment agency managed to get sufficient money—sorry, I don't know how much it was—and was able to set up really good in-patient units, as well as community-based



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therapy. But once it got the basics there, it never had the opportunity to really wrap around it what we are trying to do this time.

If you like, I have gone back many years and looked at what has been done before and built on it. It is not that we didn't have good ideas. We also, at that time, had more addiction psychiatrists and more research going on into addiction. When I did the review, I was really sad to see how few academic studies there are and how little investment there is in addiction. Things have really deteriorated in the last 10 years. It is hard for me to understand why something wasn't done before. If it were breast cancer, nobody would have allowed us to get to the state that I describe in my review.

Q183 Tim Loughton: Looking at a country like Portugal—you raise a very good point—is it down to decriminalisation or better treatment? What have they done well there that has had that impact?

Professor Dame Carol Black: They do very good treatment and recovery. They have put in place the things that we would like to put in place—the availability of treatment, the quality of treatment and recovery programmes. Those are the things that we are now, at the base, trying to do. They have developed, to a high degree, diversion into educational programmes or treatment. They try very hard to catch people as early as possible and enable them to get the right support so that they don't become part of the hamster wheel of going into and out of prison.

Q184 Tim Loughton: You said that when countries have decriminalised, it doesn't get rid of drug dealers; there is a black market. Do you think, and is there evidence, that where people are, in those countries, using drug dealers and the black market, the risk of being supplied with what are harmful, dodgy drugs—because they have impurities or whatever in them—acts as a deterrent to people accessing those drugs at all, or do they just take a higher risk because they can get them more cheaply?

Professor Dame Carol Black: I don't know the answer to your question; I don't know of any research or studies, but I suspect that people take a higher risk. We know that a lot of people do not necessarily know exactly what is in the drugs that they are taking. When you buy them on the street, you probably don't know what percentage of that is the actual drug or whether there is some filler in it.

Q185 Tim Loughton: We have heard quite concerning evidence about the huge increase in fentanyl and just how hugely powerful they are and how difficult it is to know what is a safe amount to take, which has led to a lot of deaths. Do you think that is probably the most challenging and worrying aspect of drug increase at the moment?

Professor Dame Carol Black: Sorry?

Tim Loughton: Do you think that the emergence of fentanyl, which appear to be much more linked with fatalities ultimately—because it's so difficult to gauge what it is safe to take—is the most worrying aspect of the way drugs are going at the moment, or are other, worse things coming



down the tracks?

Professor Dame Carol Black: I think it is a worry. In the States, as you know, there was a very steep incline. I don't think that it is doing that at the moment, but, as we have heard, if the poppy supply from Afghanistan really is going to be cut off—I presume poppies do come in from Turkey and elsewhere—is the supply of heroin going to be reduced? I think that is something we should keep a very close watch on, because it is a worry. I certainly worry about what appears to be, in the figures, a real increase in the consumption of powder cocaine. That is increasing—it is in young people. One in seven drug deaths, when I did the review, was due to cocaine.

Q186 **Tim Loughton:** Are you more concerned about the consumption of illicit drugs than about the way things have gone in the States, where there is the increasing dependency on prescription drugs, which is causing most problems now, or do you think we are headed the same way?

Professor Dame Carol Black: No. Public Health England did a report on prescribed drugs. I think it came out maybe 18 months or two years ago. I don't think we have anything near the problem that, say, America has, but I think it needs to be watched immensely carefully. I think that most general practitioners and hospital doctors are very well aware now—more aware than they were before this emerged—of the risks of genuinely prescribing people painkillers. Of course, guidance has been issued on that.

Tim Loughton: Thank you.

Q187 **Chair:** I would just like to ask you a few very quick questions. We had a little bit of discussion with the previous panel about Project ADDER. What are your views on that?

Professor Dame Carol Black: I think it is really interesting and I see it as a sort of forerunner for what I tried to create in my review, because Project ADDER brings together at local level the types of organisations that I envisaged coming together in a relationship, on a board or something, to do what we have said in the review. I hope we are going to learn what was good about ADDER and what is not so good, because there will be learnings and we should apply that as we roll out the new drugs strategy. ADDER is doing exactly what I wanted to do in my report, with all the different players at local level—I have been impressed, in visiting the police and crime commissioners, by their interest in being part of the solution, rather than just being part of the criminal justice system, and their real interest in diversional systems and working with local authorities and the NHS. Therefore, ADDER is really interesting to me as a sort of prototype of what might happen.

Q188 **Chair:** On the right to recovery, we had a discussion in the previous panel—I know you were in the room for it—and I wondered what your view is.



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Professor Dame Carol Black: I have a sort of problem with this. If this is a health condition, and I believe it to be a chronic health condition, don't you have a right in the NHS to proper care and the delivery of that? I find it appalling that we have to go to the level, with something that is a health condition, of saying that you need the right.

I know it is more complex, because you need all these other things around you—you need safe housing and somebody to help you get your life and work together, so to speak—but in many health conditions, such as bad rheumatoid arthritis, you need all kinds of agency to make you able to function. So, I worry that we are putting it outside what a person should be able to have access to in the health service.

Chair: Thank you. Stuart McDonald has a quick question.

Q189 **Stuart C. McDonald:** I have two quick questions, if I may. To take you back, you mentioned what I think was a Social Market Foundation report on the possible reform of cannabis laws. The conclusion of that report was: "All approaches have shown to be effective in reducing harm. As alternatives to cannabis prohibition, any of the above liberalisation models could conceivably work in the UK if they were to be implemented." You made the fair point that not all of them had had great success in getting rid of the black market, but there are other positives to different models, such as limiting cannabis consumption, improving treatment, reducing police enforcement, decongesting criminal courts, separating cannabis from harder drugs—all those things surely have to be weighed in the balance, not just the issue of the black market.

Professor Dame Carol Black: I think that is right. If we had—which we don't have in this country—good treatment and recovery systems, you would get a lot of the same results. We know, as there is absolutely strong evidence, that if you have high-quality treatment and recovery, people are not committing crime, they are out of harm's way and so on.

Q190 **Stuart C. McDonald:** That brings me to the final point. You spoke at the outset, and again just now, about how this is a chronic health condition and about stigma and the poor treatment that people receive. Fundamentally, however, isn't a lot of that down to the Misuse of Drugs Act and the criminalisation of these people? In fact, the previous panel spoke about how that puts up a barrier to trust and stops some people accessing treatment, because they have to speak about having committed a criminal offence.

Professor Dame Carol Black: If that were true, why then, with alcohol, which is a legal drug, do only 13% of people with a problem go into treatment?

Q191 **Stuart C. McDonald:** Well, there are other barriers to that, surely. Do you not think that criminalisation acts as a barrier to anybody, or contributes towards the stigma that you spoke about?

Professor Dame Carol Black: It may contribute to some, but I think if people know that there is high-quality, good treatment available, we will



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have more people accessing it. If you look at the results of my review, looking at the number of people going into treatment, I have shown quite clearly that we have had a declining number of people accessing treatment and staying in it. The reason for that is that it has not been high quality and they have not wanted to stay in there. We know that we have had a declining number, and that is whether you look at adults or at young children.

Q192 Chair: Thank you. May I ask one final question? What do you think it will be most useful for the Committee to focus on in our remaining sessions on our inquiry into drugs?

Professor Dame Carol Black: I think it would be really good if, as part of your work, you made sure that—if you like—what is in my review happens. We have an awful problem of people dying from drugs, an increasing number of people dying on the street and a great deal of harm. The best way of getting on top of that is to get this country to have a high-quality recovery and treatment service. Anything you can do to keep people's feet to the fire to make sure that money is well spent I think would be of great value. That is our immediate problem. I have listened to your discussions so far, and obviously there is great interest in whether the Act is fit for purpose or indeed whether part of the Act should be changed, but we have a real, practical, clinical problem, and it is worse in our most deprived areas. It is a real issue that we ought to be ashamed of, and I think that you could do a lot to make sure that the right thing happens.

Q193 Chair: Thank you for that, and we will certainly do our very best on that point. I thank you for your time today. It has been very instructive to hear directly from you.

Professor Dame Carol Black: A lot of the questions you were asking earlier about facts and figures are in the annexe to my report. If you do not have a copy, I am happy to donate it right now. It is the annexe to part 1, and it has a lot of good facts and figures, which might save you a lot of work.

Chair: Thank you for your evidence.