

Health and Social Care Committee

Oral evidence: Drugs policy, HC 1822

Tuesday 7 May 2019

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Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Diana Johnson; Andrew Selous; Dr Philippa Whitford; Dr Paul Williams.

Questions 1 - 116

Witnesses

I: Professor Susanne MacGregor, Honorary Professor of Social Policy, London School of Hygiene and Tropical Medicine; and Professor Tim Millar, Professor of Substance Use and Addictions, University of Manchester.

II: Karen Biggs, Chair, Collective Voice; Boris Pomroy, Chief Executive, Mentor; Professor Harry Sumnall, Professor in Substance Use, Liverpool John Moores University; and Mike Flanagan, Consultant Nurse and Clinical Lead, Drug and Alcohol Services, Surrey and Borders Partnership NHS Foundation Trust.

III: Kirstie Douse, Head of Legal Services, Release; and Adrian Crossley, Head of Addiction, Centre for Social Justice.

Written evidence from witnesses:

- [Professor Susanne MacGregor and Maggie Telfer](#)
- [Collective Voice](#)
- [Mentor](#)
- [Professor Harry Sumnall](#)
- [Release](#)
- [Centre for Social Justice](#)

Examination of witnesses

Witnesses: Professor MacGregor and Professor Millar.

Q1 **Chair:** Good afternoon. Welcome to the Health and Social Care Select Committee and our inquiry into drugs policy. Mark Johnson, who we hoped would join us on this first panel, has, unfortunately, not been able to join us today, but we are hoping to include him in a later panel, for those of you who have seen that he is listed. We have a fantastic set of three panels.

To set the scene, we are trying to get at what a high-quality, evidence-based policy on drugs would look like. Today we are hoping to set the scene and have some guidance from our three panels as to where we should most focus our attention over the course of the rest of the inquiry, so we are keen to hear from you as experts about what you recommend we focus on.

For those following from outside, could I ask you both to introduce yourselves, and who you represent?

Professor MacGregor: I am Susanne MacGregor. I am an honorary professor at the London School of Hygiene and Tropical Medicine and an emeritus professor at Middlesex University, London. My expertise, in so far as I have any, is in social policy and public health. I have been an observer of the drug scene, the drug field, for about 40 years, so I have a commentary to make on that overview.

Professor Millar: I am Tim Millar. I am professor of substance use at the University of Manchester. I am also a member of the ACMD, but I am not here today in an ACMD capacity but purely in an academic capacity. I suppose, if I am anything, I am an epidemiologist in drug misuse. I have a particular interest in drug-related mortality and other drug-related harms, particularly in the group of heroin users I have watched age over the last 30 years in the field.

Q2 **Chair:** Thank you both very much. Could you set the scene for us, giving a background for those following this inquiry on the key health and other harms associated with illegal drugs and where you would like to see us focus? Perhaps, Professor Tim Millar, you would like to kick off on this section.

Professor Millar: I will do my best. It is a very complicated question, and I am conscious that I should not spend an hour giving you a complicated answer. It is very important to recognise, when we are talking about harms related to drug use, particularly health harms, that they vary according to the drug people are using, the nature of the user, the way in which they are using it and the context of their use. Many drug users are unlikely to experience significant health harms because of the drug they use or the pattern in which they use that drug.



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Where we see very significant harm is in respect of drug-related mortality, which I suppose is the ultimate health harm; dying is the ultimate. In that respect, the primary issue relates to opiate users and opiate use. It does not matter where you look in Europe, 80% to 90% of drug-related mortality—mortality attributed directly to the effects of drugs—involves opiates. Many people do not realise that the mortality we count as drug related, the overdoses, represents fewer than half the premature deaths in that group.

We have done the biggest study in the world, of a group of 150,000 illicit opiate users in England, and we found that overdose accounted for only about 43% of the premature mortality in that group. There is a very high level of disease mortality—cancers, cardiovascular disease, respiratory disease, and lots of liver disease, of course, and lots of deaths due to external causes, primarily homicide and suicide. The group was 12 times more likely to be the victim of homicide than a member of the general population. In total, they were six times more likely to suffer premature death than the general population. Some of those deaths are not due directly to the intrinsic properties of the drug they are using; they are due to the lifestyle that goes along with that drug. It is a highly marginalised group that finds it difficult to access mainstream healthcare. Most of the deaths were preventable.

Q3 Chair: How should we be looking at that alongside the problem of deaths due to legal opiates that we see across the United States, for example, and increasingly over here?

Professor Millar: The context in the States is quite different. The whole framework in which doctors operate and are able to prescribe opiates in the States is different. Doctors in this country have a far more cautious approach, in my experience.

The heroin epidemic of the 1960s was attributed to overprescribing by doctors, and the framework that we established around the prescribing of those drugs was at the time very much geared towards a public health model of trying to stop the spread of use. I think doctors are far more cautious in their use of those drugs in this country, and I do not see the same drivers and scope in this country that I would see in America. That is not to say that it is impossible, but it is far less likely in this country that we would see anything on that scale.

Q4 Chair: If we were looking, as you say, at the ultimate health harm of mortality, your advice would be that we should focus on opiates. For other drugs, particularly cannabis, for example, could you give us your thoughts on whether that is something we should also be looking at, and the harms associated with it?

Professor Millar: Most drug users in this country are cannabis users, and the majority of cannabis users use cannabis in a fairly irregular pattern. Most of them are not daily users; according to the survey data, it is perhaps one in 20. I would need to confirm that. Those people are



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quite unlikely to suffer significant health harms. We will all be aware of the evidence that there is an association between some forms of cannabis use and some forms of mental illness. It is an association. I do not see that there is strong evidence of a causal link. I do not think the evidence is as clearcut as perhaps the media portray it.

Q5 **Chair:** We are often told though that the evidence is clear for young people. Do you think that is correct?

Professor Millar: It may precipitate the onset of mental illness in people who are vulnerable, but if we look at the changes in the prevalence of cannabis use over the last 40 years or so, we do not see a corresponding change in the prevalence of mental illness.

Q6 **Chair:** Professor Susanne MacGregor, would you like to come in?

Professor MacGregor: We focused on the substance, and I think you are right to focus on heroin and perhaps cocaine—they are the most problematic drugs—but there is an issue around cannabis, which I expect you covered to some extent in your inquiry on medicinal cannabis. There has been a concern among psychiatrists about increased presentation of people, and indeed cannabis is a common drug of use for new entrants to treatment. There is an issue around cannabis. I think you would be wise to follow that through, perhaps with some investigations with neuropharmacologists and people like that.

The other things I would talk about would be to agree that the way the drugs are used matters—when, by whom, where and how; if you use in a safe or a dangerous environment and if you use alone or with other people. Most problematic drug use is associated with long-term heavy drug use; it is that use of drugs that causes most problems.

The other point I would pick up on is the link with mental illness. Comorbidity has long been recognised, but has not been responded to adequately, so the association of mental illness with drug misuse, whether it is a cause or consequence of taking drugs, is more problematic if you are mentally ill. That whole area, and whether we have the services to respond to comorbidity, is an important point.

Chair: Thank you.

Q7 **Dr Williams:** You have both talked about the harms done to the individual. What about the broader harms to society?

Professor MacGregor: Yes. There are harms to others, of course. Crime has been the one that was given a great deal of attention, but there are the harms to family members and carers and to children of drug-using and drug and alcohol-using parents. It has been an issue since the “Hidden Harm” report of 2003, so it has been recognised. It is important to listen to the voices of young people in families. It is a problem for social work, so responding to the issue is not just a matter for



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psychiatrists; social workers become very involved with that group of people.

I suppose you could talk about the violence associated with the drug trade to some extent. It is an issue in the public arena, but how much it is an issue for this Committee, I do not know.

Q8 Dr Williams: My constituents talk about a breakdown in trust, a breakdown in social cohesion. Is there any evidence of that?

Professor MacGregor: Certainly community impact has long been a problem. Again, is it cause or consequence? There is a concentration of problematic drug use in areas that suffer from poverty and multiple deprivation. Those are the communities with least resources to be able to respond. They may have many resources as individuals and families, and community groups should not be underestimated, but they are poor areas, so the pressure is on the areas that have least resources to respond to them. It has periodically been an issue.

Particularly in the 1990s, it was one of the issues of community concern, and the Home Office in fact made some attempt through the Central Drugs Coordination Unit¹ to have innovations in community development and prevention. In the early part of this century, there was Communities against Drugs. They were small attempts, but there have been innovations that have basically aimed to encourage communities to respond to and support the people in communities who are trying to respond.

Q9 Mr Bradshaw: Does prohibition and a criminal justice approach to drugs help or hinder harm reduction?

Professor Millar: That is another complicated question. It is undeniable that a prohibition approach probably increases the risk of harm to individuals. If you are using a substance that has been produced by a criminal in an illegal laboratory with no proper controls, it is more dangerous than something that has been properly produced.

Arguably, if prohibition reduces the number of people who are inclined to use such substances, the totality of harm might be reduced, in which case we might consider that it is acceptable to elevate the level of harm at the individual level. That is a philosophical decision rather than a scientific one. It hinges on whether you consider that prohibition is effective in reducing the number of users.

Q10 Mr Bradshaw: What do you think? Is there any evidence in the history of humankind that prohibition works?

Professor Millar: The evidence is weak in both directions. Certainly, the Home Office's investigation or consideration of it led them to the

¹ Note from witness – 'I spoke of the Central Drugs Coordination Unit at the Home Office - I should have referred to this as the Central Drugs Prevention Unit.'



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conclusion that they did not see a link between how vigorously drug laws were enforced and the levels of use in different countries, but that is fairly weak evidence.

Q11 Mr Bradshaw: Prohibition has essentially existed in the drugs field since, what, the 1960s? What have been the trends since then?

Professor Millar: The Dangerous Drugs Act 1920.

Q12 Mr Bradshaw: What has been the trend since then?

Professor Millar: The trend in?

Q13 Mr Bradshaw: The trend in illicit drug use.

Professor Millar: Upward.

Professor MacGregor: The Home Office comparator study, which compared drug policy in different countries, concluded that the severity of the policy did not bear any relationship to the extent of use. Prevalence is affected by a whole range of other factors—supply, culture and so on. That is not to say that policy does not have a role in that particular regard.

I support the point that has been made that taking drugs of unknown content and strength, and the variability in the nature of the drug and its toxicity, can lead to overdoses and harms, because people do not know what they are taking. The adulterants in the drugs are often the cause of the problems as much as the substance itself. The combination of drugs with alcohol in particular can be very dangerous. The use of drugs in an unregulated, inconsistent and variable way is dangerous.

Q14 Mr Bradshaw: Have you or any colleagues that you know of working in the field internationally, who are advocates of a public health approach, ever done a comprehensive cost-benefit analysis of what could be done and what could be achieved if all the billions of pounds currently spent on trying to police the international drugs trade, the cost of crime globally—not just in this country—were to be spent on education, prevention and public health? Has an assessment been done of what that could achieve in either improvement or deterioration?

Professor MacGregor: There is speculation, given that 90%, or the vast majority of the expenditure, can be in that direction—on the criminal justice system and the control of supply. It is whether it would be feasible.

Q15 Mr Bradshaw: What is your own assessment? What is your own hunch?

Professor MacGregor: If you could divert that amount of money, it would be radical change. Diverting small amounts of money would help, and that is something that has been tried, and was to some extent tried in the early part of this century in this country, and is being tried in other countries. A radical move would be quite difficult to introduce, but



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diverting some of the costs from expenditure on police, prisons and criminal justice into health would make a big difference.

- Q16 **Mr Bradshaw:** Do you think there is political reluctance or reluctance among serving politicians to pursue or articulate some of those options? It strikes me that we have a series of very senior former Presidents of the United States and of other countries and the United Nations calling for a completely different approach internationally to drugs, yet there is reluctance among current policymakers in post to contemplate it. Why is that?

Professor Millar: It is an understandable reluctance, in so far as it would upend decades of what we have been doing. Susanne is correct in suggesting that diverting some of that resource into communities, into harm reduction, would certainly be feasible and advisable. I have worked in this field for 30 years; I think about these problems every day and I am still uncertain as to what the solution is in terms of the legal framework. I do not really know the answer to that question.

- Q17 **Mr Bradshaw:** You mentioned cannabis earlier and the effects on young people in psychological harm. Am I right in thinking that it is mainly the modern high-strength skunk that we would be talking about in terms of the potential danger to young people's mental health?

Professor Millar: The evidence for an association seems to indicate that, yes, but it is still a relatively rare outcome.

- Q18 **Mr Bradshaw:** You said earlier that most people who use cannabis would not come to harm, and the same, I guess, could be said of people who occasionally use ecstasy. Do you think there is a danger that the way the UK Government classify and criminalise different types of drugs, as opposed to the potential harms of legal drugs such as alcohol and tobacco, could discredit the whole system in the eyes of young people?

Professor MacGregor: On the whole, I do not think young people know much about A, B and C classifications and schedules and so on. It does not impact; it may when they get arrested or get into trouble. The idea that taking a substance is going to have a terrible effect immediately is perhaps presented in some circles, but I would say it is increasingly not the case. We have seen over the years how familiar drugs are now; they are present in soaps; they are on television. There is a familiarity with drugs that was not there 40 years ago. People are perhaps more likely to know people who have taken things and may therefore decide not to take them because they have seen the effects.

Professor Millar: Or vice versa.

Professor MacGregor: The danger is that, if you take something and it does not have anything like the effect that has been warned, you may think there is no harm at all. Lack of education and reliable information could be a problem.



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Q19 **Chair:** Could I clarify a point? In your opening remarks, Tim, you were talking about the difference with the States—that they have a much more liberal approach to prescribing opiates. Is there a danger that we would, if we liberalised access to them here, end up in the same direction as the States? It is not that over there they are accessing opiates that are street heroin with all sorts of other additives in them; these are pharmacological products.

Professor Millar: They are pharmaceutical products that were very heavily marketed by the companies that produced them, as I understand it. There may even have been some indications that they were not addictive in some of that marketing.

Q20 **Chair:** If we legalised them, wouldn't the same happen here? They would be very heavily marketed and we would see more people using them, with the kinds of harms that we have seen in the States.

Professor Millar: It depends what you mean by legalise. I certainly would not want to see us return to the 1860s when you could go into any corner shop and buy opium.

Professor MacGregor: No one is proposing that.

Professor Millar: No, absolutely not.

Q21 **Chair:** That is why I wanted to invite you to clarify it. What do you envisage when you say that we need to change our drug policy around opiates? Where would you like to see that?

Professor Millar: My concern in our drug policy around opiates is that we latterly have neglected some of the issues around harm reduction, particularly in respect of mortality. There may be some parts of the opiate-using community who might benefit, for example, from safe facilities in which to use drugs. If you are homeless and using heroin, a safe facility in which to do that might reduce your risk quite considerably.

We have also seen a shift in the emphasis of treatment provision away from opiate substitution treatment. We know that opiate substitution treatment reduces the risk of fatal overdose by 50%. Its effect is profound. It is a life-saving medicine in that respect. We also know that when people leave opiate substitution treatment their risk quadruples. In so far as we have seen a shift in the system towards an emphasis on moving people out of OST, of course people are entitled to and deserve the opportunity to do that, but it is a dangerous thing.

Q22 **Chair:** By OST, you mean observed supervised treatment, do you?

Professor Millar: Opiate substitution treatment.

Chair: Thank you.

Q23 **Andrew Selous:** You talked a little about the trends in illegal drug use. Focusing on the last decade, what has been noticeable in what has



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changed?

Professor Millar: Over the last decade, according to the survey data, in this country we have seen some quite interesting decreases in some forms of drug use. We have seen decreases in drug use overall, particularly among the young adult population. We have seen decreases in cannabis use.

We have seen increases in cocaine use, particularly in the last few years when they dipped from 10 years ago but came back up to their position of about a decade ago, and that is worrying. We have an ongoing group of heroin users. Originally, their problem was with heroin and they are polysubstance users now; they are getting older and they have increased needs. Thankfully, we are seeing far lower incidence of heroin use among young people, so young people are not adopting heroin in anything like the numbers they were.

Q24 **Andrew Selous:** Can I ask about that? We have some evidence that for reported use of drugs in the last year there has been a slight increase in the proportion of 16 to 24-year-olds. Do you think that is not enough data to say?

Professor Millar: It may have fluctuated. Over the last decade, it has probably gone down slightly. I have some figures here somewhere.

Q25 **Andrew Selous:** You are not alarmed by what has been reported, showing a slight increase since 2012 onwards, looking at the graph that the Committee has in their briefing?

Professor Millar: They fluctuate year on year, but if you look at the situation over the last 10 years compared with the previous 10 years, use seems to be lower.

Q26 **Andrew Selous:** What about Spice and the impact of that on the prison population and the homeless population?

Professor Millar: I work in Manchester. Spice use among the Manchester homeless population has been the subject of a lot of media attention. It is a very visible problem. It affects a relatively small number of very unfortunate people, but it is very visible. You are talking about perhaps 100 or 200 people, bearing in mind that in the same city there are 4,000 heroin users, but, because it happens in public places and because the effects are highly noticeable, it generates concern, and clearly those people require some sort of response.

Q27 **Andrew Selous:** It is pretty rife among our 85,000 prison population as well.

Professor Millar: It seems to be, yes. I think the effects of that are well known.

Q28 **Chair:** Tim, could I ask you to speak slightly louder? You are very softly spoken and it might be difficult for people sitting in the back row to hear



you.

Professor Millar: Sure.

- Q29 **Andrew Selous:** Could you compare what has been happening in the UK with other European countries over the last decade or so? How do our trends compare with our European neighbours?

Professor Millar: If you look at drugs like cannabis, for example, we used to have relatively high prevalence compared with a lot of European countries. We are now closer to average. We have much higher rates of illicit opiate use in this country than elsewhere in Europe. That is why we have a higher rate of drug-related death in this country than elsewhere in Europe. We have more people at risk.

- Q30 **Andrew Selous:** What do you think is the reason for that? Why is opiate use higher in the UK than in Europe?

Professor Millar: It is historical. It goes back to the 1980s and 1990s, and what the media refer to as the Trainspotting generation—people of my generation—who adopted heroin use in the 1980s, and a second wave in the 1990s, whose use has persisted. That group, or the group we have now, are the group who have been unable to stop. There has been a distillation within that group to the people who have the most entrenched problems. For many of that group, heroin probably is not their main problem; they have multiple problems in their lives, and to some extent it is perhaps a symptom of those problems rather than a problem in and of itself, albeit that it exacerbates them.

- Q31 **Andrew Selous:** What about UK cocaine use compared with European countries?

Professor Millar: UK cocaine use is high compared with other European countries, and has increased.

- Q32 **Andrew Selous:** That is in recent years, so it is not an ageing use group.

Professor Millar: No. It is interesting that cocaine increased across the whole age range over the last 15 years. It ebbed somewhat in recent years, but it has come back up again.

- Q33 **Andrew Selous:** The same question: why is it higher in the UK than European countries? What is your best estimate of the reason?

Professor Millar: I do not know. I do not think anybody could easily tell you the answer to that question.

- Q34 **Andrew Selous:** Susanne, what are your thoughts on that?

Professor MacGregor: They come and go, and fashions change. Supply of course is important. There are so many variables, and they are difficult to control. Going back to the issue of opioids, and the feeling that heroin had been controlled and heroin epidemics were a thing of the past, the



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situation in the States is a reminder that they can come back. Quite why they are in these waves is very difficult to know.

Q35 **Andrew Selous:** Is the UK phenomenon of county lines a particular UK phenomenon that you do not see to the same extent in Europe?

Professor MacGregor: It is a very interesting phenomenon. John Pitts noticed it some time ago when he was investigating gangs. About eight years ago, he noticed that organised crime was making connections with low-level delinquents in the community; where they had been separate worlds, a connection between organised crime and local deviants was established. It is now called county lines. It is part of the business model.

Q36 **Andrew Selous:** These are major drug supply networks in—

Professor MacGregor: You would find it in Italy.

Q37 **Andrew Selous:** It is often market towns, often towns that are not particular hotspots of poverty.

Professor MacGregor: It is a way of spreading your—

Q38 **Andrew Selous:** Is this unique to the UK?

Professor MacGregor: I do not think so, no. It is a business model, which is probably learned.

Q39 **Andrew Selous:** In terms of prevention, actually stopping people getting into illegal drug use in the first place, what would you advise we need to do more of to stop people ever starting on that journey?

Professor MacGregor: There are people who will speak later who know a lot more about that than I do. My personal view is that I would like to see drugs embedded with the Healthy Schools approach and the Healthy Places approach, and to be seen as part of a general health promotion activity. Drugs have tended to be seen as something separate. It has become more mainstream, but drugs, alcohol, smoking and food are all part of the same kind of complex, so I would like to see it built into a broad-based, whole approach to healthy living, which is happening; there are some very interesting developments in housing developments and community developments. To see Healthy Schools also including drugs education would be very helpful.

Q40 **Andrew Selous:** What is happening in housing policy that is helpful in this area?

Professor MacGregor: In some areas, they are trying to devise new housing schemes that have a health focus, so there is concentration on moving, exercise and using—

Andrew Selous: Active travel I think they call it.



Professor MacGregor: Active travel and using local resources like schools as hubs for community activity—those sorts of things. They have been tried before, but they are trying to do it again.

Q41 **Andrew Selous:** I am very interested in this area, along with the Chair, I think. Are you saying there is evidence that active travel leads to lower drug use?

Professor MacGregor: No, I would not say that there is evidence, but, if we had demonstration projects that were evaluated, we might have the evidence. There is partial evidence from demonstration projects that have been tried over the years, which tends to show that if you have a multi-component, whole-system approach it improves health in general, including attitudes to substances.

Q42 **Dr Whitford:** Andrew was touching on county lines and the issue of gangs and drugs. In Scotland, they used the public health approach to violence reduction, which was tackling the whole gang structure across multiple agencies in quite a, let's say, free-form approach. Because a lot of gang members are quite young, do you think that trying to take that approach rather than the criminal justice approach might make more of a difference?

Professor MacGregor: Indeed. There are attempts to do that in various places, such as King's College, London and so on. Precisely. You know about it. It is using that approach to see this as something that is infectious or contagious. Those are metaphors, but most introduction is through peer networks, friendship groups and so on, so noticing when those connections are being made and intervening at that critical point, when minds are open to change, is effective. It would be lovely to see that develop further.

Q43 **Dr Whitford:** Taking a public health approach to knife gangs is not an obvious one, whereas one would think that such an approach to drug policy, particularly reducing harm, would be a more obvious area. Both you and Tim talked particularly about deprivation, which means homelessness and all the things that often conspire to drive people to drugs simply because the real world looks far too bleak.

Professor MacGregor: The American professor—whose name I cannot recall—who initiated that approach was focusing on drugs when he began and then linked it to violence. It is taking an epidemiological approach, collecting the data, sharing the data and then intervening. I think it has been tried in the States.²

Q44 **Dr Whitford:** Tim, you wanted to come in.

² Note from witness: 'I was wrong when I said I thought the professor who had developed the public health approach to violence began work on drugs. I think he has mentioned drugs - because they are often associated with violence in the city as well as AIDS - but his main focus has been on ending violence per se. I remembered his name afterwards - Gary Slutkin. I attach a couple of articles he has written [not published].



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Professor Millar: With respect to deprivation and lack of opportunity, those are things, if people embark on drug use, that can drive them deeply into it, to the extent that they develop severe problems around their use and become enmeshed in it. They are not necessarily drivers of drug use per se, but a variety of those factors cause people to become enmeshed in drug use and dependent on drugs. That is what we were trying to convey, I think.

- Q45 **Dr Whitford:** In tackling knife crime, there was a real investment in helping gang members get jobs and homes. Sometimes, as politicians, there might be people who are not happy with that: "Why are they getting all that help when they are druggies and gang members?", or whatever way they are judged. Is there evidence for that being successful within the drugs field, and what do you think are the barriers?

One of my colleagues has been trying to get a drug consumption room for Glasgow, which has the highest incidence of deaths, and we cannot get past the criminal justice side of it. Do you think it is the legislation that creates barriers such that we cannot actually join services and tackle the problem?

Professor Millar: If you have been using heroin for 30 years and have, at best, a patchy employment record and probably quite a substantial criminal record, it is difficult to reintegrate yourself. If we can support people to get jobs, friends and houses—there is a project in Blackpool that calls itself exactly that—that is highly likely to be productive.

- Q46 **Dr Whitford:** Certainly, I would echo that. My husband is a GP and he has his own little cohort of now very ageing drug users who have other problems. Would drug consumption rooms not allow people who are a long way from help to come in, and then those services are able to engage?

Professor Millar: That is an important point. Potentially, they could be a bridge, yes. On the continent, where they have used these approaches, it has tended to be in very specific circumstances where they have street-drug scenes of homeless users. It is not something that you might want to apply across the board, but in very specific circumstances I can certainly see a role for those facilities. As far as I am aware, no one has ever overdosed in one of those facilities anywhere in the world.

- Q47 **Dr Whitford:** There could even be the ability to have drugs tested. You were talking about the completely unknown provenance of things.

Professor Millar: Yes.

- Q48 **Dr Whitford:** It is implied in legislation that you are complicit with it rather than trying to reduce harm.

Professor Millar: In terms of reducing harm, it is a very sensible approach.

- Q49 **Diana Johnson:** I want to go back to the 1990s and the approach that



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the Labour Government took around linking, as I recall, concerns around crime and drugs that were fuelling crime to say that, if more investment was put into treatment, you could get the public on your side: “We are going to treat these people, it is going to reduce crime and going to make neighbourhoods better”—all of that. Am I recalling that correctly? Was that the idea?

Professor Millar: Yes, that was the ethos.

Professor MacGregor: Yes.

Q50 **Diana Johnson:** And that worked?

Professor MacGregor: It worked, yes.

Q51 **Diana Johnson:** It worked. When I was reading the briefing paper, I was concerned to see the cuts to treatment budgets in the last eight or nine years. I know it is not the public health approach that perhaps Philippa was talking about, but we have gone from a time when there was a focus on health and treatment and we have now cut that right back. I want to get your view about how you get buy-in from the general public on how you spend money most effectively on a group of people who often are not seen in a very positive way. How do we do that?

Professor MacGregor: If there is a lesson from history, the pressure that built up in the 1990s was at community level from acquisitive crime, burglary and shoplifting, discarded syringes, drug houses and the nuisances in the local estates. It was also from families who saw their children being affected and wanted them to get into treatment and found that they could not get into treatment; there were long waiting lists. Those pressures, combined with the crisis of acquisitive crime, were the political opportunity for that change.

There were many cost-benefit analyses made, which came out with all sorts of different conclusions. Now we say that £1 spent on treatment saves £2.50, or sometimes it is £4, sometimes it is £6—there are various calculations—but the conclusion at the end of that assessment was that treatment works in the sense of being cost-effective and in dealing with the harms to the individual and so on.

There was a lot of money, but the important thing, to go back to your point, was that the money was a pooled treatment budget from the Department of Health and the Home Office, so it was a combination of the two. The establishment of a national treatment agency was, I think, a very clever political device. There was the feeling that if you put the money into the national health service it would disappear into diabetes, cardiology or something of that kind. There was distrust about giving new money to the national health service, so the national treatment agency was set up to control that large amount of new money. I think it was fivefold; it was a huge increase in money—I have the figures somewhere—at least fivefold, or more. That was then controlled.



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The head of the NTA, Paul Hayes, who was very effective, came from probation, and his deputy came from the voluntary sector, so it was a partnership approach, a combination from crime and treatment, which was very effective. It was politically very astute, and, personally, I think that the demise of the NTA is to be regretted. A lot had been achieved. There were lots of problems that people complained about too, because, if you have so much money going in, you have to have central control, so there were targets and there was pressure. There was a feeling of too much central control and not enough recognition of local needs, but at the end of that period there was an assessment that, in general, it had been extremely successful.

Professor Millar: It achieved a great deal—a huge amount.

Professor MacGregor: At that point, the other criticisms were about people being parked on methadone. Periodically, there is always a reaction against methadone and arguments about methadone. They came in the 1990s and then again in the 2000s, so you have battles around that. There was general agreement that one needed recovery as well. Having got people stabilised in treatment, you could then add social integration, aftercare, links to education, training, housing and so on, with voluntary work and mutual aid as well. It was very important to add that, and there was a strong recovery movement developing. That was great if it was added on.

Professor Millar: Yes.

Professor MacGregor: But, unfortunately, the 2008 financial crisis and austerity policies cut the money and cut away all those extra services, so the great hopes, and I think they were well-meaning hopes, for recovery have not been successful; they have come up against the lack of social supports, the lack of services at local level, that would be necessary to see that through.

Q52 **Dr Williams:** I have a very simple question around cost. The Government have estimated that the overall cost of illicit drug use is about £10.7 billion a year. Do you recognise that figure?

Professor Millar: It seems entirely plausible.

Q53 **Dr Williams:** What do you think, Susanne?

Professor MacGregor: It is a reduction from the estimate that was used earlier, which was about £13 billion, and that could be explained by the fall in crime and the decline in heroin. The heroin epidemic and acquisitive crime went together; a Home Office report—the Morgan report—concluded that, so the decline of the heroin epidemic contributed, not entirely but largely, to the decline in acquisitive crime. The decline in cost is related to the reduction in crime.

Q54 **Dr Williams:** Do we have any estimate of how much is being invested currently in prevention or in treatment?



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Professor MacGregor: I don't know. Do you know?

Professor Millar: Some of our colleagues might be better placed to answer that question.

Professor MacGregor: It would be a very good question for you to pursue with Government officials. It would be interesting to get that information if you can.

Dr Williams: Thank you.

Professor Millar: Could I add some comment to the previous question? I absolutely agree with all the things that Susanne said. The difficulty we have observed is that the policy that is set by Government is sometimes implemented in a slightly haphazard way at local level. There have been examples of target-setting for the number of people you should get off opiate substitution treatment. That seems to me fundamentally wrong; it is something that should be an individual clinical decision, not something that is done to meet a target.

The decisions about spend now sit with local authorities, who are obviously operating within reduced resource, and the population group we are interested in is competing for that resource with all sorts of other worthy causes. It is a difficult sell.

Q55 **Chair:** Thank you. Are there any final points that either of you wish to make before you leave today?

Professor MacGregor: Yes.

Chair: Please do.

Professor MacGregor: We mentioned Scotland. It would be very useful to look at the Scottish agenda, at things that are happening in Scotland. Their policy, which has recently come out, is a very laudable one. Similarly, in Wales the attention to adverse childhood experiences is part of their public health approach. Both in Scotland and Wales, alcohol and drugs are taken together, so there is something to be said, given that they are used together, for having a policy that looks at the two together.

My main points are that I want to see harm reduction added as a third pillar to the drugs strategy, if we are only making small amendments. We have two pillars. If we were to add a third one, of harm reduction, I would like to see central control and responsibility for the budget, precisely because this group of people is the least favoured—at the end of the queue, the least popular. Where we have had effective policies, both in the 1980s with the Conservative Government and in the 2000s with the Labour Government, regardless of Administration, there was a central initiative and central control. To make sure that the money is spent in the way it was intended is important.

Chair: Thank you both very much for coming this afternoon.

Examination of witnesses

Witnesses: Mike Flanagan, Karen Biggs, Boris Pomroy and Professor Sumnall.

Q56 **Chair:** Thank you all for coming this afternoon. Could you start by introducing yourselves to those who are following this inquiry, and say who you represent today?

Mike Flanagan: My name is Mike Flanagan. I am a consultant nurse and clinical lead with the drug and alcohol services provided by an NHS trust called Surrey and Borders Partnership NHS Foundation Trust. I have worked in the drug and alcohol field for the last 31 years, and have worked in various clinical, academic and research positions. Over the last 10 years or so, I have chaired a national peer support network for non-medical prescribers in the drug and alcohol field.

Karen Biggs: I am Karen Biggs, the chief executive of Phoenix Futures, a charity that provides support for people with drug and alcohol problems. I am also here today on behalf of Collective Voice, a national alliance of drug and alcohol treatment charities. Our members support over 200,000 people in treatment every year.

Boris Pomroy: I am Boris Pomroy, the chief exec of Mentor UK, one of the UK's leading drug and alcohol prevention charities for young people. We are also the deliverers of the UK Alcohol and Drug Education and Prevention Information Service, or ADEPIS, which is funded by Public Health England, among others.

Professor Sumnall: My name is Harry Sumnall. I am professor in substance use at the Public Health Institute at Liverpool John Moores University. My research covers all aspects of substance use, but primarily illegal drug use in young people. For example, my researchers have investigated the evidence base for prevention and education, and tried better to understand risk and health issues in young people who use substances. A lot of the work I do is at European level as well.

Chair: We will start off by looking at prevention aspects.

Q57 **Dr Whitford:** These questions are very much for Harry and Boris, because they are on your particular area. Looking at effective and evidence-based approaches to prevention and early intervention, do you think that it is about combining universal and targeted, or do you lean more towards one or the other? Should we look for the vulnerable, or have broad messages, or both?

Boris Pomroy: For me, they are all mutually reinforcing, so it is both, not least because any prevention needs to start and end with local need and to be reflective, in our case, of what young people are actually experiencing out there. Even in the context of universal drug education and prevention programmes in a class or school, you want them to relate to local conditions and the environments that those young people are experiencing, so that they are relevant and timely for them. The evidence



seems to show—Harry will probably have more information on this—that if you just take the big public health approaches, whether that is big outdoor advertising campaigns, or whatever, and they sit in isolation, away from more direct intervention with young people, particularly vulnerable young people, they do not have the impact that we would like and need to see.

Professor Sumnall: I agree with Boris that there is a strong case to be made that the two approaches should be integrated. We need to think carefully about what are the intended objectives and outcomes of prevention. For universal approaches, they would be around developing general skills around decision making and health education. The new curriculum on sex, relationships and health education is very welcome in that regard. Within that system and process of delivery, you need effective means of identifying the groups or individuals who are at higher risk.

The type of universal education on prevention that you deliver to the general school pupil is very different from the sorts of response that you need for high-risk pupils, who often only come to our attention through the police or mental health services. There are prevention programmes that take that model. For example, there would be a general classroom curriculum with information not just about facts and figures around drugs but about developing skills for healthy decision making and risk. They are skills that all young people can benefit from.

In a sensitive and supportive way, we need to identify young people with family histories or personality or psychological risk factors, and provide more targeted support to those individuals. Programmes have been based on that; the prevention programme delivered in London schools and successfully in Australia and North America is a good example. My key point is that there is no one-size-fits-all approach to prevention education. Similarly, it is a lot more than drug facts and figures.

Q58 **Dr Whitford:** Professor MacGregor touched on adverse childhood experiences—ACEs. In meetings with local police, they are trying to identify those, and police are having training in how to identify them as a reason why a young person is having problems. I was interested in how they were changing their behaviour to not contribute to them. They no longer do dawn raids, because a child in that house could grow up thinking that police come and smash your door in when it is dark and wake you up. How much is the modern understanding of adverse childhood experiences feeding into this and allowing us to identify children in a classroom, or whatever setting, at a much earlier point?

Professor Sumnall: The increased focus on adverse childhood experiences is really welcome. I am particularly pleased that police in Wales and Scotland, for example, are very cognisant of that. A word of caution is that we are very good at screening and identifying affected individuals and groups, but the key thing is what happens next. That is where we need to think about the sorts of services and interventions that



we have. You can screen a class of young people and identify children in that class with four or more ACEs, and we know that, potentially, they are at higher risk of future harm, but what do you do then? That is the big question at the moment.

In terms of the response from major providers and services, I agree that there is increased recognition, but it also points to the importance of having better joined-up thinking, in drugs policy, for example. If a young person is growing up in a household where there are parental substance misuse issues, it may be that there is also a high level of maltreatment or violence in that household, and it may be more likely that one of the parents goes to prison for a drug-related issue. If we are getting a lot more information about the long-term impact of ACEs, we need to reflect that in our policies and laws responding to this. If we know that problematic substance use is partly a response to adversity, our criminal justice response also needs to reflect that.

Q59 Dr Whitford: You touched on the fact that it is not just a matter of having a website, such as the “Frank” website, but does it have a place in providing facts and figures? How do you think school-based approaches are tied together? Sometimes it seems as if we have bitty things happening, rather than a joined-up approach that supports young people to not get involved in drugs.

Boris Pomroy: You are absolutely right; it is incredibly patchy and variable. I am always nervous of saying that schools have a huge responsibility and opportunity, because I know how much pressure teachers and schools are under. I imagine that everyone who comes in here says that we should just add this to what teachers do and everything will be okay, but the truth is that schools are fundamental in drug education and prevention.

What we know is that, long term, drug education is ideally reinforced through a young person’s time in school. It starts as early as primary and goes all the way ideally to 18, but at least to 16. It is iterative and, crucially, interactive; it is issues based, looking at both the physical and mental harms of drugs, and links up with all the other areas of the health curriculum, because all these things are so interlinked. It helps to develop the key skills that young people need so that, when they are in challenging situations as they grow up, they have the skills to navigate and negotiate them. Crucially, it is fostered on open dialogue, honesty and trust, which is where teachers are so important. In their life, second to their parents, teachers are often the adults they interact most with and for whom they have the highest level of trust. They are in pole position to develop those trusting conversations.

To add to that, the best drug education programmes that we see are developed alongside young people, parents and the wider community, so that everybody has a voice and a stake in the output, too. There is a big skills gap for parents. I am relatively new to my role at Mentor, so I have been doing the thing where you go and speak to everybody. Consistently,



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wherever you speak to parents in the country and wherever they are in terms of affluence and poverty, they are scared of talking to their children about drugs. They do not know the best approach, and they are fearful that even by talking about drugs they will somehow make it more likely that young people will use them. Therefore, they back out, and what happens, inevitably, is that something else fills the gap.

From the evidence we are seeing, people are more and more going on to YouTube and Google, googling and finding something that could either be unhelpful or directly misleading, but which also does not give the opportunity to ask questions. There is a real stigma attached to that, in that children are fearful of asking questions either of their parents or of teachers, as it somehow may show a sign that they are using.

Q60 Dr Whitford: Do you think that the “Frank” website has a role, or could even be something that would help parents? Even just language questions, how to open a conversation, might be something that parents would find helpful.

Professor Sumnall: The “Talk to Frank” website has been highly criticised over the years, but actually I think it has got a lot better. PHE undertook a review of it and updated the information on it. Sometimes we expect too much of the “Frank” website. It is there to act as a resource to support other types of activity; it is not a prevention intervention in and of itself, and the new content reflects that. There is already guidance on how to talk to your children about drugs—Mentor produced it—which could be reflected on it.

In Welsh schools and some schools in the south-west of England at the moment, a new schools prevention initiative has been started to train peer educators to have informal, everyday conversations around substances. They gain some of the information from the “Frank” website and are supported by mentors themselves. Those peer educators have very informal, day-to-day conversations about substances. They are not there to replace teachers or drugs workers, but just to address some of the social norm issues and social stigma issues, so that pupils feel comfortable talking about drugs. They are in a school environment that supports those sorts of discussions, which is where whole-school drug policies are important. Perhaps another topic for discussion is the link between pupil drug use and school or pupil exclusions. That is a really important topic, and I know that Mentor has recently done some work on it.

Q61 Dr Whitford: Do you think the fact that drug use in young people has fallen means that some of what we are doing is working, or is it due to totally different factors and we would be misled to think that we are on the right track?

Professor Sumnall: My view is that, because we have not had a coherent approach to prevention and education in this country over the last 20 years, it is probably happening independently. That is my



personal view. We know a lot about what works and does not work in prevention and education; the issue has always been that it has never been consistently implemented. This is where we think about drugs in a wider social and health and public health context; things that happen at a societal and neighbourhood level are probably much more important than what may be happening in education and prevention. If we look at tobacco and alcohol, we know that when we have a co-ordinated approach we can make a real difference. We have not really done that in relation to drugs, in my view.

- Q62 **Andrew Selous:** You touched on the drug and alcohol aspects of the relationship and sex education that becomes mandatory in secondary schools from next year. Do you think schools are ready to teach that? How do we make sure that they do it properly?

Boris Pomroy: In short, no, they are not ready to teach it or support it. We have just done a big qualitative research piece, speaking to teachers on the quality of drug education in their schools as it is. Less than a third of them feel that their school is doing it well, and that is in current circumstances. Less than half of teachers seem to even know their own drug policy.

- Q63 **Andrew Selous:** What are the plans to equip teachers to do that work?

Boris Pomroy: That is a very good question. Within Mentor we are redeveloping the ADEPIS site, which is a resource for teachers. We are actively out there trying to speak to teachers on drug policy. It is exactly as Harry said: the challenge right now is that there is no centralised approach. Even within the guidelines, although they recommend a couple of specific resources, our own included and the PSHE Association's too, that stuff is not mandatory. There is such a lack of knowledge in schools and a lack of training for teachers in this, from teacher training college all the way through. They just do not know where to look or go, even for the first steps.

When you couple that with the lack of resource going into this, because there is no significant additional resource that we can see going into schools to support what is on paper quite a good piece of legislation—although we would always pick holes in it, but that is the nature of coming from my side—I am really concerned that schools are not ready or able to deliver it in the consistent way that we think we need to move the needle.

- Q64 **Andrew Selous:** To come back to the prevention piece, you have both made suggestions around ACEs, what schools can do and having a community approach, but what more can we do to stop anyone going down a journey of involvement with illegal substances? Could you summarise what more we need to do as a country on the prevention front?



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Professor Sumnall: The top 10 wish list. It is important to be realistic. We are never going to achieve true prevention. That is never going to happen.

Q65 **Andrew Selous:** By true, you mean 100%.

Professor Sumnall: Yes.

Q66 **Andrew Selous:** Do you think we can do better than we are doing?

Professor Sumnall: Absolutely. Particularly in schools, all children and pupils deserve high-quality health education, which includes prevention, on a universal level. Within that system, we need effectively to identify and screen young people in a sensitive way, and there are different ways of doing that.

We need to make sure that we link schools with community services; I know that we have representatives from those services here. We need a co-ordinated whole-school approach. It is not just about what happens in the classroom between the teacher and the pupils, but what the ethos is throughout the whole school. I mentioned exclusions. What sort of links are made with local services? How are the police involved? It would be in a limited way, but they certainly have an involvement.

I am a public health academic and, when I think about health behaviours, it is obviously not just about a focus on the individual. It is about the individual's relationship with their family and community, and how social structures, policy and national norms affect those issues as well. We need to start to focus on the bigger picture. Rather than asking what we need to do in individual classrooms and for individual pupils, we need to try to understand how that individual fits within the wider system, and to have a joined-up approach. That would include some suggestions around activities and interventions. We need to take into account that, unless we address some of the wider determinants, individual-level approaches will never be effective.

Q67 **Andrew Selous:** Boris, do you want to come in on that?

Boris Pomroy: Yes, I support everything that Harry said. Specifically, we have a lot more work to do to remove the stigma around drugs and alcohol. Until we do that, young people will not feel that they can be open and honest about their questions, concerns and fears. If they start going down that route, they get overwhelmed, and they do not know how to get back. It is about removing stigma and trusting young people, and including them in the development of services, whether that is prevention or early intervention treatment.

It is also about recognising that young people who may fall into using or criminality, perhaps through county lines, as you were saying earlier, are often victims of exploitation or other concerns, rather than seeing them first and foremost as problems or criminals. That would make a massive



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difference in opening up the conversations we need to have with young people to drive the prevention agenda.

Q68 **Dr Williams:** Harry, you have mentioned exclusions a couple of times. Can you expand a little bit on that? We are seeing rising levels of exclusions. What might be the impact of that, and what would better look like?

Professor Sumnall: Boris and Mentor have just published a report on that. If we think in terms of risk and protective factors, what protects young people or what drives them into substance use, lack of educational opportunities and school engagement is, for me, the No. 1 risk factor for involvement in substance use. I totally appreciate that in some circumstances some pupils need to be excluded or provided with high-quality alternative provision. The danger is that, if the social and educational safety nets disappear, what sort of affiliations do the young people then generate? As Boris was saying, those sorts of pupils are ripe for exploitation, but I am sure he has a few more words to say about that.

Boris Pomroy: As Harry said, along with an organisation called Volteface, we released a report called "Making the Grade" last week, which I will be very happy to send to the Committee. The report goes into this, along with a number of recommendations. Harry is right: it is about academic opportunity and a sense of hope and aspiration. From a schools perspective, it is about how we support them to ensure that they can put support in place for young people who fall foul of drug use or get involved in criminality. There are a number of ways. As I alluded to earlier, drug policies are not consistent in schools, and not yet compulsory within schools. Even when they are written, they are quite often sitting up on a dusty shelf rather than out there, so neither the teachers nor the young people or their parents know of the drug policy and the consequences of their using or supplying drugs in their school.

Secondly, as I was saying to you earlier, it is about having a sense of intellectual or professional curiosity. If a young person is caught with cannabis, say, on them within school premises, I would urge schools to ask why that is happening, rather than instinctively looking at that young person as a problem. They should ask what is going on and why it is happening. How do we, and crucially for schools all the agencies around them, support that young person to get them back where we want them to be and where we know they can be? For me, that is the critical thing. When we see a problem, we should try to deal with it in the best interests of the child, rather than necessarily packing them away from the school and trying to get them out of the school environment, not least because I do not think that solves the bigger problem either, in addition to failing the individual child.

Chair: We are going to move on to a discussion on legal status.

Q69 **Diana Johnson:** This is for all of you on the panel. Is there any evidence



that legal status affects the use or misuse of substances?

Professor Sumnall: In relation to young people, there was a very interesting analysis by Professor Alex Stevens from the University of Kent recently. He analysed some of the international health behaviour surveys and concluded that there was no relationship between changes in legal status and an increase or decrease in young people's substance use. That echoes similar analysis at European Union level, particularly in relation to cannabis.

My own personal view is that legislative change should not be seen as a barrier or a preventive intervention in and of itself. Legal change might make some things easier to do, and it might lead to a shift in social norms, but it is about what you do in addition. Portugal is a good example. We often focus on the fact that Portugal decriminalised drugs, through their dissuasion committees, which is certainly true, but they also have huge investment in harm reduction and treatment, and those additional activities are what make the difference. Legal change might make those sorts of things easier or, sometimes, more difficult.

Q70 **Diana Johnson:** Does anybody else want to add anything?

Boris Pomroy: I would say broadly the same as Harry. The current legal status and situation is incredibly confusing for young people. We mentioned cannabis earlier. Young people have phones and the internet; they listen to the news, and they see that cannabis, for instance, is legal in countries such as Canada. At the same time, they get messages saying that if they use cannabis this and this and this will happen, and they will be put in prison. There needs to be clarity around the legal position for young people, which needs to feed into the prevention stuff. I agree with Harry. I do not see legalisation either as a preventive measure or a prohibitive issue around prevention.

Karen Biggs: I take a similar view. Collective Voice, as an alliance of treatment providers, has a focus on providing treatment to individuals regardless of the legal status of the substance they are using. For the people we see coming to treatment, there are myriad other causes and consequences of their substance misuse, and the legal status of the substance that they are using is fairly low on the list of causes of their situation.

Mike Flanagan: From a treatment providers' perspective, it is very hard to say that there is any particular benefit in maintaining drugs' illegal status. I am not for a minute proposing legalisation; I am referring to some of the measures that one of the previous speakers, Tim Millar, mentioned. It is not a case of making drugs legal but a case of taking away some of the sanctions. Giving someone a criminal record for possession of small amounts of illicit drugs young in their life places an enormous burden on that person and disadvantages them hugely for the rest of their life in a disproportionate way to the crime. That is something worth bearing in mind.



Many people in treatment become completely inured, and almost do not notice the legal status of drugs over time, so it becomes almost irrelevant whether they are illegal or not. But the illegality additionally complicates the lives of otherwise extremely disadvantaged, disfranchised and stigmatised people.

- Q71 **Dr Whitford:** Do you not feel that the illegal status of many of these drugs, particularly ecstasy and cannabis at the softer end, means that young people, particularly students, may be accessing them from illegal providers and are therefore already getting caught in an area where we do not want them to be? It can create a barrier, if someone has got sucked into using heavier drugs, to them coming forward. To go back to the issue of the drug consumption room in Glasgow, we cannot get it because the Home Office policy is, "Oh, that would be terrible," as opposed to looking at harm reduction.

Boris Pomroy: We have anecdotal evidence from young people all the time that it is not creating conditions where they can be honest and open. That lack of honesty and openness can then put them in more vulnerable situations. The reason why you are hearing such caginess from some of us is that there is just not the deeper evidence yet to say one way or the other. From talking to young people, we know that they say very similar things to the thing you have just said.

- Q72 **Dr Whitford:** Many would see it as a step to decriminalisation and, as you say, not going down that line, as opposed to legalisation.

Boris Pomroy: Absolutely. I certainly echo Mike's points around the impact of criminalising young people early for things like possession. We are seeing not just an increase in exclusions among young people but an increase in the number of charges and prosecutions for possession and intent to supply, which is a huge cause for concern.

Professor Sumnall: I am pleased that you mentioned the example of drug consumption rooms and some of the legal barriers there. Festival drug checking, for example, opens up debates that we are prepared to make legal changes when the policy affects some segments of the population. Drug checking is primarily oriented towards clubs and festivals and younger, middle-class and maybe primarily white users of class A drugs, such as ecstasy and cocaine. There is local tolerance around that from police forces, although there is not yet guidance from the Home Office. We have been able to be flexible around that because of who is using those drugs.

With the Glasgow drug consumption rooms, we are talking about highly marginalised and stigmatised individuals, and street-based injection, as you know better than me from looking at the figures around HIV and hepatitis C. If there is a population where we need radical policy change, it is that population. It is interesting that we have tolerance around some types of substance user, but not other types of substance user. It would be interesting to ask why that is.



Q73 **Dr Whitford:** With my colleague, Alison Thewliss, we have certainly been raising it repeatedly here, and getting precisely nowhere.

Professor Sumnall: Yes, I know.

Mike Flanagan: I have another comment related to legal status. Increasingly, I see many drug users buying their drugs over the internet and on the dark web, which has an additional effect. If the drugs can be obtained through those means, it almost normalises them; the relationship between drug user and dealer breaks down, and it is with a faceless entity on the internet.

Q74 **Dr Whitford:** But still with no surety about what you are actually buying.

Mike Flanagan: No surety whatever. Increasingly, young people are buying Xanax. Many of my service users are buying Fentanyl on the internet, and the purity and provenance of the drug is completely unknown.

Q75 **Andrew Selous:** I am a little bit confused. Some of you are advocating a policy whereby it is not criminal but it is not legal either. How does that work?

Mike Flanagan: An example would be heroin-assisted treatment, which I hope we will talk about. There is a population of opiate users in treatment where, no matter how hard you try or how gold standard the drug treatment is, they struggle to engage and retain engagement with drug treatment services. They end up dropping off their prescription, going back to jail and going in and out of hospital with infections, overdoses and so on. That group of people responds incredibly well to supervised access to pharmaceutical heroin, in a very controlled way, with a very high level of psychosocial input. Even though it is a very costly service, it saves the economy the cost of keeping somebody in prison and dealing with overdoses and infections and so on.

I do not know whether you have had a chance to look at the evidence from RIOTT, the randomised injectable opiate treatment trial that took place in Brighton, London and somewhere in the north-east. They were highly effective treatment programmes. That is an example where you can give very complex, treatment-resistant drug users access to legal supplies of heroin over a time-limited period, with high levels of psychosocial support alongside. It is a highly effective treatment approach, but it is very costly. I think there is one example in the north-east where it is beginning to be implemented, some years after the evidence came out.

Q76 **Dr Williams:** Karen and Mike, how effective and evidence-based are drug treatment and recovery services?

Karen Biggs: The evidence base has been developed over a significant period of time; it is widely understood and used in the sector. It is set out really in two broad documents. There is "Drug misuse and dependence:



UK guidelines on clinical management”, although that is a mouthful, so we refer to it as the orange book. Then, obviously, there is the NICE guidance. That evidence base gives us a range of interventions and approaches that we can use to support people at different stages of their drug use to meet a range of the myriad circumstances individuals find themselves in.

We can separate that broadly into two distinct offers: clinical interventions and psychosocial interventions. Clinical intervention is more of a medical intervention, which will provide a substitute for the drug being used and therefore reduce the harms associated with that drug use. Over time, it can also be used to reduce the substitution.

People who come into treatment, as Mike has just alluded to, have some very entrenched behaviours, which it takes a lot of internal and external resources to start to address. Psychosocial interventions can support people through motivational interviewing, or in a more intense offer for people with adverse childhood experiences or who have experienced trauma. The social interventions can be as basic as supporting people with basic needs such as food and housing, and developing positive relationships with families and communities.

The evidence base is very clear; it is used across treatment. In terms of how effective those interventions are, the first thing to say is that there is always more that we can do. Too many people are dying from drug-related issues. As the Committee will be more than aware, people are dying in our prisons and on our streets from drug-related issues, and that is unacceptable. While that is happening, I do not think that any of us can say that we are doing enough to help, but we cannot negate the significant impact that treatment has.

More than 200,000 people entered treatment last year, which provided a range of benefits for families, communities and the individuals themselves. Many of those benefits are not quantified. It also brought some benefits in the NHS and the criminal justice system; again, many of those benefits are not quantified. As your previous panel said, there is a reducing pot of money, which presents stress and strain in a system trying to deal with significant causes and consequences of drug use. Those causes and consequences are around physical and mental health, housing, problems relating to employment and family life, and crime issues. As we try to respond in a fast enough and comprehensive enough way to those issues in a very financially constrained environment, there are some groups that are not getting enough support.

Q77 Dr Williams: Which groups?

Karen Biggs: As was mentioned earlier, older people are presenting, as Tim said, with physical issues around the length of time they have been using drugs, and the normal issues that getting older present, on top of long-term use of substances. We are also seeing that people who try to



present to treatment with co-occurring mental health and substance misuse issues really struggle.

Q78 **Dr Williams:** Is that something to do with fragmentation of services?

Karen Biggs: Absolutely, and the need for a multidisciplinary approach across a number of different health and social care sectors.

Q79 **Dr Williams:** Local authorities tend to commission drug treatment services from one provider, while CCGs commission mental health services from another provider, and primary care sits somewhere else. From a user's perspective, in my experience, they rarely feel joined up. Is that your experience as well?

Karen Biggs: It is hard to ensure that those services are joined up when they are commissioned in such a fragmented way. Another example would be services that support people as they exit prison. We know that that is a high-risk period for people who have been in treatment, or are using drugs when they go into or out of prison. That transition is really risky. Trying to ensure that there is a very joined-up multidisciplinary approach that addresses all those issues in a locality is very difficult. It does happen. There is some good commissioning that cuts across those funding pots and silos across the country, but it is not consistent enough.

Q80 **Dr Williams:** Mike, can I ask you in a slightly different way, what does a really good high-quality, evidence-based public health approach look like?

Mike Flanagan: It looks comprehensive and responsive to the population it serves. One of the major challenges, which is the elephant in the room, is the cuts that drug treatment systems have had to endure for six or seven years or more. They have had an absolutely profound effect. The extent to which we can innovate, design and deliver very responsive services that respond to the changing patterns of drug consumption has been taken away from us. We are struggling to remain standing at the moment, with the cuts that we have taken. It has made the disconnect between services worse.

In the last session, there was mention of the problems in providing effective responses to people with comorbid mental health and substance misuse problems. That has been a historical problem for a whole range of reasons, some of which you mentioned in terms of the differences in commissioning. The extent to which drug and alcohol services can reach into mental health services has been made much harder.

You mentioned new populations, and Karen mentioned older people, which I completely agree with. One of the other groups is people with addictions to prescriptions of opiates, and some of the codeine compounds and weaker opiates that you can buy over the counter. There is a huge hidden iceberg of people addicted to those drugs, and to some extent they do not find traditional drug treatment services terribly attractive, because they are designed and set up for illicit drug users.



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In a climate where we could deliver innovative and attractive services and had the capacity to innovate, we would deliver services responsive to that population, working alongside primary care providers and pain consultants. All those things exist, but they are hanging on by the skin of their teeth at the moment.

- Q81 **Dr Williams:** We heard from the previous panel a policy suggestion that this needs a bit more central control of funding. In my local authority area, drug treatment services are commissioned from the public health grant. It is the largest single spend of that grant, but the public health grant is falling, and there is tremendous competition for that spend. Is that a pattern that we see throughout the country?

Mike Flanagan: Very much so. You have got to the nub of the problem. We desperately need the ring fence on that budget again. It comes back to stigma and discrimination. In councils, people are making decisions about spending money on drug treatment services without any knowledge of those services and with no compassion, in some cases—it is probably unfair to say that in other cases—for the population they serve. That is what I see in discussions with commissioners. When they are struggling to retain their budgets, they are having to argue for cuts against things where human lives are not at stake. That is a false economy because, ultimately, it comes back to the public purse anyway, but several-fold, because those people will end up in prison and hospitals and needing probation and social services and so on.

- Q82 **Dr Williams:** You have stolen the words from my mouth. When I talk to my local chief constable, he says that there is not going to be a criminal justice solution and that it needs an investment in public health solution, but, of course, public health funding is increasingly constrained.

Mike Flanagan: It is interesting that it is often the police arguing for legalisation, isn't it?

- Q83 **Dr Whitford:** I am based in Scotland, where drugs and alcohol fall within mental health. Was it in mental health before, and then it went to local government, or has it always been different?

Mike Flanagan: No, it only came into local government about five years ago.

- Q84 **Dr Whitford:** With all the other prevention things, smoking and so on.

Mike Flanagan: That's right. I talk to colleagues in Scotland. They look at what is happening south of the border, and they are worried. The retendering cycle for drug treatment services is another thing that has been incredibly unsettling for the drug treatment sector. Everyone understands the need for competition to ensure that you have the best possible service, but, with retendering cycles, local authority procurement services do not really understand that process. It is very damaging, so I look to Scotland as currently having a much better system.



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- Q85 **Dr Whitford:** The change in ours locally is getting away from the little, divided areas where you live and linking community to hospital, the acute services dealing with drugs or alcohol linked much more to in and out, so it is the same team that you see all the time.

Mike Flanagan: Yes, that is ideal.

Karen Biggs: Can I go back to the central oversight point? This was an issue that came from the narrative that Susanne gave around the history of how treatment had changed and what we lost when we lost central oversight through the national treatment agency. It was a specialist agency that was able to monitor changing trends, consistency in performance, with some central levers, located within a public health framework. Obviously, Public Health England supports local authorities as best it can, but it is a body focused on mass population public health issues. We have lost the central focus on that specialism that would help to ensure consistency, and some of the levers we need, which would help the drug strategy to be implemented.

The causes and consequences of drug use are well articulated now, certainly in some of the most recent strategies. Our inability to deal with those issues is not because of an absence of strategic intent. Sometimes it feels as if we are drowning in strategies that understand the causes and consequences.

- Q86 **Chair:** Thank you. We have quite a lot to get through. There are a lot of parallels with the evidence we heard in our sexual health inquiry, on the consequences of moving into public health. There, we heard a great deal about the variations—that you can have two areas with the same level of funding, but where you have much better buy-in and joint commissioning they can achieve so much more. Do you see the same with drug services—that you have some areas with fantastic local leadership and joint working, and they make it work?

Karen Biggs: Very much so. In some areas, the health and wellbeing boards work well in supporting substance misuse, but it is a very mixed performance. In some areas, as I mentioned earlier, commissioners take it on themselves to come together to pool their funding, and commission mental health and substance misuse services jointly. There are other examples of that, but, yes, it is incredibly mixed.

Mike Flanagan: Karen mentioned earlier that we have our drug treatment bible, a document called “Drug misuse and dependence: UK guidelines on clinical management”, or the orange book. Public Health England noted, after the last iteration of that publication came out in 2017, that there was a divide between the published evidence and what is happening on the ground. It started something called the opioid substitute treatment good practice programme, which is a two-year programme led by Public Health England, with a group of experts that advises Public Health England to clarify the gap between published evidence and current practice, and to come up with a set of resources to



support the drug treatment system to align to the evidence. That is a piece of work you might want to cross-reference.

Q87 Chair: That would be very helpful. Thank you for that. Another area flagged up to us in our recent inquiry was the impact on workforce training and development. When it becomes very fragmented, it is easy for people to offload their responsibility for training, particularly around dual diagnosis. Is that an issue that you see as well?

Mike Flanagan: On workforce, one of the areas that has been hugely challenging for the field over the last 10 years is a big reduction in the involvement of the professions in clinical services. There has been a 24% reduction in consultant addiction psychiatrists in drug treatment services. I struggle to recruit medics at all levels, nurses in particular.

The drug treatment sector has become a less attractive option for a whole variety of reasons. First, its procurement cycles make it an unattractive option. The increasing involvement of the third sector has been positive for the field in its ability to deliver good, evidence-based psychosocial interventions and being rooted in communities, but newly qualified doctors and nurses often do not want to work for third sector providers; they prefer to work for the NHS, where they get pensions, CPD and so on. There is a whole range of issues that has made future workforce planning challenging, and recruitment is a real problem. That is another issue for consideration.

Karen Biggs: Mike is right. What has been required is a change in the way we train our professionals and clinicians. Work is ongoing and just starting, with the Royal College of Psychiatrists, looking across the sector to try to develop new approaches for trainee psychiatrists. When we work in heavily commissioned short periods of contracts, when TUPE applies—we may have mentioned the reduction in funding—it is very hard for us to ensure that we have a happy, highly skilled and expert workforce. We do it. We work really hard at it, but it requires additional effort in that context.

Q88 Chair: Thank you all very much for coming. Is there anything that any of you wants to stress that you have not been asked about this afternoon?

Karen Biggs: We have mentioned it a few times in passing, but, if there is one thing that I would like the Committee to hear, it is the impact that stigma has on our ability to bring people into treatment, whether they are young people or adults. We need to give good messages to young people, as Boris and Harry said, and stigma is a significant block to people accessing treatment, and a significant block to their living the lives they want after treatment.

There are many things we can do that will not cost money. We can stop politicising substance misuse, at national and local level. The media can stop using very stigmatised messaging and language to some of the most vulnerable people in our communities. Leaders of the NHS, local



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authorities and housing organisations can properly audit their processes and approaches to ensure that they give people who use drugs the same care, respect and services that other people in our communities have.

Mike Flanagan: It is notable that, in terms of isms, it is unacceptable to be racist, sexist and so on, but to be disparaging about junkies does not raise an eyebrow in any setting.

My final point is that for some years the Government have spoken about parity of esteem in mental health services. Parity of esteem is a really important concept in drug treatment services. The quality of services that has become accepted would not be accepted if it was a service for cancer, hypertension or diabetes, but somehow it becomes tolerated because it is a drug treatment service. I wanted to put in a word about that.

Chair: Destigmatising is very important. Thank you very much for ending on that note.

Examination of witnesses

Witnesses: Kirstie Douse and Adrian Crossley.

Q89 **Chair:** Good afternoon. I am sorry to have kept you waiting. It is good that you were here to listen to earlier panels. We do not want to ask you to go over the same questions, but to build on what you have heard already and to have a discussion with you about your advice to the Committee. Can I ask you to introduce yourselves and who you are representing?

Kirstie Douse: I am Kirstie Douse. I am a solicitor advocate and head of legal services at the charity Release. Release is the UK centre of expertise on drugs and drugs law. We provide services directly to people who use drugs and those who are impacted by the drug laws. We use our client experiences to inform our research and policy work. Specifically, we advocate for the decriminalisation of personal possession of all drugs.

Adrian Crossley: I am Adrian Crossley. I am the head of addiction at the Centre for Social Justice, a political think-tank based in Westminster. Our concern is to represent those in society who perhaps are at a disadvantage, and we deal with pathways to poverty, including addiction. I was a barrister. I worked in the Probation Service and later in the Crown Prosecution Service. I represented clients in defence and have worked in the CSJ for about a year.

Chair: Thank you very much. Andrew is going to lead off with some questions and discussion.

Q90 **Andrew Selous:** I will start with you, Kirstie, if I may. Could you outline why you oppose the current criminal justice-led approach to drugs policy?

Kirstie Douse: It can be categorised under three broad headings: first, the criminal justice-led approach fails in its aims to deter use and to



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suppress drug markets; secondly, criminalisation exacerbates or causes harms; and, thirdly, there is significant international evidence for a different approach, namely decriminalisation.

Perhaps I can expand on the first two. You have heard from the previous panel, so I will not repeat that there was a Home Office report in 2014 that determined that the toughness of a country's law enforcement approach had no bearing on the levels of drug use in that country. Professor Sumnall also mentioned research by Alex Stevens and the EMCDDA.

A 2017 review of the 2010 drug strategy found that there was limited impact on the availability of drugs from the enforcement approach and that the drug market was resilient. Similarly, a review in 2018 of the Psychoactive Substances Act 2016, which adopted a blanket approach to criminalising novel psychoactive substances, found that NPS use was widespread before, continued afterwards and in some cases actually increased. It is clear that the criminal justice approach does not work and that something else needs to be done. Alongside its not working, it causes considerable harms to the people who are impacted by it.

The first panel spoke about drug-related deaths. In the UK, they are the highest on record: 70 deaths per million of the population compared with other countries such as Portugal, which I am sure we will speak about later, where it is four per million. The majority of those deaths occur in people who are not in treatment and have not been in treatment in the recent past. It is clear that treatment is a protective factor, but people are not entering treatment for some reason. Investigation into that is needed. One of the things that deters people from accessing treatment is the criminal nature of drugs, particularly if you are looking at specific groups of people. Parents, particularly pregnant women, will not access treatment because they fear there is going to be a report to children's services; they fear losing their children or being accused of harming their unborn child.

If those levels of deaths were happening in any other group, it would be declared a public health crisis and action would be taken. It is not for this group of people. You have heard about the stigma and marginalisation. Rather than assisting these vulnerable people, and treating them with compassion, dignity and respect, we criminalise them further. We further limit their life opportunities by giving them a criminal record. Even if they enter drug treatment and recover from drug use, they are prevented from moving forward.

Every week, we have calls and emails on our helpline from people who are impacted by criminal records. Last week, we were advising somebody who had been offered two different jobs at two different points in different institutions. He had been offered them provisionally; they undertook a check with the Disclosure and Barring service, which is normal; the offers were rescinded. The only thing on his record was a



conviction for possession of cannabis, 2 grams, four years previously. People are being prevented from accessing work even after just recreational use. People who use problematically, and perhaps have a longer criminal record, are impacted even more.

Q91 **Andrew Selous:** Do you not believe there was a case for the Psychoactive Substances Act, given there was no legal basis to do anything about it in prisons in the UK?

Kirstie Douse: If you are talking about prisons specifically, the use of novel psychoactive substances in prisons is actually a direct result of prohibition. There are drug-testing provisions in prison where people are tested for the most common drugs. People in prison wanting to use drugs started using those in order to circumvent the normal testing regime, similarly in the homeless population.

Q92 **Andrew Selous:** My point is that there was no legal basis to take action against them before that Act came in.

Kirstie Douse: In prisons there was. There is the disciplinary and adjudication process. If you are caught doing something you are not supposed to be doing, that could be the route to go down, rather than doubly criminalising somebody.

Q93 **Andrew Selous:** There was some confusion about that. Could you explain a bit more about your views on the decriminalisation of personal possession offences and why you think that is important?

Kirstie Douse: It is important because a criminal record can have a detrimental effect on education—we heard about school exclusions in the last panel; on employment, as I have already described; and even on travel opportunities. I frequently get people calling who are not able to go to the States in particular, but to other countries as well, because they have a conviction for a minor possession offence on their record.

Q94 **Andrew Selous:** Thank you very much. Adrian, what is your view on decriminalisation?

Adrian Crossley: In the hope that it is helpful, I am going to adopt the same structure in terms of the three points and deal first with its failing in its aims. That is a very interesting point. Earlier today, we heard some evidence that it is quite difficult to look at how effective prohibition is because it already existed under this regime for a long time. There is a necessary division that needs to be drawn between toughness of sanction—sentence—on the one hand, and prohibition on the other. These are distinct things.

It is quite right and proper to say that if you increase the sentence for a criminal offence it is not likely that you are going to have a huge impact on the rate at which that offence is committed. That is accepted. There is a separate concern, and sometimes the line between them is blurred, about people who would not want to commit a criminal offence at all and



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those who decide that its being criminal is enough to deter a certain action. That is the deciding point. That is the point where the Misuse of Drugs Act has an effect. My submission is that we ought not to be surprised by the fact that many people care what the law is. They are aware of the consequences, not just on their career in the future, but their present career and their reputation. That is enough to stop many people.

We have seen some polling in that respect. In 2014, Opinium asked people who said they had never taken drugs whether perhaps they would in the future. About 4% said they would. When it was suggested that it was legalised and they were asked what they would do, it was around 16%—a fourfold increase. We had similar polling on cannabis in 2010. That looked at whether or not there would be an increase in use if it was legalised. About 10% of people who said they had never taken drugs said that they definitely would or probably would if it was legalised. That is an interesting point. We have to be careful about those polls because they are polls. We also have to be careful about how we use polls when we look at the larger population, but there is a firm indication that many people care about the law and it is a barrier to use. I would submit that that is true.

In terms of causing harm, I feel very strongly about the point that it is disproportionate. The case was put forward by Kirstie of somebody asking for help and advice who had a criminal conviction for simple possession and only one conviction, with a detrimental effect on their career. Most people would think that was hugely disproportionate. There are lots of people who are flying 747s or doing operations who smoked cannabis in their youth but were lucky enough never to get caught. There seems to be an artificial distinction between those unfortunate enough to get caught and those who were not.

A further point on that is that you are more likely to get caught if you live in Acton than you would be if you lived in a village in Cambridgeshire. That is another increase in unfairness. Just by way of your background and your circumstances, you are more likely to get stopped. When the point is made that it is disproportionate, the only sensible option is to say that that is absolutely right. I do not concede the point; I wholeheartedly agree.

The solution is more complex than a review of the entire Misuse of Drugs Act. We have seen examples across the country of diversion schemes that work to get people out of the criminal justice system and into treatment. Thames Valley is a good example. There are two benefits. If we really mean it when we say this is a public health concern and we are worried about people's futures, and it is not just some way of keeping the status quo regardless, that has to manifest itself in something real. That would be adding some real help. I know Kirstie will want to talk about this more, but I will touch on it lightly now. The dissuasion panels we hear about in Portugal work on a basic principle; if you do not turn up,



you can get fined—under decree 30/2000, I think. You have to turn up and you get some sort of education, or you meet a panel that can talk through your drug use.

Q95 **Andrew Selous:** I am fascinated by that. If you do not turn up for treatment, you get fined. Presumably, that fine is under criminal law.

Adrian Crossley: No, it is decriminalised in Portugal. That is something that you touched on earlier, Andrew, and it is worth clarifying. There was an example given about opiate substitute treatment. I would like to use a slightly different example to give some clarity. This is different from legalisation in the respect that it is something that is effectively prohibited by the state but there is no criminal sanction. I think Kirstie and I will start to disagree in a minute, but we start with the common point that lack of criminal sanction is an important consideration. It is what distinguishes Portugal in that way.

We are not in a position where we have decriminalised; as you well know, the Misuse of Drugs Act is still in force, but local police forces are given some discretion to act proportionately when somebody is found with cannabis. In an effort to both educate and limit the damage to their career, they have these schemes.

Enhanced criminal record checks can have an effect on someone's criminal record. They currently use something called a community resolution. That is, essentially, an agreement between the police force and the individual: "If you do this thing," go to a drugs course, "we will cease the prosecution." It is possible under enhanced criminal record checks for that to show. Unlock looked at that and said it was quite unlikely, but it is certainly possible.

We are not yet in a situation where we have crossed the divide and got to a point where somebody is guaranteed never to have that disclosed. Currently, we are looking at the Rehabilitation of Offenders Act, and there is a live and very good debate about what we as a society think should be recorded and for how long. I feel very strongly that causing more disadvantage to somebody who is perhaps already struggling with life is deeply unhelpful.

To suggest that the solution is something as wholesale as to decriminalise drugs very much endangers our younger community and the rest of the community into accepting drug use, which is damaging to health and damaging to our community. There is an option being explored, which is not where it needs to be, where we can keep all the positive points of the Misuse of Drugs Act, all those benefits, and take a scalpel to the problem and ask how we can make it more proportionate.

Q96 **Andrew Selous:** That is helpful, Adrian. Thank you. On the basis of what you said, what policies is the CSJ advocating in this area, and what is the evidence base that they are the right ones to choose?



Adrian Crossley: Portugal is a good example as a good evidence base. It has been running since about 2001, so it is not new. Portugal has, like every other country in the world, some problems with drugs; it is not a complete success story. They have in recent years seen a slight increase in cannabis use, according to EMCDDA data.

It works because they take an honest approach. They understand that the solution is not in flicking a switch. The solution is boring. It is complex, it takes a long time and it is expensive and difficult to sell to the electorate. It is about creating a proper social framework, and understanding and providing people with opportunity, not just with drug relief—it is not just a health issue—but with the rest of their sometimes very complex lives. You help somebody out of drug dependency or drug use, which is damaging. That is the takeaway for us from Portugal.

It is the understanding that you have to get in the weeds and help somebody with multiple complexities in their lives. It is not simply about decriminalising. In fact, the architect of the system, João Goulão—I am afraid I have butchered the pronunciation; apologies for that—said to the BMJ that it is difficult to draw an exact causal link between decriminalisation and the effect it has had in Portugal, precisely because he acknowledges all the other infrastructure that goes around that help. That is what we need to get better at. We have a history in this country; there was a time when Britain was regarded as almost a world leader in this, and we were very good at doing this sort of thing.

Q97 **Andrew Selous:** When was that?

Adrian Crossley: More than 20 years ago. We see the beginnings of holistic governance here. Troubled Families is a great example of that, where Government groups are encouraged to work together and look at a person rather than name them after a Government Department. You are not a criminal who has to be dealt with by the MOJ. You are not a patient in the health service. You are a person with multiple complex needs, and we need to work together to find strategic solutions.

There is real hope for that type of work here. We are not a million miles away from what Portugal was able to do, but there seems to be some political disincentive or lack of will to spend in public health. It is not just addiction spending; if you reduce the public health budget, you create further health injustices and it can lead to entrenched division.

Q98 **Andrew Selous:** Is it just Portugal or would you point us to anywhere else around Europe, or anywhere else around the world, that has lessons for the UK, such as the drugs courts?

Adrian Crossley: Drugs courts have mixed evidence. America was a bit of a pioneer of drugs courts. In Liverpool, we started an initiative that was very similar. That enforces holistic approaches. Leaving the evidence to one side for a moment, and acknowledging that it is not where perhaps it should be, I remember that when I was defending judges



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would often say, "Right, there is your drugs order. Come back in a month. You are going to see me and I am going to hear about how well you are doing." That was an interesting approach, very similar to a drugs court, where they would say, "Somebody is watching." It is not just the defendant who is being watched. It is all those other people—the Probation Service who promise the world about what is going to happen next. If he did not have a drugs appointment given to him or nobody phoned him, there would be somebody for him to give an account of himself to.

Those sorts of things can work, but the focus should be on the wider community infrastructure in addiction, not just looking at what happens after sentence, because by then we have had goodness knows what going wrong so far. It is not just drugs; alcoholism has a huge impact. It is important that the community infrastructure is there to prevent people going through the criminal justice system and, if they do, that there is something at the other end that can pick them up and help them.

Q99 Andrew Selous: To come back to my question, is there anything in Europe or anywhere else in the world? You have told us about Portugal.

Adrian Crossley: America has the drugs courts. Sweden is often referred to as a country that has a very strong social infrastructure that deals with social harm problems in a way that is perhaps more holistic and on which they spend more money. That is not something I would gravitate towards. We have something very close in this country. We have the infrastructure and we have a lot of expertise; we do not fund it properly. The thing that makes Portugal distinct is proportionality when people are caught in possession of drugs.

Andrew Selous: Thank you very much.

Q100 Chair: Does that apply to all drugs?

Adrian Crossley: Yes. Uruguay has legalised; it has a system. I would not advance that before the Committee as something that had the social structure behind it to deal with drug abuse, but yes, it applies to all drugs.

Kirstie Douse: Can I come back on a few things? In relation to the polls, I know Adrian urged caution, and any researchers in the room, or listening, would also urge caution in relying on what someone says they would do in a hypothetical situation, compared with what would happen in reality. If we are going to do that, we need to look at studies that have come up with a different outcome. Global Drug Survey asked people whether or not they would be more likely to seek assistance in relation to their drug use if things were decriminalised, and the majority said that they would. That is an important thing if it means that people are more likely to seek assistance.

In relation to disproportionality, the criminal law is disproportionately applied to black and ethnic minority people. Black people are more likely



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to be stopped and searched for drugs; they are more likely to be prosecuted rather than receive an out-of-court disposal. If you follow them through the criminal justice system, they are more likely to receive a harsher penalty. They are more likely to receive a custodial sentence than a community order or a drug rehabilitation requirement.

In relation to decriminalisation not being the answer to health harms and problematic use, only about 10% of people who use drugs have a problem and are dependent. Decriminalisation would have a significant positive effect for the 90% of people who use recreationally, and do so without harm to themselves or to other people.

In relation to drug courts, you said the evidence base is varied. Previous evaluations of drug courts have been criticised for being poorly defined or having biased controls. It needs to be questioned whether or not courts have the specific technical health expertise to make those kinds of judgments. If that is to be an alternative to the punitive measures, you need to look at the outcome if you do not engage. If the alternative is that you end up in prison, it is not a voluntary option and we are then talking about mandated treatment.

Q101 Dr Whitford: Can I ask both of you what your views are of drug consumption rooms? I raised it in the earlier panels because of the problems we have in Glasgow and around the west of Scotland, particularly as a way of reaching out to the hardest to reach?

Adrian Crossley: I am tempted to lead on this, but I am aware that Kirstie has a different position from me. I don't know which is more helpful to hear first.

Dr Whitford: I am sure we will hear you both.

Adrian Crossley: I hope this does not sound evasive. I want to start with where we are now in terms of how we treat addiction in the UK. I won't repeat too much of what has been said before, but if we look at how effective drug treatment recovery practices are in the UK, and we look at funding levels together, that is a helpful start.

Between 2001 and 2003, we had a death rate in England for drug poisoning of 5.2 in every 100,000. By 2008-10, it had moved down very slightly to 5—a negligible difference, and you couldn't read anything into that. Around 2010 and again in 2013, there were significant shifts not only in the way that funding was ascribed but in the decision making on how treatment centre contracts were procured. We saw a rise of about 28% in the death rate in a relatively short period of time to about 6.4. Dealing with just over 10,000 deaths over that two-year period, 2015-2017, I read into that two things. You can trace the death rates back even further than that; you see fluctuations certainly but vague consistency. I read into that that there is a strong correlation, with multiple factors involved, between reducing funding very significantly, some say around 25%, and the increase in death rates of about 28%. We



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are already in a position where, if we look at what we have now and why we are where we are, we can say that reduction in funding is causing significant harm to our communities.

The reason behind drug consumption rooms is a desire that we all share. I have spoken to Professor Strang about this, although I should say that he does not agree with my position, but he is quite clear that if we get back to the weeds, and look at what we mean by harm reduction, we are only really talking about reducing harm to the community and reducing exposure to risk. I suggest that, where we underfund a treatment sector, we are knowingly dismantling a treatment sector. I say that because the ACMD was very clear with the Home Office after the 2017 drug strategy that if there was continued reduction in funding it would lead to the problem we are now seeing.

We as a community own that problem, and we should be making no bones about the fact that we have every reason to believe that, with some care, and strategy employed and reinvestment in what we already have, we could see a substantial reduction in drug deaths in the UK. I will not say that we can reduce it by 28%, and I am sure lots of people could comment on that, but I suggest that it would be unsurprising if it was close to that.

I went to a lecture yesterday with about 30 psychotherapists who were talking about skill in the industry. They were talking about how it had effectively been deskilled; you heard some evidence from the earlier panel. I spoke to the Royal College of Psychiatrists, who said exactly the same thing. This is salvageable now. It will not be in five or 10 years, they say, because of the change in skillsets.

We are on the cusp of going too far and we could reinvest, with that skillset, and reduce deaths significantly. When I think about drug consumption rooms, I understand completely. I gave significant thought to this because I understand the evidence, and you will hear more about it in a moment; we are moving from a point where we have decided for a decade to underfund an industry. We have seen the deaths we were warned about, yet we are looking at solutions that involve people taking drugs in safe locations when there is a safe alternative.

Q102 **Chair:** Couldn't you do both?

Adrian Crossley: Yes, I understand the thrust of it. You could not do both. I say that, having considered that point more than anything else.

Q103 **Chair:** You couldn't just invest in services and reskill your workforce and also have drug rooms. Are you saying that drug rooms are just a response to the fact that you are underinvested?

Adrian Crossley: Yes, of course it is logistically possible and administratively possible. The reason I do not think we should do both is that drug consumption rooms are, or appear to be, evidentially very



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valuable, and they are. I wanted to talk about that and the only way I can answer that question is to do that.

Drug consumption rooms are aimed at people who would not otherwise engage in treatment. That is important because, if they are never going to engage in treatment and they die, all the rest of the stuff you want to do is never going to reach them. I understand the thrust of that, but I reject the premise because I have seen people across the UK who have been written off as someone who could never be helped, and they are helped by people who are proactive enough to reach out.

If you fund something to the bare minimum, you deal with the people who come through your front door. If you respect this industry properly, and it is funded properly, you allow people to do outreach programmes. In Doncaster, Complex Lives and Changing Lives do that. They do not wait. They find people that they know are in desperate need of help. What makes someone engage? Is it heroin or is it the interaction they have with the person in front of them?

To take another example, and an organisation that is funded less, Coffee4Craig in Manchester understands that people who are addicted to heroin, novel psychoactive substances and a plethora of other things do not just need drugs. They need a change of clothes; they need some food; they need a sense of community and connection. Some of that is provided in drug consumption rooms. They are made to feel like they are human again, and that is important. That is its value.

When you have something like Coffee4Craig, they give you a change of clothes, a shower, something to eat, a cup of tea, you watch "Corrie" and then they leave you alone. They do not force treatment on you; they gain a lot of trust with people and over time people approach them for help and they are helped. It is far too easy for us sometimes to say that there are people that you cannot access and help. There are directors of treatment facilities across the UK who tell me stories about where they were in their life. They would have appeared to be the person who is beyond help. If you reach out and make the effort much slower, in a more human way, you can achieve the same things that drug consumption rooms do.

Chair: Thank you.

Kirstie Douse: I can't disagree with Adrian on reinvestment, but perhaps that is where it ends. I will deal with that briefly and then I'll come back to your question, Philippa.

It is not just about reinvestment. Our drug policy, our drug strategy, at the moment is recovery focused and it defines recovery as abstinence only. There is a lack of harm reduction. Karen and Susanne mentioned earlier that they wanted to see harm reduction as a pillar. If you reinvest in those services but you do not change the policy or the way that the services run, you are not going to get the changes that Adrian describes.



There is a strong evidence base on drug consumption rooms from a number of countries. They operate in nine EU countries, and in Canada and Australia. They reduce the risk of overdose—of course they do. There are people there who supervise people and can respond to an overdose if that happens. They facilitate access to health services. They do not force treatment on people, but people who want to engage in treatment can do that at a point when they are ready. There is a decrease in the spread of BBVs and other diseases because people are not using in unhygienic, unsafe environments. They have access to clean needles and syringes and everything else they need. In terms of societal issues, which Andrew mentioned in one of the previous panels, they reduce drug litter; you do not have people who are using in the streets. It reduces the antisocial behaviour that some neighbours might complain of.

Saying that there are legal barriers, and that the law prevents it, is a cop-out, to be honest. There are offences that will be committed by the very nature of the operation of drug consumption rooms, but those can be dealt with through CPS guidance in the same way as we do around needle and syringe programmes, whereby there are agreements that people will not be prosecuted for possession of drugs in the vicinity of them, and those areas are not over-policed. It is the same as with the drug checking facilities at the festivals that Harry described. I completely endorse what he said about us innovating for a particular group of people but leaving others to fall by the wayside.

That is not to say that you could open one tomorrow but, if there is the political will, it can be done. There are things that can be done through letters of comfort from police chiefs and CPS guidance, so that people who use those rooms are not prosecuted and the people managing those facilities do not fall foul of laws.

Q104 Dr Whitford: That is the whole cleft stick that Glasgow is stuck in, in that justice is devolved but drug policy is not. The Home Office, despite repeated requests, will not give letters of comfort, and will not allow a drug consumption room in Glasgow which has the highest death rate in the UK and pretty much in the whole of Europe.

I am not sure I agree with Adrian. This is not the idea that people just come in, shoot up and go away. It is a way of reaching the absolute hardest to reach, because the vision in Glasgow is to provide health services. It is not instead of. What was described is not something we have had in Scotland. We do not have tendering in public health, and drugs and alcohol is not in local government; it is still part of the NHS. That side of it does not explain it, and it largely seems to be older drug users who have ended up an awful long way from services.

The two of you do not agree with each other. You are saying that it is down to police chiefs, but it simply is not in the devolved nations. We have to have permission from the Home Office.



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Kirstie Douse: That is a wider issue, and certainly I support the devolution of drug powers to the Scottish Parliament.

Q105 **Dr Whitford:** Do you think it is a “tough on drugs, tough on the causes of drugs” kind of political thing that we cannot seem to get past and look at how to have as few deaths and as many people recover as possible, how to manage drugs?

Kirstie Douse: It must be. When we have that level of drug-related deaths and we have evidence-based solutions that can deal with them, that can be the only reason why they are not permitted to be implemented.

Q106 **Dr Whitford:** Adrian, you were describing giving someone a shower and clothes and various things as good, but drug consumption rooms as bad. We used to have a service in Central Station, but because the Home Office keep refusing a drug consumption room they have now become nervous and they have withdrawn it. We have the indirect impact of a legal approach that is inhibiting people who were happy to host services and are now afraid to host services. Why do you see a difference between your Coffee4Craig and a drug consumption room that contains all sorts of social and health support as well?

Adrian Crossley: It comes down to the defining point of a drug consumption room, which is that the person is administering drugs, not just heroin; people use all sorts of drugs in drug consumption rooms. We have spoken to people who sometimes feel a sense of anger and betrayal that they have spent a lot of time on opiate substitutes and not engaged in substance services that they feel were always available to them, and not had the opportunity or encouragement to move forward. We feel that it is incumbent on us to help people out of drug addiction. I will move on in a moment to deal with your wider point, which is about engagement with people who are suffering drug addiction.

This is not just about that last moment where you are injecting or smoking something. That person goes home. We have thousands of children at home across the UK who have drug-dependent parents and alcohol-dependent parents. You are twice as likely to suffer domestic abuse at home if you have a drug-dependent parent, three times if it is alcohol.

It does not end with the drug consumption room. The misery to society is very significant, and unless we are doing everything we can to pull in the right direction and help people—and that does not mean just being encouraging; it means offering them real support and a way out—I feel that we are failing people who desperately need help.

Q107 **Dr Whitford:** You do not see drug consumption rooms as a way of getting the hardest to reach group through your doors and then being able to engage and offer support.



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Adrian Crossley: What I am failing to do is to communicate here my confusion and frustration about why drug consumption rooms are put forward as having a monopoly on that sort of compassion.

Q108 **Dr Whitford:** I do not think it is a monopoly. Glasgow is not suggesting any kind of "This is our one drug service," not even slightly.

Adrian Crossley: Groups like Coffee4Craig are quite common and can engage people in a way that is really constructive. There is nothing about the drug consumption room, other than the administration of heroin, which differentiates that. You can take all the positive stuff, which I think we all agree is really important, to engage someone and pull them into drug services.

I want to touch on a couple of things. The Cloud in Denmark was looked at by a Home Office report. It looked at the clientele that went through the DCR. Much of it was utterly unsurprising. Around 80% were homeless; a third were street sex workers. We do a lot of work with charities that support homeless people and street sex workers. Pippa Hockton has a charity called Street Talk. She is really clear about the disconnect between people who need those services and professionals. They are routinely disbelieved about what they say; they have distrust that builds up.

Places like Coffee4Craig have a very light touch. It is not as if people who suffer from drug abuse do not interact with the state; they do, at A&E, and sometimes with the police and social services. They have plenty of interaction. What they need is positive interaction—somebody who can help them. Places like Coffee4Craig that can do that add value. I do not see how a drug consumption room done well—we are always talking about drug consumption rooms done well, aren't we?—is necessarily distinguished in any way from other groups that reach out and connect with people in more positive ways.

Q109 **Dr Whitford:** You do not see that someone who is still using and injecting heroin and has been doing it for a long time, but it is starting to get problematic because they are older, is simply not going to engage with that other service that in essence dismisses their use. They do not feel ready to make that step, whereas if they go into a drug consumption room they might reach a point, a bit further down the line, when they are ready.

Adrian Crossley: It is about the skillset that is employed at the point of contact and the person who is able to engage. There is nothing about the drug consumption room that means that they are likely to have a more engaging person.

Q110 **Dr Whitford:** It would be having health and drugs and alcohol people there and people looking at homelessness. We are not talking about something that has no services behind it.



Adrian Crossley: I am not suggesting that somebody who is going through drug addiction does not need healthcare, but I am saying that the critical point is engaging someone to the point where they want to change their life and move forward. That is a decision-making process that needs to be encouraged.

Chair: I think we are going round in circles. You have both made those points.

Q111 **Andrew Selous:** I want to take us to a different area, which is one Kirstie touched on: the abstinence issue and where we are with methadone. I know it is quite a contentious issue. What is your take on that, Adrian, in terms of drugs policy overall?

Adrian Crossley: Historically, the dividing line in that debate has been too stark. Methadone is an extremely useful tool to help someone get from a place where they are using street heroin and not engaging, to a point where they are able to engage with somebody who wants to help them. To suggest otherwise is foolish.

Often people have polysubstance use, comorbidity, and there are issues beyond just the sort of thing that methadone can help with. It is incumbent on all of us to try to encourage someone to move past that. Two months? Two years? It can take one person a lot longer than another. That journey is very individual. We feel strongly that encouraging someone to deal with the issues that are the underlying effects of addiction, which can take lots of different forms, is a very constructive way of helping someone live the rest of their life in a fulfilling way. When that is not done, when someone is parked on methadone for long periods of time, it is a failing.

Q112 **Andrew Selous:** Thank you. Kirstie?

Kirstie Douse: I have to take issue with the phrase about being parked on methadone. OST as a wider thing is one of the most researched medications. We heard from the previous panels how it prevents premature mortality. It is part of a holistic and wider service. Of course you would look at why people are using drugs and address that through counselling and so on, but I deal with people every single day at legal surgeries that we operate across London in drug and alcohol treatment centres.

For many of those people, methadone allows them to get up every day and go to work and to care for their children. To say that that should be removed as a matter of course is wrong. It needs to be a tailored approach, bespoke to the particular person. For many, complete abstinence, even from illicit drugs and from substitution therapy, is possible, but for many others it is impossible and they should be supported in whichever way works for them.

Q113 **Chair:** Thank you. Were there any points you wanted us to hear that you have not been asked about specifically?



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Kirstie Douse: I thought I would have an opportunity to speak more about some of the international experiences. Andrew raised that and I didn't come back at that point because I thought there might be an opportunity.

It is not just Portugal. Release conducted research analysis in 2012, updated in 2016, of 25 jurisdictions that had adopted some form of decriminalisation. It is important to say that there are different models across the world. Some will be within law, *de jure*, some are *de facto*, and some have the addition of civil sanctions, whereby if you fail to engage in the treatment programme there will be a civil penalty.

There are countries such as the Czech Republic that adopted decriminalisation following a cost-benefit analysis of criminalisation. They found that criminalisation did not impact on availability and there were a number of negative consequences. Similarly, in Australia, a number of states have adopted some form of decriminalisation. A study in 2008 comparing the outcomes of people who were criminalised compared with those who had received a civil sanction in a different state showed that there were improved outcomes, in terms of health, accommodation, relationships and not having further contact with the criminal justice system, for people who had received a civil sanction under the decriminalised model as compared with the criminalised.

Q114 **Chair:** Can I ask where in your opinion the model works best?

Kirstie Douse: That is a very difficult question. I would say that taking pieces of some of the different models from around the world would be the best approach. Portugal is the one that is most researched, and I would support the essence of the dissuasion committees in terms of involving legal, health and social workers and so on. I do not think that imposing a civil sanction for failing to engage is correct. It is a similar situation if somebody is fined in court here for drug possession. If they do not have the means to pay the fine, they are further criminalised. The complete removal of sanctions needs to be the aim.

Q115 **Chair:** Are there examples of countries where that happens—where there are no sanctions at all?

Kirstie Douse: I would have to come back to you on that.

The only other thing I wanted to raise was diversion schemes. Adrian mentioned Thames Valley police. They are also occurring in Durham with Checkpoint, and in Avon and Somerset with the drug education programme. We are privately advising a number of other areas on them. They take different forms. Some of them are post-arrest; others are street diversion pre-arrest, which would be the better method to adopt. They are coming because local police forces, who are at the forefront, recognise the futility of continuing to criminalise people for drug possession, particularly in light of their reducing resources.



Lack of national and political leadership has meant that local police forces are having to exercise their discretion, and are getting good results. Reviews and analysis of both Checkpoint and the drug education programme have shown decreased use of drugs and alcohol, reduced reoffending and improved outcomes in terms of accommodation and housing.

Q116 Chair: Obviously decriminalisation applies to the user but not to the supplier of the drugs. Is there variation in the international experience about what the penalties are for the person who continues to supply the drugs?

Kirstie Douse: We have just done that. Durham has extended the diversion scheme to low level supply and the user/dealer situation, whereby someone is technically supplying drugs but they are doing it in order to fund their own drug use and are supplying only to their peers.

Internationally, there is lack of proportionality around sentences for drug supply as compared with other offences—offences against the person, sexual offences, and so on.

Chair: Thank you both very much for coming this afternoon. We appreciate your evidence.