HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Reducing the harm from illegal drugs, HC 72

Thursday 30 November 2023

Ordered by the House of Commons to be published on 30 November 2023.

Watch the meeting

Members present: Dame Meg Hillier (Chair); Dan Carden; Mrs Flick Drummond; Peter Grant; Anne Marie Morris.

Home Affairs Committee member also present: Dame Diana Johnson.

Gareth Davies, Comptroller and Auditor General, National Audit Office, Oliver Lodge, National Audit Office, and David Fairbrother, Treasury Officer of Accounts, were in attendance.

Questions 1-40

Witnesses

I: Professor Dame Carol Black DBE, Independent Adviser on Combating Drugs; Mike Trace, CEO, Forward Trust; Alice Wiseman, Addictions Lead and Vice-President, Association of Directors of Public Health, and Director of Public Health, Gateshead Council; Mark Lay, National Drugs Co-ordinator, National Police Chiefs' Council.

HOUSE OF COMMONS

Report by the Comptroller and Auditor General

Reducing the harm from illegal drugs (HC 1864)

Examination of witnesses

Witnesses: Professor Dame Carol Black, Mike Trace, Alice Wiseman and Mark Lay.

Chair: Welcome to the Public Accounts Committee on Thursday 30 November 2023. Today we are really privileged to have an expert panel in front of us, ahead of questioning Government officials on Monday about the Home Office's "From harm to hope" strategy, which is its third strategy to deal with drug issues since 2010. The Government have put some extra money into this up until 2025. The strategy focuses on the consequences of illegal drug use. We are keen to look at how that is working and what the Government are doing about the causes of harm as a result of drug use.

Progress on implementing the strategy has been mixed. Treatment and recovery outcomes vary across England in terms of places available and numbers of staff. We will probe a lot of that with our witnesses on Monday, but I am really delighted and privileged to have in front of us today our witnesses, who are experts in the field.

Professor Dame Carol Black was the Government's independent adviser on combating drugs. She headed up the Government's major review into drugs policy, which is legendary in the field, reporting first in February 2020 with the second part in July 2021. It is possibly a good time, Dame Carol, to review where things are at in advance of questioning the Government on Monday.

I am also pleased to welcome Mike Trace, who is the chief executive of the Forward Trust and was also the deputy UK anti-drug co-ordinator from 1997 to 2001. In a career that has spanned this arena for some time it is hard to pick out a highlight, Mr Trace, but a very warm welcome to you.

We are also pleased to be welcoming Alice Wiseman, who is the addictions lead at the Association of Directors of Public Health and the director of public health at Gateshead Council. I think that we have had you in front of us before, Ms Wiseman, so welcome back.

We also have Mark Lay, who is the national drugs co-ordinator at the National Police Chiefs' Council, which is obviously a key part of this whole process. Often it is police officers who are having to deal with issues at the sharp end, so we are really pleased to have local government and police in front of us as well.

I am delighted to welcome Dame Diana Johnson, who is guesting on our Committee today. She is the chair of our sister committee, the Home

Affairs Select Committee. Before we go any further, I would like to ask Mr Dan Carden MP to make his declarations of interest.

Dan Carden: I am ambassador of Tom Harrison House and Adfam, director of Addiction Recovery Now and chair of the drugs, alcohol and justice all-party parliamentary group, and I refer the Committee to my register of Members' interests.

Chair: Mr Carden is steeped in this issue, a champion of it in Parliament and a very welcome member of this Committee. Without further ado, I am going to ask Dame Diana Johnson to ask a question about a policing matter before we go off into the main session.

Q1 **Dame Diana Johnson:** Mr Lay, one of our recommendations in the Report that the Home Affairs Select Committee produced on drugs, which was published in August, referred to the use of naloxone. We were very struck by the fact that Police Scotland had rolled this out to all officers. We know that there was work going on in England and Wales and I wondered whether you could give an update as to how far that has got.

Mark Lay: I certainly can. You are quite right that Police Scotland was the pioneering force to do that. It overcame a number of challenges to roll out naloxone. It has now successfully been rolled out to all frontline officers in Police Scotland. The pioneering force in England was West Midlands. We have undertaken a number of webinars, and I have had one-to-ones with force leads around demonstrating the benefits of naloxone. Chief Constable Richard Lewis and I have had meetings with the IOPC, as well as the Advisory Council on Misuse of Drugs and OHID, to ensure that we get letters of comfort so that officers feel comfortable that, if they issue naloxone and there are any untoward circumstances, they are not going to find themselves being investigated due to circumstances where someone may, sadly, pass away.

There are some clear, real benefits to naloxone. We now have 20 forces using naloxone in England. I have recently baselined all the forces to understand any challenges that they are having. We are in the process of producing new guidance on naloxone to try to encourage the other forces. Naloxone administration and issue features within the synthetic Government taskforce as well, as a key action there. We are working with the ambulance trusts as well to look at other ways to encourage and to include naloxone within first aid training, so that it becomes additional to the training. You would issue naloxone while waiting for ambulance arrival to keep someone alive. We are also then training people to ensure that you are maintaining airway clearance as well, so people know that holistic approach around first aid, so it is not just naloxone.

The naloxone that is issued for policing is a nasal spray, so it is a really small spray, no bigger than Sinex. We also find that, in the commissioning services within custody, we have 33 medical areas that have now issued naloxone within the custody units as well, so we have good coverage there. That said, there are clear benefits.

Some of the challenges we have had, rather than being the policing challenges, have actually been from commissioning groups that have said that they would prefer us to use normal first aid rather than the naloxone. I disagree. The evidence is clear on its benefits in terms of saving lives. To date, across England and Scotland, through the encouragement and promotion of naloxone that we have been doing for the last 12 months, we have saved over 350 lives of the most vulnerable in society. We should be very proud of that. There is some really good work but, as I say, we need to continue with it at this moment.

Q2 **Dame Diana Johnson:** You said 20 out of the 43 forces, so that is not rolled out to all frontline officers.

Mark Lay: It will be very much the first responders. It is your uniformed first response officers. We are looking at it also being rolled out to firearms officers and anyone who is in an incident response vehicle. Some forces have rolled it out even further. If you look at areas such as Durham, they have seen a number of successes by rolling it out even further.

In terms of the synthetics that we are now seeing coming into the UK, we are working with health and ACMD to make sure that naloxone is still effective against some of the stronger nitazenes that we are seeing coming into the UK. We have seen examples over the weekend where someone might need two or maybe three doses of naloxone to keep them alive until the ambulance arrives.

Chair: That is a whole other area to get into. We might touch on some of it today. We are into our main set of questions.

Q3 **Dan Carden:** Dame Carol, to what extent do you think the 10-year drug strategy is beginning to address some of the issues that you identified in your landmark reviews?

Professor Dame Carol Black: The first thing to say is that I set Government and local authorities a very difficult task. It is a very complex picture, and I was asking them to change their culture and to start to work together in a collaborative and integrated way to deliver a whole-systems change, which they did not have before. I was asking them to do this in collaboration with the police and education. It was a completely different way of working, not more of the same.

I asked them to do it at a time when, due to almost 12 years of austerity, I found in my report, as you know, that it could not have got much worse as far as treatment and recovery was concerned. We had a broken system. We had demoralised staff. Indeed, most of the protective factors that had protected young people from ever taking up drugs had been destroyed or diminished. I was writing a report at a very difficult time. That really must be said.

I will tell you the good things first and then come on to the things I would like more emphasis on. The first good thing is the structure that has been

developed. It is good that we now have a central unit with six Departments of State. We never had that before. We did indeed have drug policy, but it never brought together six Departments of State with a Minister for drugs, which I think is the first in almost 25 years. We have a senior civil servant, Matthew Rycroft, as our senior responsible officer, who has done an excellent job in bringing this together, so we had a proper central structure relating to a local structure, which is now much more altogether. We have our drug delivery boards. We have our senior responsible officers. We have been recreating the right structure in which to deliver this.

We have a national outcome framework, which is a great step forward. I would like the evaluation of the whole system to be much stronger. We have, therefore, the means to deliver this. We would have to acknowledge that we have the right structures through which to deliver it.

I have seen many green shoots when you go around the country, and I go around a lot. It is quite different now. When I was doing my report, I went around and found very demoralised, unhappy groups that did not think anything good could happen and acknowledged that they were delivering nothing much other than an opioid substitution service, not wanting it to be like that. In the last six or seven months, the places I visit feel engaged. They feel that they have the capacity to deliver more.

It is patchy. I am not going to sit here and tell you that it is good all around the country. We have a number of local authorities that have found it very difficult to make this whole system change, but they are being given extra support from OHID to try to get them to that place, so we see good things there. You see around the country—again, it is somewhat patchy—much improvement in continuity of care. That is particularly good in the north of England. You see that numbers into treatment, especially for the non-opioid substances, in many areas have reached their target.

We have a challenge on those dependent on heroin and getting those numbers up to speed. You can see areas where people have really come together. There is very good practice in mental health and substance misuse services integrating. That is very difficult to do, but we have one or two areas around the country where they have taken that very difficult step. In recovery, again, the quality of our recovery communities varies, but I think people understand that it is possible to do.

What would I like to see done much better? I want to be sure that we can evaluate a whole system. We have the NDTMS, which of course evaluates treatment, but treatment is the beginning of this journey. You have to be able to evaluate the mental health support, the recovery support, housing and enabling people to get into work. That whole system needs supporting.

I want to see us move faster on getting mental health and substance misuse services together, so that they can support each other. Something I missed in my report, quite frankly, which I now realise is terribly important, is the availability of trauma resolution. That is particularly important for people who are in the secure estate. I did not pick up enough on that, so that needs to be changed.

We need to have flexibility and the capability to offer enhanced rehabilitation. We lost, as you probably know, most of our in-patient rehabilitation units in those interim years. I am not advocating that we need as many of them back, because there are some very interesting experiments around the country—I am sure Alice could tell you about what is going on in her area—but we need a concentration on that. I want to see recovery communities up and running, because that is the essential part of this.

You cannot do this in three years. You cannot have what we have lost and rebuild in three years. We need to think about the strength of the joint unit. It is not separately funded. How does it maximise what it can do? I would say that of course it is not as much as I want, but is it a change from what I found when I started? Yes.

Q4 **Dan Carden:** You talked about the difficult situation in which you were conducting your review. Drug-related deaths rose 80% between 2011 and 2021. There was a funding cut to addiction treatment services of around 40% between 2015 and 2021. There has now been a big injection of cash, £900 million, in this period. How do we make sure that that money does not just refill the jobs, workforce and services that were lost, and that your strategic changes do not get lost in that?

Professor Dame Carol Black: If we are frank, the first thing local authorities did—one can hardly blame them—was indeed to appoint more drug workers. If you look at the figures, they have more than met their targets for appointing drug workers. That was not unreasonable to begin with, because the caseload, as I said in my report, was sometimes as much as 100 drug-dependent people to one caseworker. That is totally impossible. We would recommend about 35. That would be what you would expect the caseload to be.

Then they started to look for psychologists, mental health nurses and indeed psychiatrists—all the additional people you need, who we must get into the service. Quite frankly, they are difficult to find. If we are being honest, the attempts to recruit the more professional workers meant that we had to be taking it from mental health services. There are not a lot of these people around, but I think that there is now an understanding that you are not doing more of the same alone and that you have to put some of your resources into building recovery communities and the other things that are going to deliver.

We have IPS on its own, so to speak. We have funding for that, so getting people into work with caseworkers. There is money there for that.

I would be the first to acknowledge that in the beginning the first response was "We are going to get more drug workers," but that is now changing.

Q5 **Dan Carden:** I remember when we secured the three years of funding from Government. That takes us to 2025. We have a general election coming next year. What are your concerns for the future? Can I broaden this out, after you, Dame Carol, to Mr Trace and Ms Wiseman? One of the most important aspects of this will be how we measure the success of the new strategy. Can you tell us a bit about how you think Government should be measuring the success of this strategy?

Professor Dame Carol Black: It is a huge worry for all of us. I know that we cannot ask the Treasury for money outside spending reviews. That is the way the system works, so I think it is our responsibility—well, it is not my responsibility, but it is my responsibility to encourage the creation of a bid for whatever the length of the spending review is that persuades the Treasury and those who need to be persuaded that we have used the money as well as we can so far. There has been some underspend, as I am sure you are aware. We can show, quite convincingly, that we can make a difference: it is turning around lives and it is beginning to change some of the statistics that we do not want.

What do I want to see measured? I am sure Mike will go into this in greater detail, but personally I want a measure of recovery. In my mind, it ought to be possible for the providers of treatment to say whether the person who they have been looking after is now in a recovery community. There could be some measure that would tell me that we are now on the next part of the journey. As you probably know, I do not like the idea that treatment is a defined box, because it is a chronic condition. There will be relapses. I see treatment as the beginning of a journey to get you to a secure place where, with peer workers, you will, over several years, progress. We need a proper measurement of recovery.

I believe that the DWP—I stand to be corrected—will be measuring the ability to get people into work. Different Departments are measuring bits of this, but we need to be able to start to think about what those measures are, apart from reduction in drug deaths and the reduction in crime, that will give us an idea of whether we are making progress. I suspect that Mike would enlarge on that.

Q6 **Dan Carden:** Mr Trace, you were involved in the first drug strategy under the Blair Government and you are head of the Forward Trust, which is a provider in this area. If we consider the Dame Carol Black money as grant money, what are the Government currently measuring and how do you think the Government should be measuring this model?

Mike Trace: Thanks for the invitation. I echo Carol's analysis of the situation and the history. That is very important to understand. We invested very heavily in treatment 20 or 25 years ago for a very good reason and a good evidence base. The treatment system can deliver

health gain, which is very important; crime reduction, which is very important to public finances; and social inclusion. That was always the contention. That is something I call a universal truth that evidence still backs up. That was the reason we invested 25 years ago.

Carol is absolutely right. There was a period of loss of focus and disinvestment and the treatment system suffered very hard during the austerity years, but also before that. There was a loss of direction before that. The architecture put in place in response to Carol's report and in the drug strategy is good. It is showing that it is good, this cross-Government commitment. We know about the machinery of Government, cross-cutting issues, but a really good architecture has been put in place.

The only thing I would say about it—I think that Carol started to mention this—is that the Joint Combating Drugs Unit is the right co-ordinating structure but it is pretty underpowered. It is in the Home Office. It is not massively staffed, but it has a very big job to draw together billions of pounds worth of very important expenditure. The only thing I would say is "Look at the JCDU." It has done a good job so far, but it needs backing.

I would agree with Carol that progress is encouraging since the drug strategy was published. The architecture, as I said, is good. The indications are that improvement is happening as a result of the investment. That is the context. That is the good news, but yes, there is a real challenge. The Committee needs to look at this challenge in terms of how we are evaluating progress and creating accountability. The current system has its good points. The outcome framework and the concepts are excellent, but the way we actually implement the accountability is creating perverse incentives and diluting what everybody wants.

If we talk about the headline outcomes, what we are after in the drug strategy, broadly helpful, is that we want less drug use. We want less drug-related death and less drug-related crime, which are very clearly stated at the top of the pyramid stated in Dame Carol's report. Those are what Ministers, taxpayers and the Treasury want. Those are the outcomes.

There is one that I would draw your attention to and say needs to be improved. Once again, the JCDU and the Home Office did a good job of articulating those outcomes very quickly after the Carol Black report, but they have not nailed the issue of recovery, which, as Carol says, is absolutely crucial to the treatment system. In that outcomes framework, there is not a clear statement that the Treasury and the Government want as many people as possible who have addiction problems to get into real recovery. That one is not properly articulated in the drug strategy at the moment. It could be quite easily adjusted and give greater leadership.

Generally, that idea of an outcomes framework, filtering down through how the money is spent and how organisations such as mine deliver on

the ground, is good architecture. The problem is that, quite rightly, the Treasury wants to make sure that this granted money, this increase, is not wasted and is well spent. I say Treasury, but the Government are trying to track that through process measures and micromanagement. When you are doing a tough job on the ground, and that is a provider or a budget holder on the ground, the local partnerships that have been set up, being micromanaged for every decision you make on a few hundred quid and having to report massively bureaucratic sets of figures about your inputs and processes takes everybody's eye off the ball of those outcomes.

It is not just annoying for provider chief executives to have to send reams of paper back to the local partnerships. It is not just annoying for the local partnerships to have to send reams of paper up to Whitehall. It actually takes the attention away from what everybody wants, which is reducing deaths, reducing crime and increasing recovery. I will give you an example of how that works. Right now, the main pressure that the Treasury is applying to the Department of Health and Social Care and the Home Office, which is then applied to local partnerships and then organisations such as mine, is to meet the target for getting more people into the treatment system. That seems sensible on paper. We want more people to come into the system, but that means that there is an obsession in delivery right now with numbers rather than outcomes.

Being in contact with the treatment system is not the outcome. Having more staff in the treatment system is not the outcome. We are all being pressed to meet those targets and 100 other process targets: "Have you completed the NDTMS forms? Have you reviewed a client's case once every three months?" and so on and so forth. We are spending all our time chasing around those process measures, which takes everybody's attention away from the outcomes.

Alice Wiseman: I would agree with everything that both Mike and Carol have said. There is probably performance that is needed at various levels, so I would challenge you, as Government, to say, "What is your performance on this? Is this still a priority in three years' time?" That needs to be as challenging for you as it needs to be for us at a local level. It is a 10-year strategy for a reason. It will take 10 years for us to turn some of this around.

You can also then have a look at the local combating drugs partnerships and the way that they function—the architecture that Carol has already spoken about—and ensuring that they are functioning in the right way. We work really closely at a local level with our OHID teams. The OHID teams are in a great place to work with us to understand that those partnerships are functioning in a successful way.

At a local level, Mike has already spoken about some of the quantitative indicators that we have. Some of the most important things that we have been rebuilding over the last couple of years have been pathways into

treatment from acute settings, from mental health settings, from prison and from police, those things that had potentially been lacking over the last decade as a response to the cuts. There is the broader look at recovery as well that Carol mentioned, ensuring that we are also taking account of the mental health and employment needs and the things that build social capital that enable people to recover.

I would also say that, underneath each of these quantitative data sources that you have, there is a story. I will give you a really quick example of one in Gateshead. We do not have any residential rehab in our region. That happened as a result of cuts years ago, where we just were not able to, as a region, fund. If I am going to send anybody to residential rehab, I have to send them out of the area. We can do that, but, for lots of people, that is not appropriate if they have families that they are wanting to recover with.

We developed a quasi-residential rehab in Gateshead. We have had 18 people through that in the last 12 months. It is a six-month programme. It is exactly the same as a residential rehab, but at the moment it is not counted in the data that is provided to Government. We have done it because it is the right thing to do, but some of the bits underneath are being missed by looking at the quants data in isolation.

Q7 **Chair:** They get the treatment but they go home to their own homes.

Alice Wiseman: We can give them accommodation if they are homeless. We have got some flats with our council housing properties that we have set aside for this particular cohort. They can go home or live in those flats that we have provided.

Q8 **Dan Carden:** There has been a rapid recruitment of about 1,200 local government drug and alcohol specialists. What are the difficulties with the funding cut-off in 2025 and the inability to plan for the long term?

Alice Wiseman: It is a risk for local government and for our local providers. We really want to recruit the best people. These are the people who need to work with the most vulnerable in our society, so we need people who are coming into this not because they are giving a 12-month contract but because they are giving a career and a lifetime within this type of service. There are risks that local government is taking in providing contracts that are extended beyond 2025, hoping that we will continue to receive some security and funding for that. Equally, I know that there are providers that are taking risks employing people on permanent contracts. It is a problem.

That, again, has been an issue that we have had over the 10 years, where we were seeing cuts in staff. There was not the workforce out there to go out and recruit. We have had to recruit and train, and we really want the best quality of staff for this group.

Q9 **Mrs Drummond:** On their draft strategy, their outcomes are very much "How many drug related incidents? How many people in prison?" and so

on. You talked about work as well. Should they be looking at outcomes for five to 10 years for that particular individual, rather than the whole thing? What other outcomes can we use to measure it?

Mike Trace: A long-term view is needed, but I make a distinction between the outcomes for the individual and the outcomes for the system. If we are measuring outcomes for the individual, it is the sort of thing that has been mentioned: you want to see a cease in drug use; not committing crime; getting back off benefits into work; secure accommodation; and those individual measures. That is basically what we call recovery. If somebody is ticking the boxes on those measures, that means that they are generally in recovery, and that is what the investment is for. On an individual level, it is absolutely that.

At a system level, which is what we have to hold the local partnerships to account for—they are given the money and have to spend it locally—you want to have it as close as possible to your individual outcomes and your strategy outcomes. At the moment, the local partnerships are measured on their processes. My strong advice to the Committee is that that should be amended, so they are measured on, "Have you reduced crime? Have you reduced deaths? Have you increased recovery?" That is the big change that is needed.

It is understandable, because when the strategy was brought in, there was a very quick rush to create the outcomes framework in the architecture. The system did quite a good job to move fast, but this is the time where we now need to have a look and say that this is a 10-year challenge. We have to get the outcomes across that 10 years. It is not going to be good enough to say in three or five years' time that we have more workers or that more people came into the system. We have to show that we have achieved the outcomes. There is a way to do that, but that would be quite a detailed discussion.

Professor Dame Carol Black: You have hit on a very important point about follow-up. As you know, traditionally it has been that you went into treatment and a measure of success was that—I hate these words—you had successfully completed treatment. I am a medic. With a bad diabetic, you did not say to them, "When we have got you stable, we have got your insulin right and we know you are in balance, we are going to discharge you." What you say to someone with a chronic condition is, "We have got you in balance. We may have a phone call with you in three months and check you in six." There is ongoing collaboration and care with a person to keep them stable.

We do not have that philosophy in drug dependency. If someone can get into work and sustain that work, that is surely a measure of success. Again, it is the outcome. Are they maintained in safe housing? You cannot succeed with drug-dependent people if you have them on the street or if they are in a house where someone is shooting heroin. They will shoot heroin.

Q10 **Mrs Drummond:** Is there a worry that people are trying to do quantity because of the three-year funding, rather than quality?

Professor Dame Carol Black: In some local authorities I have seen them try to do quality as well as quantity, but of course—I think Alice would reflect this—you get pressure from the centre if you do just quality. Quite frankly, both are needed. I understand that you need to get people into treatment in order to work with them. If they are not there, you cannot do the work. It is how, in the short time we have of three years, you balance those two. When I did my report, people were leaving treatment early because of the poor quality of treatment, and that is an equally bad outcome.

Chair: Do you have any brief comments, Ms Wiseman?

Alice Wiseman: I agree with everything that has been said.

Q11 **Dame Diana Johnson:** That was a very useful look across the piece at what is actually happening.

I want to ask a specific question in relation to a recommendation that the Home Affairs Select Committee made. We recognised, as has already been set out, that the local work is the important stuff—getting partners to come together and fund services—but one concern that the Select Committee had was around diamorphine-assisted treatment.

We saw one up in Middlesbrough that did not have sufficient funding, and the funding ended. We were really concerned, because we were told that it was very expensive and central Government should fund that type of very expensive treatment for a small group of people. Every other treatment option they had tried did not work. The Middlesbrough option was reliant on local funding. That stopped. We wrote to the Minister to ask whether there could be some centralised funding. I wondered whether there are cases like that where there should be something from the centre, rather it being left to individual local authority partnerships.

Professor Dame Carol Black: With this particular form of treatment, you could make a case for a specialised commissioning because it is, for me, the equivalent of the heart transplant in cardiology. It is the absolute end of treatment. The best work on this is done, by the way, by John Strang, who did the initial trials in this country and has written all the best reports on it. It is necessary for a few people, but it is a few because it is a lifetime. It is not that you come off it. It is there for the rest of your life. I think that it is about 15 times more expensive than any other substitution therapy. If you are going to do it in its original format, in the proper way as it was originally described, it requires medical supervision, so you are using expensive people to do it.

If I were setting it up, I would have it as a specialised commissioning service with very high standards and specification. I would also hold those people to account. If you want a model to look at, we developed a national service for pulmonary hypertension. It was part of what my

medical job was at the time. We have a specialised service for pulmonary hypertension with only certain centres around the country that can deliver it, and that works very well. People are held to account. You could make the case that it should, for a few people, be available.

Chair: Ms Wiseman, you are dealing with this one at the sharp end.

Alice Wiseman: I would agree with what Carol has just said there. It would be something that, if it were made available, would reduce drug-related deaths. It has been shown to have a real significant benefit for—as Carol says—a very small number of people who have struggled to get into recovery in any other way.

It sometimes acts as a way into treatment for people as well. If there were people who were struggling to engage in treatment, that approach, which is more about harm reduction, is beneficial for some over a number of years, but it is understanding that that is going to take longer. At a local level, there is no way I could prioritise that amount of funding out of the budget that I have for my area for something like that, which would meet the needs of a small number of very high-need people, when it would mean it would disadvantage a bigger group of people. Specialised commissioning at a national level would also mean that there was not a postcode lottery.

Q12 **Dame Diana Johnson:** We were very well aware in Middlesbrough that that very small group of people were actually committing a very large volume of crime. The effect of dealing with them and taking them out of that situation for the local community was a very positive one, but it was very expensive.

I will move on now to prevention—how you stop people getting into taking drugs in the first place. In the 10-year drug strategy, one of the aims is to achieve a generational shift in the demand for drugs. They talk about the Government aiming to reduce drug use to a historic 30-year low; I think it is by 2031. I wonder what your thoughts are on that.

I am also conscious that the Advisory Council on the Misuse of Drugs said in May 2022 that the UK did not have a functioning drug prevention system and that significant investment was needed to rebuild prevention infrastructure and co-ordinate support services.

Alice Wiseman: I will start by saying that the most harmful patterns of substance misuse are strongly associated with other factors such as deprivation, trauma, adverse childhood experiences and mental ill health. The challenge that we have at the moment is that in our communities we are seeing all those issues increasing. We have had a generation of kids born in the middle of the 2000s who have never known anything but disruption in their lives, with the 2008 banking crash and the austerity for the last decade. All the infrastructure and support networks that were available to families, and particularly families from more disadvantaged backgrounds in those communities, have been eroded.

We are now starting to see massive increases in children presenting with mental illness; I think it was a 44% increase from March 2020 to March 2022 in the number of children and young people who were referred to child and adolescent mental health services. What worries me is that we have a generation of children and young people with whom we have not managed to do any of the preventative work that would largely have reduced the likelihood of their engaging in problematic substance misuse later in life. For example, if you reduce adverse childhood experiences, you can reduce somebody's risk of heroin use by 66% over their lifetime. It is 42% for cannabis. There are some real, significant benefits.

At the moment, we are doing the preventative work when we are identifying people with problems already, but we are not doing the primary preventative work that we would really like to be able to get. That requires a huge infrastructure at a local level where we are providing support to those families. There is an opportunity, certainly with the additional resources that came through. We are looking at our young people's treatment services as well. With that resource, we are providing services not just for young people who are actually using substances, but for the children of families who are using substances, as a way to try to break that intergenerational cycle of substance misuse. At the moment, that bit of the work feels like it is probably the least well served.

Q13 **Chair:** There is the research that the Department of Health and Social Care has commissioned into this.

Professor Dame Carol Black: Yes, we should acknowledge that we did not have good evidence. All that Alice has said, of course, is absolutely true, but if you wanted to say which interventions have been shown to work outside the social determinants of health, there had not been any investment in research, as you said, Dame Meg. It has been a really barren area. We did not have things to pull off the shelf and say, "Let us pilot this, because we know that it is probably a good idea." There was £5 million that came out of my review for pilot studies; they are ongoing at the moment.

The Committee might want to look at what is called the addiction mission—you are probably aware that we have several Government missions, and one is addiction. Most of the current money is designated for trying to improve the academic base of research in addiction. Quite a lot of that money is going into PhDs, the training process and doing good clinical trials. You could consider some of that money—or money in the future, if the addiction mission continues—being put into a much broader programme of research. We really need that.

Q14 **Dame Diana Johnson:** Why have we never had that? It seems very strange to me that we have never had that research.

Professor Dame Carol Black: Addiction has been an unwanted specialty, if you want the truth. Nobody really talks. If I had a cardiologist sitting here, he would really be pushing for his specialty, pushing for the

research. Who pushes for addiction professionally? There is a faculty in the Royal College of Psychiatrists, but you do not get the sense that there are people saying, "We must do research here. We must have a base on which we can move forward." No clinical specialty succeeds if you do not have a research base. I feel quite strongly about this area that, again, we need to build up over years, but we could do a lot on the social determinants while we are gaining the other stuff.

Q15 **Dame Diana Johnson:** At figure 9, the NAO Report sets out that more than half of the funding for reducing demand has been allocated to the detection of drug use on an individual's arrest for other offenses. It looks as if, rather than doing the stuff before you get to being arrested, it is when you capture them. There is very much a criminal justice approach to this, is there not? I know that one of the issues that the Home Affairs Committee was concerned about was stigma. Just focusing on the criminal justice aspect is not going to help with that. Mr Lay, would you like to comment on that?

Mark Lay: In terms of reducing demand and of prevention and education, if the police have an interaction with someone the first time where they have any drugs on them, whether they be class A, class B or class C, and if they are not a vulnerable person, not involved in organised crime and not part of a county line, we would advocate looking at what safeguarding opportunities are there for early education. We find that most people would benefit from education, and they have not had education around drugs.

Particularly if you are looking at people aged around 15 or 16, we have seen in some areas that rather than bringing people into custody, there have been those opportunities, while out on patrol or on the street or interactions at any point during the day where you actually speak to people, where you can divert them away into drug education systems. It is that triage process—avoiding unnecessary need for treatment but providing opportunities around education. There are some pilots ongoing for that from the Home Office and the NPCC, and there are some really good opportunities there.

We see some real gaps around people's understanding of drugs. When we talk about why people are taking drugs, it is also sometimes about looking through that education piece to say why people do not. Looking at people within university environments who have made a decision not to take drugs or are abstinent: why is that? It is about understanding more there.

I will touch on around drug testing on arrest as well, while I am here. It has always been a really passionate area when I have looked at where we do drug testing on arrest in custody. An area that we have expanded recently, in the last 12 months, has been looking at the link between domestic violence and cocaine. We have undertaken seven different pilot areas where we have specifically drug-tested persons arrested for

domestic violence for cocaine. In one particular area, of the first 150 people arrested, 127 tested positive for cocaine.

That puts it into perspective when we look at longer-term prevention measures. You are looking at persons who are arrested for domestic violence, tending to be poly-use with alcohol, and then returning to the home where you have violence in front of children, so you then get the onset of trauma. That shows sometimes the scale of the challenge, particularly around cocaine and its prevalence.

One key thing that we are now advocating is that we need to expand the drug testing across the UK in respect of domestic violence. That is not to say not to treat the domestic violence, but we need to use more education around the perpetrator programme. When you are looking at the perpetrator programme for people who commit domestic violence and how you look to protect the victim, you need to make sure that we are including drugs education within that, as well as alcohol abuse. We are seeing case studies where people are really starting to understand the impact of their drug abuse when it is mixed with alcohol, and the impact that it has on their family. There is some early ongoing work in relation to that.

Across London, the Met is doing some fantastic work as well. It was one of the first to take up the evaluation of that. Its percentage positive rate is somewhere in the region of 38% of all people arrested around domestic violence—not as high, but still a significant amount of people testing positive for cocaine.

Dame Carol said in her report the mantra that no one should be released on a Friday without the right support. What I would say to policing is that your custody unit environment should be a departure lounge of options. When someone is arrested, it is then a case of looking at what the earliest opportunities are in terms of mental health support and housing support.

We have seen some brilliant work in some of the ADDER areas. We have 13 areas now, but we are looking at self-funding in London other areas, particularly the ones that were affected by the isotonitazene outbreak in 2021. It is looking at some of the opportunities there around education in some of those areas as well. We are seeing some really good opportunities for the future there.

Q16 **Dame Diana Johnson:** Can I ask about diversionary schemes? Again, the Home Affairs Select Committee was concerned that it was a bit of a postcode lottery. Should be some kind of national diversionary scheme approach?

Mark Lay: Once again, for me it is about looking at the evaluation. It is understanding what works in terms of national diversion schemes. Coming back to that departure lounge of options in custody, I would advocate that for every person who is in custody we should not just be

looking at the drug testing on arrest; we should be looking at health workers speaking to those persons and understanding any issues around trauma, vulnerability or safeguarding and looking at their early opportunities for treatment.

Already in some areas, even if someone does not meet the trigger for drug testing and arrest, they will still be spoken to and provided with an opportunity for care, and then the signposting that needs to take place will be looked at. For me, that is looking at that earliest opportunity. Yes, you would want it before custody, but once you are in custody it is about looking at what the opportunities are there. I would agree.

We can evaluate the best practice in the West Midlands, for instance, in one of the areas there. We can look at some of the other areas where we have had out-of-court disposals. The really good work that the JCDU is doing in this area is looking at increasing opportunities for pilots around out-of-court disposals. It is learning from that and then sharing that across. We have seen some great learning from ADDER, but, once again, it is funded until 2025. With a 10-year strategy, it has to carry on for at least 10 years.

Professor Dame Carol Black: If we are a little later in the process, so to speak, when the courts get people—as you will recall, in my review I was asked to look at diversion at that point. Magistrates were not diverting into treatment; treatment had become so poor that there was no point in diverting into treatment, because people did not stay there.

There is just a flicker now. If you look at the latest figures, we are now getting more diversion from the judiciary at last. That really needs to be pushed, because the magistrates did not always have the right paperwork from probation—they need a report. If they divert, they can also add in a mental health order, which would often be quite helpful, because mental health is so important.

In addition to what Mark has said, we need it at the police level and then we need it further on, because fewer drug-dependent people have to go to prison. Our prisons are full and we send far too many drug-dependent people to prison without a good result, so you are quite right that diversion is crucial.

Q17 **Chair:** Can I refer to figure 9, which Dame Diana mentioned, and the out-of-court disposals? Mr Lay, there is only £3 million allocated for 2023-24 and 2024-25. There is never enough money, in one sense. How much money would you need to make sure that that was rolled out and really being used? Do you have an estimate, or could you find that out for us?

Mark Lay: The £3 million is for seven pilot sites. Before I made a judgment on what was needed further than that, I would like to see the evaluation to understand what works to make sure that money is being spent correctly in the right area. Having seven areas across different

areas of England, Wales and Scotland gives a really good understanding of what may work in some of the more complex areas.

Q18 **Chair:** What is your timetable for evaluation on that? Are you doing it, or is the Home Office?

Mark Lay: That comes under the Home Office. It is being evaluated over the next 12 months, so you will get the early indications within 12 months. There have already been four other sites. Evaluation has taken place in other areas that have done out-of-court disposals.

When we are looking at early prevention, I would certainly signpost people to the work of the family drug and alcohol courts, because they have done some fantastic work. We meet with the MoJ and some of the judges involved in that work. There is the evaluation around keeping families together, and some of the treatment services that are available there as well. I would certainly direct people to speak to judges in the MoJ. The way they have kept families together really helped in reducing harm, looking at safeguarding and vulnerability. There are some really good examples there.

Mike Trace: Maybe I could help on the scale of the challenge to achieve what Dame Diana was asking. We need not to have a postcode lottery in terms of intervening in the criminal justice system, but that is what we have at the moment. There are good projects and good bits of spending in parts of the country, but there is nowhere near a national system. We did have one, and I can tell you how much it cost.

There was a thing called the drug interventions programme that the Home Office ran up until about 2011. It was a casualty of austerity. At its peak, that programme, in every part of the country, had what we used to call arrest referral schemes in police stations, which was the early version of what Mark was talking about. We had processes for producing reports to court, in every magistrates court and Crown court in the country. That was a national programme. I think that at the peak the budget—maybe the Home Office could help you with this—was about £160 million nationally, but it went away in austerity. What we have had since is patchwork.

It is very important. You are absolutely right to be worried about the stigmatisation of people, and saying that somebody with a drug problem equals criminal. The reality is that lots of people whose behaviour we want to affect come through police stations and courts. Absolutely, as Dame Carol said, a big challenge for this next phase of the strategy is to help with the prison population crisis.

Of course, the Government want to be able to intervene in different ways than sending everybody to prison, but not to increase crime by letting everybody out. One great way to do that is to take the cohort who are currently in prison—most of them—and offer them treatment instead of prison. That worked really well 15 years ago. We had a national system,

but it has been hollowed out since. That could be reintroduced as a cost-saving measure. It costs a lot less to have people in community treatment facilities than to have them in prison. It would help not just with the drug strategy objectives, but with the wider Ministry of Justice.

Chair: We recently published a Report about resettlement of prisoners, where we touched on some of these issues.

Q19 **Dame Diana Johnson:** Finally, I wanted to ask about the tougher consequences White Paper, which came out with an escalating approach for people found in possession of drugs, particularly cocaine: you would have your passport removed, I think, and driving licences and all sorts. The Government have not done anything since it came out; I think the consultation happened and they are looking at it. What are your views on that as an approach to preventing people from taking drugs?

Mike Trace: I am not a fan. I did not think that that was a helpful part of the White Paper, not because the objective is wrong. Prevention and reducing overall drug use in society is the right objective. The problem is that, depending on your estimates and your interpretation of the data, we have several million current drug users in the country. A small proportion of those are the population we have just been talking about, which is people struggling with addiction, committing crimes and causing other problems in their communities.

If you are going to clamp down on the act of drug use, you have to answer the question of what we are going to do with 3 million to 4 million citizens who are breaking that law. Unfortunately, any attempt to clamp down so far, and any that I could see being implemented in the future, will clamp down on a small proportion of those 3 million to 4 million people. Unfortunately, it will be the most marginalised and minority communities who are most affected.

That is not to say that the objective is not worthy, but it is very difficult to move from, "We are going to reduce drug use by clamping down," to a workable policy that achieves that without being discriminatory and bearing down on sub-communities. I do not think that you can follow up on that objective without causing other problems.

Alice Wiseman: There is no evidence at all that more punitive approaches to substance misuse have any impact on drug use. If you look to other countries across the world where they have much more punitive measures, they often have higher levels of substance misuse. For me, there is just not an evidence base.

Mark Lay: One of the benefits of the paper was that it looked at starting at the lowest possible means of dealing with any form of possession offence, and at the need for the Government to provide advice to frontline officers in terms of the escalation process that would need to take place. At some point, if people continually do not comply, what is

the answer for Government? It is not an easy situation for people to be put in.

Dame Diana has touched on the removal of driving licences. When you get to the point where someone has an acute problem with drugs or is using different types of drug and still getting behind the wheel of a car, you have to protect the wider public.

Q20 **Peter Grant:** Happy St Andrew's day to all our witnesses. Mr Lay, can I pick up on a statistic you cited earlier? You said that 127 out of 150 people who were arrested on suspicion of domestic abuse tested positive for cocaine. Unfortunately, I don't think *Hansard* has a way of recording the collective intake of breath from the Committee at that point.

To put that into context, approximately what percentage of the wider population are regularly using cocaine? If you picked 150 people completely at random, how many of them would you expect to test positive?

Mark Lay: We estimate that 117 tonnes of cocaine are used within the UK. You would then need to break that down. That is our GB consumption. If you wanted me to break that down across wider society, I would need to look at some of the NHS figures to be able to give you the right figures. I would not want to make an estimate without knowing.

If we refine the figures and look across the whole of London, the figure is about 38% for domestic violence. Under the current legislation, we only drug-test and arrest when there are certain triggers, which tend to be around serious or acquisitive crime. You are then using an inspector's authority to be able to test, for domestic violence.

At the moment, the Government are looking at widening the legislation for what those triggers are. In mainstream policing, we tend to see that the majority of offences are committed while using cocaine, pills and other types of drugs. They tend to happen at night-time. You would not necessarily be testing people for drugs if they are arrested and in custody and then diverting them into treatment.

There are clearly opportunities there, especially around the younger generation. If you are looking at some of the testing that could take place, people could be diverted into treatment at an earlier stage.

Professor Dame Carol Black: Mr Grant, that figure is in appendix 1 of my report; I am trying desperately to remember it. There is a nice diagram of that. Those would be the 2019 figures.

Chair: Thanks to the NAO, we may have an answer to this. I will turn to Mr Lodge, director at the NAO.

Oliver Lodge: Figure 1 in our Report uses the data from the crime survey for England and Wales. That suggests that in 2021-22, 2.1% of the population have reported taking cocaine.

Q21 **Peter Grant:** The figure you cited, Mr Lay, was almost exactly 85% of the sample. I hear what you are saying that we have to treat that with caution; it might have been that people were tested because they were more likely to give a positive result.

Ms Wiseman, we have heard from a number of witnesses about what Professor Black described as social determinants, the things in somebody's life that mean that they are much more vulnerable to fall into drug misuse at some point. How firm is the evidence base? Are we in a place where we know, closely enough, what things in somebody's life make them vulnerable, or does more research need to be done?

Alice Wiseman: There is a really strong evidence base for the things that create an increased risk of somebody falling into substance misuse. I have talked already about adverse childhood experiences. They would be the most significant factors. There is lots of research on it.

One of the challenges, as Carol has said, is that there is not necessarily lots of research on how you identify those people. Having adverse childhood experiences does not mean you will end up with problematic substance misuse; it just increases the risk. It is a correlation rather than a cause.

Deprivation is also really significant. Deprivation is not only a cause of people using substances, but a cause of people ending up on the supply side as well. Poverty creates the environment where these sorts of things thrive.

It is not just substance misuse. We know that people who have adverse childhood experiences are 30 times more likely, for example, to complete suicide. There is a whole range of poor outcomes that come from those.

Q22 **Peter Grant:** Does the Government's current drug strategy adequately fit in with their other actions to prevent people from having those experiences in the first place? Is there an adequate link-up between the drug strategy and everything else, or is there a disconnect?

Alice Wiseman: In the work that Dame Carol has done, there was a recognition of the things that drive substance misuse and the risk of substance misuse. At the moment, we have an opportunity around secondary and tertiary prevention for substance misuse, but we do not have a primary prevention element. That is largely because a lot of the services that would do that work sit outside the traditional treatment services. They will not only improve outcomes in terms of substance misuse; they will also improve outcomes in terms of educational attainment, employment and all those other things.

Nationally, there has been a 54% cut to local authority budgets. When I looked at Gateshead's recently, it had had a 68% cut. The cuts are not equal across the country. We are now seeing an increase in children entering our care system. We know that those children are more at risk of substance misuse. We need to focus on that early work. There is some

positive work coming through around the family hubs, which sits outside this programme, but this is about rebuilding things as opposed to making sure we have the right arrangements in place to support families and children.

Peter Grant: Dame Carol, do you have anything to add to that?

Professor Dame Carol Black: No.

Q23 **Peter Grant:** I should apologise; I am never sure whether being a professor or being a Dame takes precedence, but congratulations on both.

Mr Trace, the Government strategy has a number of strands. There is disruption of the supply; there is enforcement against those who break the law; and there is treatment recovery. Does the strategy have the correct balance, both in prioritisation and funding, across each of those objectives?

Mike Trace: It is a complicated question, but broadly I would say yes. As I say, the architecture is right. The approach to the problem is right, with those strands, those possible Government levers, those interventions and the investment. There is no major mismatch. There is not a glaring area where I would say, "Do not spend money there. You should spend money there." You also have to take into account, as successive strategies have done, not only the importance of the objective but the likelihood of the investment delivering results.

The balance is broadly right. The thing to look out for—the comment has been made by all of us previously about the importance of taking a long-term view and sticking the course—is the concept of resilience. The strategy was written two years ago or so. We have our evidence and reviews now, but the situation on the ground is changing. That is most worrying on the supply side.

The law enforcement authorities have been dealing for decades with a changing drug market and changing external conditions. The one thing we know is that the changes are happening more deeply and more rapidly. I am sure you have had evidence previously about fentanyl and synthetic opiates. We have the balance of investment right for our current drug problem, but if fentanyl and the nitazenes significantly come into our market, we will have to react very quickly, and we have to prepare now. There is some good work going on. These are basically much more potent opiates. The risk of drug-related death and the risk of the social impacts of addiction could get a lot worse very quickly.

Thankfully we do not have US-level problems here, but it can happen very quickly. The balance is right at the moment—that is the short answer to your question—but staying resilient in terms of seeing the next threat is a really important part of the strategy.

Q24 **Peter Grant:** Mr Lay, looking particularly at enforcement, how do we

know whether police enforcement action is contributing towards a long-term improvement, as opposed to simply keeping things as they are? If we arrest a group of drug dealers somewhere, for example, how long does it take for somebody else to move in and replace them?

Mark Lay: If you look at some of the models we have in policing, you can see the clear benefits in the fantastic work of the national county lines teams. Through the work they do, they are able to identify the most vulnerable people who are either being exploited, in terms of being the suppliers, or are the people who are being supplied to. Invariably, a lot of the people who are being supplied by the county lines are not in treatment programmes or are not really known to services.

It is not just the enforcement side. It brings with it a whole suite of options around identifying people who have been cuckooed. Certainly, some of the people there are extremely vulnerable and extremely in need, and they need protecting. We look at the enforcement side not just in terms of the arrest, but in terms of how that leads to safeguarding opportunities.

We clearly believe that you have to reduce demand for drugs to have any impact on the restriction in supply. As you quite rightly say, even in the national county lines models, yes, we can be very effective in dismantling some of those county lines, but there are a host of people who are willing to take the place of those people who were dealing because of the money involved.

This comes back to what Alice said about the opportunities for those young people. They have no other opportunities: that is why they move into some of those models. They will be exploited by some of the organised crime groups concerned.

We just need to look at some of the examples of enforcement that have taken place in the last year. Operation Mille was an intensification of the enforcement against cannabis farms. Due to some great work by the regional organised crime units, they dismantled 1,000 cannabis factories across the UK. If there are cannabis farms in local housing and within built-up estates, it gives the public the impression of lawlessness in society. It does really affect people.

We have seen the effectiveness of dismantling 1,000 different cannabis factories. From speaking to the chief constable in Bedfordshire recently, they were seeing a cannabis factory every single day in Bedfordshire. That is a small county. They are now only being reported one a week because of that level of intensification that has taken place. There are some clear benefits to the intensification as well.

Q25 **Peter Grant:** One of the themes that runs through a lot of the Committee's work is how we properly measure and evaluate success. There is always a tendency to count the things that are easy to count, without being sure whether counting it makes a difference. For example,

it is relatively easy to measure an increase in arrests or an increase in the quantity of drugs seized. Are those good enough measures of success? If they are not good enough, what else should be used as a measure of the success, particularly of police enforcement action?

Mark Lay: I agree. You need to have a certain level of enforcement. You need to create a hostile environment for organised crime and for gangs working in our towns and cities.

Where our forces have mapped organised crime groups and gangs, we need to look at whether we have a meaningful plan of the disruption that takes place across each of them. If you own 25 organised crime groups, you may need to concentrate on the five highest-harm groups, but does that mean the other 20 are not being looked at? While you are concentrating on the five, will the 20 start to escalate the level of their violence? You need to have a model that looks at the overall reduction in harm across the whole sphere of organised crime, not just at one particular group or using one particular measure.

We have elevated up from 6,400 major and moderate disruptions as part of the national outcomes framework to 8,800. The regional organised crime units are critical to that. As we have heard from other colleagues, we need that sustainability of funding to ensure we maintain financial investigators. Certainly, people with that skillset are sought after in private industry. That is particularly true for people who are involved in the cyber space and the digital space. We continually need to keep expanding our work on the dark web. It is really important that we maintain that level of funding for the future.

Q26 **Chair:** Has the action of the police made cannabis harder to get and more expensive as a result of this reduction in the number of farms, rather than having this concentration?

Mark Lay: The key issue with cannabis at the moment is that we are seeing a significant influx of cannabis coming into UK.

Chair: It is imported.

Mark Lay: It is imported into the UK. We were also very much an exporter of cannabis. We have seen the legislative changes in British Columbia and America. The surplus cannabis is coming through parcels and the mail into the UK. We have a significant increase in the expectations upon local forces to intercept cannabis being delivered into the UK.

Q27 **Chair:** There is a lot of it coming in, so it is not going up in price. It is not making it harder for people to get.

Mark Lay: It is not going up in price, but you get a real change in the levels of THC purity as well. Along with the concern around cannabis being delivered through the mail, the other key issue is the longer-term one of cannabis edibles. Once again, we have mentioned education.

Cannabis edibles are a real risk for children in the UK. If I were to bring cannabis edibles into this room now—

Chair: By that you mean sweets and things.

Mark Lay: Yes. You get different types of sweets. They look very similar to other normal sweets that children will buy as energy sweets or other types of chocolate or confectionery that they would have. They mimic that on purpose. Children will then use and take them.

Q28 **Chair:** Ms Wiseman, are you seeing this play out in public health terms?

Alice Wiseman: I probably have a slightly different view from Mark. The national policy needs to be focused much more on prevention, treatment, recovery and harm reduction instead of supply and enforcement. That is not because I do not think supply and enforcement are important. Those are important priorities for the reasons Mark has set out, particularly in terms of enabling opportunities to safeguard some of our more vulnerable communities.

I have never seen any evidence that a focus on crime and enforcement has reduced the supply of drugs in a local area. I have seen that it moves, as you have described. There is also a risk that we disrupt supply in a way that means we end up with worse drugs than we had had previously.

From a public health perspective—I would say this—my focus would be on working with those people who are using substances. I am going to say it: I do think alcohol needs to be part of this conversation as well. As Mark referred to, a lot of people arrested for domestic abuse were using alcohol and cocaine at the same time. There is a night-time economy. If you are using the night-time economy, you are significantly more likely to be using cocaine as well.

We should not shy away from the fact that we are worried about the supply of illicit drugs because of the illegal nature of them, but we should also be worried about the supply of alcohol in our communities and the impact that that has.

Q29 **Chair:** While we are on the subject, I was very struck by what you were saying about prevention and the missing cohort of children. In our generation, it was "Just say no." I am not sure how well that worked.

You made a point about the sweets. They are getting into our schools and our communities. They are easy to access. Young people are not always well equipped to deal with this. What are the top three things we should be doing? What is missing in the strategy, in terms of prevention? A lot of the focus is on the acute end. What tools would you like to have locally for prevention?

Alice Wiseman: It is not necessarily missing from this strategy. There is a broader strategy around inequalities that could be undertaken across

Government. Again, learning from the Joint Combating Drugs Unit, we need a strategy on inequalities that cuts across all the Government Departments. That would give us the opportunity.

Q30 **Chair:** What about children and young people in particular? There are potentially inequalities issues there, but if it goes into a school, any young person could be at risk if they are not equipped to understand and say no.

Alice Wiseman: For the majority of children who are in the situation where they are not able to say no, that is because they have other circumstances that they are living with. If they are living in communities where drugs and alcohol are normalised, they are more likely to be used in a problematic way.

I would focus on parenting support. I would move away from punitive approaches and think about how we support parents, particularly the children of people who have grown up in households where they are misusing either alcohol or drugs.

Q31 **Dan Carden:** Mr Lay, there are concerns about the increasing strength of cannabis, but to what extent would you be able to concentrate more on tackling cocaine and other harder substances if your time were not taken up with focusing on cannabis use? One of the concerns I have, to be blunt about it, is that criminalising young people, often in deprived communities, who smoke a spliff is not what I consider tackling the drugs problem.

Mark Lay: I agree with you. I also grew up in the "Just say no" era, with "Grange Hill". On what Alice said, I want to re-emphasise that my last answer was very much in relation to enforcement. We would always say that you must reduce demand if you are to have any impact on supply. We are very much on the same page: you need to reduce demand.

Particularly for anyone who is found with cannabis, I would go back to the example I provided earlier in relation to first-step diversion and first-step education. If it is visible cannabis use, people need to understand the impact it may have on other people. Just because you enjoy smoking that cannabis, it does not mean that everyone else wishes to feel or sense that. That does not necessarily mean it then has to start to move toward criminal proceedings. I totally agree it should not.

We have undertaken some work around visible cannabis use and what type of work takes place in different areas. We have looked at some of the work that is conducted around antisocial behaviour. Where intensification takes place through patrols in some areas, we have looked at how you make sure the people who are identified or found with cannabis or other drugs are diverted into education and treatment. That means a decision can be made, not by the police but by those expert people, about whether someone needs education or treatment services.

On your point about cocaine, in the past 12 months there has been some really good work by the NCA, the ROCUs and law enforcement. They have pivoted resource from cocaine to look at the organised crime groups dealing in heroin because of the impact on drug-related deaths.

We are doing some significant work around nitazenes as well. We had to pivot resources to look at heroin. We then pivoted resources to the intensification around the cannabis farms. It is about making sure we remain flexible enough as a police force to go towards where some of the highest harms and risks are.

Q32 **Dan Carden:** I have a question for Dame Carol on the funding allocation. There has been an underspend of 14%. That is tens of millions of pounds. Along with delays in the public health grant allocations, how difficult has that made it to deliver this strategy? Does such a high underspend signal a bit of a problem?

Professor Dame Carol Black: It has had an effect. It is very regrettable that for the first two years those allocations were delayed. Local authorities did not know what they were going to get. Thank goodness, this year at last the bureaucratic problems have been solved. That made a very big difference to what local authorities could do and how they could recruit. It was difficult enough to recruit anyway. Alice could probably answer this better than I can, but part of the housing grant was also affected by late delivery. All of that made it really difficult.

If you have your money late and you have to spend it by a certain time, we have had this terrible problem of not having people to hire. It has been that awful lateness, not giving people a chance. We were then asking them to somehow scrabble around.

Chair: It is a problem we see regularly on this Committee: money is allocated late for everything.

Professor Dame Carol Black: Alice will have had this on the frontline, but I can tell you that it was extremely irritating.

Alice Wiseman: You will remember that the last time I came to the Public Accounts Committee was at the beginning of March. We had just been given the allocation for the spending up to the end of March. We were given that at the end of February; we did not get the public health grant until mid-March. When I came to see you, we were still at a point where we did not know about that. It is great that we know about the funding for next year now. That means we can plan, although we still do not know about the public health grant. This does present challenges to local government, especially at the moment when we are all really struggling financially anyway, in making commitments.

Q33 **Chair:** You do not know about the public health grant for the next financial year?

Alice Wiseman: I do not know about the public health grant from April 2024 to 2025, but I do know about the substance misuse additional funding. I am making the assumption that the public health grant is there, but there is a risk for local government in doing that.

We are already significantly stretched. If it did not come through, it would be a real problem towards the end. The challenge it gives us is that we are not able to go and work with our local providers around what we want to see from 1 April next year. Some local authorities felt comfortable in taking a bit of a risk and having those conversations, but others have not been able to.

Q34 **Dan Carden:** We will produce a Report on this, and the underspend will be something on which we want to give a recommendation. What is it that is needed?

Alice Wiseman: We should extend the time in which local areas can spend that resource. People can spend the money, if they have the full year to be able to spend it. If they were not able to take those risks, I would recommend that that resource should go back to those local areas to allow them to spend it as they would have liked to if they had had the full 12 months.

Q35 **Chair:** Basically, they would be allowed to roll it forward.

Alice Wiseman: Yes, they should be able to extend it forward.

Mike Trace: Could I make a suggestion, in addition to that? The recommendation should absolutely be that the underspend be freed up to roll forward, but it could valuably be used to address the point Dame Johnson raised earlier about the difficulty of funding high-intensity services. They are hard to fund locally and there is not a national funding scheme for them.

Chair: It would relieve pressure on local authorities.

Mike Trace: It is one suggestion for how to relieve two problems with one decision.

Q36 **Dan Carden:** Mr Trace, would you explain for the Committee the difference between treatment and recovery? In particular, I am thinking about how Government can encourage thriving recovery communities.

Mike Trace: These definitions are contested, but my interpretation is that treatment is the process by which you achieve recovery for an individual. We talked about this earlier. An individual might have a chaotic lifestyle where they are dependent on drugs or alcohol and they may be criminally involved, homeless or unemployed. The intervention you make is the treatment. The objective you want to achieve is the recovery. That is my definition of it.

Particularly in the healthcare sector, treatment is viewed as the clinical work, the doctors and nurses, and recovery is seen as the social work. In

my view, that is not a helpful distinction. Certainly in terms of the drug and alcohol treatment system, the treatment needs to be holistic. That is a horrible word and I try to avoid saying it, but the idea is that the treatment is all those things you would do to achieve people changing their behaviour and moving towards recovery.

Q37 **Dan Carden:** Dame Carol, can I ask you about recovery and what you have learned from your time?

Professor Dame Carol Black: I would agree with that. For me, treatment is the whole thing. We do not define it like that today in the way we deliver a period of treatment. As you know, in the system we have at the moment, you get signed off as having successfully completed treatment. That is really indicating that you have given up your heroin and you are on substitution therapy. It is showing that you have moved through that.

It is a very limited phase. For me, like Mike, treatment is the whole thing. You are taking people on a journey. Part of that journey is moving them from the pharmacological intervention into the recovery intervention, which may take several years and will often involve peer support, housing, ongoing mental health support and work. It is about seeing it as a whole-system change. At the moment, we are probably stuck with the idea that you can have a successful completion of treatment. It is something we need to really broaden our minds on.

Q38 **Mrs Drummond:** I want to look at the significant barriers that we have not discussed already and the medium and long-term impact of the drug trade. It is worth £2 billion. It is a massive threat to our society. What else we can do or suggest on Monday about how we can get over those barriers? It is a tricky one. I will start off with Ms Wiseman, because she is smiling.

Alice Wiseman: It is a real challenge. My starting point would be that we should stick with the work we are doing on the 10-year strategy. I am sorry to rehearse that statement again, but it is really important that we have a commitment and that this is prioritised. We need to think about how we can prevent people from being at risk of substance misuse. Again, that will require a really long-term strategy that focuses on the inequalities that we see across the country.

We are never going to see a reduction in supply unless we see a reduction in demand. I have not seen any evidence from anywhere in the world where robust enforcement approaches have reduced that supply. We know they need to be there. I would argue that they need to be focusing on those things.

We need to have a recovery community; Dan Carden MP referred to it. Having a really positive recovery community that we celebrate would be really important. When I talk to people who are accessing treatment systems, they will often say that they came in because they saw a peer

who they knew had been in active addiction and was now in recovery, and they thought, "If they can do it, I can do it." We need to remove some of the stigma that is associated with substance misuse so that we can start to celebrate it as a really positive community and, hopefully, drive more people into treatment services.

I reiterate the point about alcohol. We are talking about substances because they are illegal, but we have a bigger problem in this country with alcohol. The harm that alcohol causes across the country is expected to cost us £27 billion each year, which is significantly more. It is just not seen in the problematic way that illicit substances are seen, for the obvious reasons of legality.

Mark Lay: If we do not have a robust policing and law enforcement policy, it sends out the message that drug dealing is okay. You cannot do that. If you look at the evidence I have provided in relation to Operation Mille, that involved Albanian organised crime groups coming across to the UK and using cannabis farms as a means to drug-deal across all our communities.

As I said, it is important to reduce demand. As Alice said, unless we reduce demand, we cannot expect to have an impact on supply. You need that two-pronged attack to make sure you have both. This also goes back to what I said about national county lines. The intensification drew out some of our most vulnerable people who needed safeguarding.

Professor Dame Carol Black: I hope that on Monday you will spend some time thinking about the responsibilities for delivering the strategy and the actual role of the JCDU, which was very much highlighted in the NAO Report, because it is a new body. We need to strengthen the approach to evaluation. The Joint Combating Drugs Unit has very poor support for evaluation; there is one member who is there to be able to analyse and evaluate. You should think about strengthening that unit.

We also need to think about how we maximise the impact of the local partnerships. We have set them up and we are pleased with the structure. You can set things up, but we must make sure they are impactful as we go forward. We need to have local variation and enable these local partnerships to innovate. We need to think about how we can strengthen that.

Then we really need to have a long-term plan. I know that funding interferes with this, but what is the long-term plan to deliver the strategy outcomes, now that we are into our third year? Those are bigger questions, but they are very important.

Mike Trace: I broadly agree with what has already been said, so for the sake of time I will not repeat it or rehearse it again.

I would make one tweak to the point about supply reduction. Mark is absolutely right that the law enforcement authorities of this country,

national, regional and local, have a big part to play in this, but I would say the same thing that I said about the treatment system: we need to adjust the expectations or outcomes we expect them to achieve.

If Government ask Mark and his colleagues to stop supply, we have lost that battle. We have mature markets. The supply is happening. If you ask the law enforcement authorities to reduce the violence associated with that supply, undermine organised crime and reduce potency, if they are given those sorts of objectives, they can achieve and have achieved that. This is a little bit in parallel to what I said about the treatment system: make sure the outcomes you are expecting from your investments are tightly and carefully drawn.

Q39 **Chair:** I was very taken by what you said about that. It is interesting. We like to see data and metrics, as a Committee, so we can check that the Government are doing what they say they want to do. I hear what you are saying. What would your recommendation be in very precise terms for what you would like Government to be measuring?

Those metrics on who is going in are still important. If £900 million from the taxpayer is going in, it is all very well getting some good outcomes for a few people, but you have to get the volume through. You need to know that people are starting. We are not necessarily against that as a Committee, but I was taken by what you had to say.

Mike Trace: I have it noted down on my pad: it is complicated. That is my first response. I am happy to write to the Committee to give some detail.

What I say now will seem a bit simplistic, but it is doable. On the treatment side, we need a laser-like focus on the ultimate outcomes: reducing crime, reducing deaths and increasing recovery. All those are countable things, but you need to have a laser-like focus and say, "We must count those things, and we must, in this 10-year horizon, be able to show that we have achieved those things." That is on the treatment side.

Q40 **Chair:** The Treasury tends to work cash in, cash out in a year. That is the challenge.

Mike Trace: Exactly, yes. There is the problem. There are spending reviews, new Governments and all those things. All of us panel members have said that these are long-term societal objectives. We should not change with the fashion.

We also need to get the outcome framework right. It is nearly there. On the law enforcement side, it is more about whether we have made it harder for people to access the drugs we worry about. There are difficult decisions within that. The police are quite good at making those operational priority decisions. Have you reduced the violence associated with the market? Have you reduced the influence of the nastiest people in your area, which is generally organised crime? There are ways of counting it.

It is the same with the issue of perverse incentives. If you are chasing zero supply, you will never get there. Your activity will be misdirected.

Chair: That is helpful. We will be able to ask some of those questions.

Thank you very much indeed for your time. We have a very important session on Monday with the Home Office and the Department of Health and Social Care, and we will be pushing them on this. We are very interested in all these cross-cutting wicked issues and how they are handled, and this is definitely one of those. We really appreciate your time and expertise, and what you are doing generally on this issue across the piece.

The transcript of this session will be available on the website uncorrected in the next couple of days; many thanks to our colleagues at *Hansard* for that. We will be broadcasting our next session on Monday at 4 pm.

Professor Dame Carol Black: Can we attend it?

Chair: You can attend in person or watch it online—on live TV, as it were. That is an advert to anyone else who may be watching or may have an interest.

As you know, our sister Committee is also interested in the issue, and we will both continue to pursue it. We will see where we get to on Monday. We will be producing a Report after Monday's hearing, but it will be published in 2024. Thank you very much indeed.