

Health and Social Care Committee

Oral evidence: Drugs policy, HC 1822

Tuesday 11 June 2019

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Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Angela Crawley; Diana Johnson; Dr Paul Williams.

Questions 117-223

Witnesses

I: Josie Smith, Head of Substance Misuse Programme, Public Health Wales, Yusef Azad, Director of Strategy, National AIDS Trust, and Matthew Hickman, Professor in Public Health and Epidemiology, University of Bristol.

II: Dr Arun Dhandayudham, Joint CEO and Medical Director, Westminster Drugs Project, Danny Hames, Chair, NHS Substance Misuse Providers Alliance, Peter Yarwood, Chief Executive Officer, Red Rose Recovery and Lancashire User Forum, and Professor Sir John Strang, Head of the Addictions Department, King's College London.

Written evidence from witnesses:

- [National AIDS Trust](#)
- [Harm Reduction Group](#)
- [NHS Substance Misuse Providers Alliance](#)

Examination of witnesses

Witnesses: Josie Smith, Yusef Azad and Matthew Hickman.

Q117 Chair: Good afternoon and welcome to the Health and Social Care Committee. Thank you for coming to give evidence to our second session inquiring into drugs policy. For those following from outside the room, could I ask you to introduce yourselves and who you are representing today, starting with you, Yusef Azad?

Yusef Azad: I am Yusef Azad, director of strategy at the National AIDS Trust, which is the UK's HIV policy organisation. I am here on behalf of the Harm Reduction Group, a coalition of organisations and individuals advocating for harm reduction principles in England.

Josie Smith: My name is Josie Smith; I am head of substance misuse in Public Health Wales, and I have a 30-year career working both on the frontline and as a researcher prior to Public Health Wales.

Matthew Hickman: Hi. I am Matt Hickman, a professor in public health at the University of Bristol, deputy head of the Bristol Medical School and head of population health science. I am a research academic with an interest in addiction, in particular hepatitis C, overdose and drug-related deaths.

Chair: We are starting today by looking at harm reduction. Angela will open the questions.

Q118 Angela Crawley: My question is specifically on the concept of harm reduction and what it means in relation to drugs policy. Could you start, Yusef?

Yusef Azad: There is no internationally agreed definition, but we think harm reduction is a rights-based approach to drugs services and drugs policy, which acknowledges that some people will choose to use drugs and for the present plan to continue to do so. For those people, it aims to minimise or prevent any health-related or other harms that might arise from their drug use—to prevent, above all, drug-related deaths, but also viral or bacterial infections and social harms such as homelessness. There are well-evidenced and highly effective interventions that can achieve those aims while people continue to use drugs or drug substitutes.

Josie Smith: I will only add that the harm reduction approach is very in keeping with a public health approach, in that it is evidence based and rights based, as Yusef has said. It focuses on reducing the harms associated with use, be they physical or psychological, acute or chronic, enabling individuals to make healthier choices, to live longer and to live more healthily and better while they use drugs, and choose to move on, or not.

Matthew Hickman: The only thing I would add is that there is a nice definition in a book from 1996 that the Institute of Medicine, a US body,



did on pathways of addiction. They do not say anything about harm reduction, but they took what is called a public health conceptual framework to the problem of dealing with drug-related harm. It is all about drug-related harm. If you take a population or public health approach, you are measuring things at the population level, which is something that our drugs strategy singularly fails to do at the moment. It is not setting targets for overdose, drug-related deaths or hepatitis C, which, if it was a population health approach, it would do.

Q119 Dr Williams: To follow up: harm to whom?

Yusef Azad: There is clearly a priority of harm to the person using the drug, but it doesn't end there. There is possible harm to, for example, the family or carers—there are the burdens on those close to the person who is using the drug—and there may be wider harms to society when people are unwell. There is a harm, you could argue, from poorly managed health of people who use drugs in terms of unnecessary cost to the NHS. That is an example of a wider social harm if we do not apply harm reduction principles effectively.

Q120 Dr Williams: So when you are talking about harm reduction, you are mainly talking about reducing harm to the individual?

Yusef Azad: That is the focus.

Q121 Dr Williams: But it is not exclusively about the individual?

Yusef Azad: No.

Matthew Hickman: We are talking about harms in the population. The individuals' harms sum up to the population. The key is that it is the population, and it harms us. Premature mortality harms us.

Q122 Dr Williams: You said there was an evidence base around this. It would be really helpful if you could summarise some of the evidence for us to understand it a bit better.

Josie Smith: Certainly, if we can get to the specifics around some harm reduction interventions, for example. One of the key, long-standing harm reduction interventions is needle and syringe provision for individuals who are injecting drugs. That has been proven both effective and cost-effective in reducing blood-borne virus transmission, so that is harms to the individual in that they are infected, but also those are communicable diseases. It also reduces bacterial infections, which I suggest are a huge issue that is perhaps not best recorded currently, as opposed to blood-borne viruses. There is a very strong and long-standing evidence base for the efficacy of a needle and syringe programme to reduce the transmission of infections, whether bacterial or blood-borne virus.

Matthew Hickman: But not alone. The best global evidence is that good coverage with needle and syringe programmes reduces HIV transmission by about 50% and hepatitis C transmission by 50%, but they are much better in combination with opioid agonist treatment and opioid substitution treatment, and we should be thinking about a much more comprehensive

strategy. To reduce hepatitis C, for instance, you can reduce transmission by 80% through opioid substitution treatment and a needle and syringe programme; one or the other has a limited effect.

Josie Smith: Harm reduction is, as you mention, a combination. It is a strategic pragmatic strategy towards reducing the range of harms. Those actions are much stronger taken collectively than individually. We certainly know that reducing bacterial infections, making harm reduction interventions—for example, we are in the process of developing self-care wound packs—and providing Naloxone to prevent drug-related deaths, taken in combination with opioid substitute treatment, have protective effects against overdose. It is a combination—a package of strategic approaches that can maintain health and reduce particularly the most severe harms of premature death.

Q123 **Dr Williams:** How many people in the UK are getting this package of care?

Yusef Azad: There is clear evidence that coverage is inadequate. For example, the last review of access to needle and syringe programmes, which was in 2017, found only 61% of people who inject drugs reporting that their access to clean needles and syringes was adequate—that was in England. Needle sharing continues: about 18% of people reported needle sharing. There has been some improvement in access to clean needles and syringes, but it is clearly still significantly inadequate in terms of the prevention of blood-borne virus transmission. That is one example of where we still have to do a lot more if we are to properly apply harm reduction and protect people from unnecessary harms.

Matthew Hickman: The thing to highlight is that compared with most other countries, what is provided in the UK is brilliant, because the global estimate is that less than 5% of people who inject drugs have any access to good services. The UK does have reasonable coverage—it could be quite good coverage—but the question is what needs to be done next to improve those services and to change them so that we can further reduce overdose mortality and hepatitis C transmission. If you are going to talk about hepatitis C, that is different, because there is a great opportunity allied with NHS England's investment in treatment that could be seized upon with good services. On overdose deaths, there is a sort of paradox: on the surface, we have good coverage of services, but the number of deaths keeps increasing.

Q124 **Dr Williams:** That was going to be my question: why isn't it working?

Matthew Hickman: We have some theses. John and I have an editorial coming out in *Lancet Psychiatry* next week saying that we need to call for a public health crisis to be declared around opioid-related deaths. They are the highest they have ever been and have been going up annually. The services are not working.

One of the potential reasons is that duration of treatment might not be long enough. We have people circulating in and out of opiate agonist treatment and in and out of prison, and that accumulates high-risk



HOUSE OF COMMONS

periods. When you leave treatment or prison, you are at the greatest risk of overdose, because you are opioid naïve. You need to avoid those risks. You need a longer duration of treatment in the population and opioid agonist treatment in prison and on leaving prison.

The other dilemma we have is that, unlike the US, where the opioid crisis is driven by an opioid epidemic, the best estimates in the UK are that that use has not gone up substantially, but deaths have gone up. There is an issue around comorbidity and polydrug use. Pregabalin or gabapentinoids increase the risk of overdose, as do benzodiazepines. Alcohol has a different effect. We believe, based on animal models, that it strips out tolerance to opioids, so if you drink and then take opioids you increase your risk.

In some primary care data that John and I have looked at, there is a massive increased risk with comorbidity. Our population is ageing, so people also have other illnesses that put them at elevated risk. That should mean that we redesign services around addressing comorbidity. It is still preventable, but our services have not yet caught up, or are not yet re-engineering themselves to reduce overdose-related deaths.

Q125 Dr Williams: In the area that I represent, until about two years ago we had a specialist service where substance misuse management happened alongside primary care, but it was decommissioned. Is part of the problem our commissioning arrangements as well?

Josie Smith: Certainly, in our experience there is huge geographic variation. You mentioned Naloxone: in some areas, such as Wales, provision of take-home Naloxone is centrally funded and has no restriction on use. That is not the case elsewhere in the UK.

Commissioning certainly presents its own challenges. I found, in my experience prior to Public Health Wales, that commissioning is very often disruptive, and where it is positive it is personality led, as opposed to structurally sound and consistent and equitable right across the UK. There are commissioning issues. There is a lot of guidance out there, but there are challenges.

Matthew Hickman: The trouble is that it is not in the NHS. Drug and alcohol services have been taken out the NHS, and they have been cut. Part of the recommissioning is to deal with a service that has been cut. I am not saying that is the reason why they have not addressed overdose mortality, but—

Q126 Dr Williams: Do you think the cuts might have led to the overdose mortality?

Matthew Hickman: No, but services do not have the capacity or the scope to change themselves to deal with the increasing problems and morbidity that we have in the population.

Yusef Azad: The cuts certainly have had an impact. The other challenge in past years, as was raised by the Advisory Council on the Misuse of



HOUSE OF COMMONS

Drugs, has been the very high rate of re-tendering, which loses any continuity of expertise and can affect quality. I also think—this is a wider issue—that there is a challenge for our health service in genuinely integrating care, which is exacerbated when drug services are commissioned by local authorities and other services are commissioned by the NHS.

There are certainly commissioning issues that need to be addressed, both in terms of funding and in terms of design. I think Naloxone is a good example of where things have not yet been joined up. Release did a very good report on take-home Naloxone provided in prisons, and we know that release from prison is accompanied by a very high risk of overdose for people who have historically been opiate clients. Only half of prisons have a take-home Naloxone programme, and only 12% of adult prisoners who were opiate clients released from prison in a relevant year took home a take-home Naloxone kit. In some areas, that was because NHS England and local authorities were arguing about who should pay for it. It is not expensive, so these sort of things really shouldn't happen.

Q127 Dr Williams: Are there any other barriers to implementation of harm reduction strategies?

Yusef Azad: We have talked about some of the core harm reduction strategies that need to be brought together—needle and syringe programmes, OSTs and blood-borne virus testing. There are some more innovative and specific interventions that can be helpful—for example, drug checking at festivals is getting under way and is very welcome. It is already having an impact, and there is a lot of international evidence that it works. Then there are the drug consumption rooms; we have seen in Glasgow that over a quarter of the publicly injecting population have acquired HIV in the last three or four years. The whole health system and politicians in Glasgow and in the Scottish Parliament and Government want to try a drug consumption room, but there is a legal and political barrier in the way. Sometimes it is commissioning, and sometimes there are other issues as well.

Q128 Chair: To put this in context, we have heard that the drug poisoning death rate is now the highest that it has been since it was recorded, and we are now three times the rate in Europe. We have also heard that the majority of deaths are actually related not to drug poisoning but to wider health concerns. To take harm reduction in its entirety: if we had the ideal package that looked at both of those aspects and was implemented everywhere across England, what do you think are the numbers of people we could be saving every year, if we actually had a very good, comprehensive harm reduction package? Could you give your thoughts about what we could achieve here.

Josie Smith: On the face of it, every premature death is avoidable. Every drug death is avoidable.

Chair: That is what I wanted to hear. We should look at every drug death as entirely avoidable.



HOUSE OF COMMONS

Josie Smith: Absolutely. From my perspective, I would suggest that drug poisoning—the drug misuse ONS data—is part of the picture. Recently we have investigated serious infections among people who are using drugs. In a short period of time, 35 required either amputation or intensive care; two died within the six-month period. None of them will be recorded as a drug-related death. There are innumerable drug-related deaths that are not included in the ONS data. Not only can we prevent those that are acute deaths from overdose poisonings, but we can save many more by providing a far more holistic, lifelong and comprehensive harm reduction approach to drug use.

Q129 **Chair:** Trying to put this in context again, there were 3,744 drug poisoning deaths. If we add to that, it will even more than double that figure because of the deaths that are not being recorded.

Josie Smith: Potentially. Unfortunately, the way that infections are recorded within the hospital system—say, the ICD-10 codes—means the risk factor of drug use and injecting drug use is not routinely recorded. As a consequence, those go under another heading.

Q130 **Chair:** Would you like that to start to be recorded, so that we can actually prioritise this more effectively? If people understood the scale of avoidable deaths that we are talking about here, would it help?

Josie Smith: I would like to see a stronger evidence base on the scale of harms that individuals who are using drugs experience, without—this is slightly an ideal—further stigmatising individuals who are in touch with the healthcare and criminal justice systems. I don't know whether that is possible, but it would be ideal.

Chair: Yusef and Matt want to come in.

Yusef Azad: Yes. Very briefly, how much is a key question, and I think PHE are cognisant of the fact that we really need to start getting data on mortality in general among people who inject drugs. We do have some data for people with HIV: the mortality rate for gay men and people who have acquired HIV heterosexually is three per 1,000 in any year, but for people with HIV who inject drugs, it is over 14 per 1,000. That gives you a little snapshot of the HIV cohort and the significantly elevated mortality rate from all causes among people who inject drugs.

Matthew Hickman: The 3,744, I need to check. I think that is all drug-related poisonings, not just those related to opioids.

Josie Smith: It is drug poisoning deaths. It is not just opioids.

Matthew Hickman: Yes, exactly. But actually, only 60% or 70% of them are opioid-related or drug-related; the others are mostly self-harm. The other thing to bear in mind is that the rate has gone up even higher in Scotland than it has in England.

I agree that we should have a comprehensive service. It would be naive to think that we know the solution, because we haven't yet refocused our



strategy and our services on preventing drug-related mortality. Of course, the deaths are all preventable—that doesn't mean we are going to prevent them—but we should have a service where that is its prime objective. It all needs to be joined up.

We have better statistics in the UK than anywhere else in Europe and, outside Australia, globally. We have fantastic record linkage through the NHS, so we can estimate what the other drug-related deaths are among people who are opioid dependent. We can do it through primary care data and increasingly we can do it through Public Health England's data on people who present to drug treatment centres. That is easy; it can be done. It needs the focus; the strategy needs to say that this work needs to be done.

We can get those statistics. The last time we did it through a clinical practice research datalink, which uses the primary care data, it seemed that the mortality rate was higher. As I said before, that was probably because of comorbidity. It was approaching two per 100 person years—2%—and for overdose, it was just under 1%. So overdose is still a critical part.

Q131 Chair: Are you saying you would like to make changes to any of the ways in which we record, to make data collection easier or do you think we can already get there?

Matthew Hickman: I think we just need a little bit more investment in the data and in the record linkage. Government needs to call for those statistics and it will happen. We don't need a massive change; we just need to make sure that we get those statistics. We have done it before and other groups have done it. We can get the best statistics you want. The reason why we have more deaths in Europe is probably that we have got better statistics.

Q132 Dr Williams: Anecdotally, people tell me that there are some NHS cultural factors at play here and that when people with substance misuse problems encounter the NHS they find prejudice and barriers to accessing care. Is there evidence for that?

Josie Smith: Are you referring specifically to drug treatment services or are you talking about health professionals in general?

Q133 Dr Williams: In general—barriers to registering with general practices, barriers to getting to see a GP, barriers in hospital or in A&E, where people are often put to one side. People describe a culture in the NHS that does not seem to fit the harm-reduction strategy that you are describing. That is what I have heard from people, but I am wondering, from your perspective, whether there is any wider evidence of that.

Josie Smith: I have experienced in the research that I have recently undertaken some structural barriers. For example, individuals who cannot access lower-threshold community-based or outreach intervention leave and delay any contact with health services until it is a crisis; then they are presenting to very busy A&Es, which is inappropriate in and of itself. I also



have experience of individuals who have been removed from primary care lists due to complex wound care requirements, for example, if they are injecting drug users. This is not a criticism of primary care, but I think the pressures that are on all of the health systems are manifesting in a further reduction in positive engagement by individuals who use drugs—not just inject drugs, but use drugs—in terms of maintaining their own healthcare at a lower threshold level.

Matthew Hickman: I think you can find many examples of stigma and bad examples. When we do qualitative research we can get accounts of horrific experiences; equally, there are many examples of really exceptional services. In Bristol we recently had a community-acquired MRSA outbreak, which was largely among people who inject drugs. The care that they got in hospital was exemplary. They are trying their best to work out what they need to do in services to prevent viremia—further bloodstream infections. As was said, one of the key aspects of harm reduction is the human rights approach. In a way, that is the focus that should be in services. You can find lots of good examples and, understandably, lots of poor examples.

Q134 **Chair:** Following on from Paul's point, we had some evidence from UCL that suggested that people who are drug users and have cancer are half as likely to be able to access services. More widely, do you come across that kind of prejudice or barrier in the system that prevents the uptake of other services?

Josie Smith: I don't have any evidence directly of that, certainly not in cancer and tertiary care.

Yusef Azad: I do not have any data, but certainly we hear many stories of stigma, which is not to disagree with what Matt said. There are also many exemplary stories, but that speaks to the need for equalities training and anti-stigma planning around this group of people in the NHS.

Matthew Hickman: NHS England is just about to invest a massive amount of money in hepatitis C treatment, which is a cure for cancer.

Q135 **Chair:** That was going to be my next question. How well are we progressing towards the WHO target of eliminating hepatitis C, and are people who are drug users being actively offered treatment? Is that going well?

Matthew Hickman: It is elimination as a public health problem, not eradication. Already, end-stage liver disease through hepatitis C is falling, although most of that is probably not current injecting drug users, but ex-injecting drug users. The next scale-up is happening now, by offering hepatitis C treatment in many different, novel pathways in the community: engaging pharmacies, primary care, and drug treatment centres with offering hepatitis C treatment. We have early signs in Scotland of falling hepatitis C prevalence among people who take drugs. Viremia is falling; chronic disease is declining, probably as a result of scaling up treatment. We will know probably in the next two to three years.



HOUSE OF COMMONS

What is critical for the investment in the scale-up of hepatitis C treatment is really good opioid substitution treatment and needle and syringe programme services, because they will be critical to minimising reinfection. Again, we can look at drug treatment services in terms of population harm. They can facilitate access to hepatitis C treatment. That is happening—I think it will only really happen in the next six months. They need to be able to think about what they are doing to reduce reinfection. If they do not, all that investment will start to rebound a bit. It looks very promising, and we have signs, but let's see in two to three years.

Yusef Azad: On the reinfection point, it may be being considered for change now, but to date NHS England's policy was not to re-treat someone with a DAA if they were reinfected having—

Chair: When you use an acronym, could you explain it?

Yusef Azad: I beg your pardon. Directing acting antivirals—the new hepatitis C treatment. If you are treated with the new hep C treatment and you are cured, if you then get reinfected, the current position is that you cannot access that new treatment again. That is something we are challenging, because historically there have been significant reinfection rates among gay and bisexual men with HIV who are coinfecting with hepatitis C. That is a policy change. If we really want to eliminate hep C transmission as a public health threat, we need to address reinfection in our policy.

The other concern, very briefly, is that we are getting anecdotal and some statistical evidence of a decline in blood-borne virus testing in needle and syringe programmes. That is a concern if we are to find people who have undiagnosed hep C.

Q136 **Chair:** Do you know why that is happening? Is that a commissioning issue—there isn't the funding to take it out?

Yusef Azad: We can only speculate, but the speculation is that in a situation where you have decreasing funds available, the needle and syringe programmes become predominantly community pharmacies where the packs are delivered. NICE recommends a three-level provision of NSPs in any local area. Level one is basic provision of a pack in a pharmacy, with no real discussion. At level two there is some discussion, and at level three, there is blood-borne virus testing and the whole package. The risk is, if you defund public health services, NSPs get thinned out, and those key public health interventions that need to accompany the provision of clean needles and syringes get lost—blood and virus testing might be one of them. Data shows that of the people who inject drugs who visited NSPs in 2017, only 59% were offered an HIV test.

Q137 **Chair:** It would be very useful to have that data. I would appreciate it if you shared that with us.

Yusef Azad: Of course.



Q138 Chair: On the issue of funding of services, Josie, you mentioned Naloxone provisions being centrally funded in Wales. I wonder if either Matt or Yusef want to comment on the commissioning arrangements. Do you agree that there should be a similar system to Wales, where is a separate clear funding stream for this kind of thing?

Yusef Azad: Do you mean for Naloxone or drugs services?

Chair: Naloxone.

Yusef Azad: There are definite advantages to having a national Naloxone programme, as Wales and Scotland have or have had. In Scotland, for example, it made a real difference in prison. I think that would be a desirable position to be in. Whether it is feasible, we do not know. In the absence of it, we need more central direction, good practice and monitoring from Public Health England to ensure that there is at least some consistency in Naloxone provision across the country.

Matthew Hickman: I would rather see drug and alcohol services and interventions in the NHS, where they would be under NICE and distributed. The take on Naloxone is that there is emerging evidence that it will avert overdose deaths, but it cannot be seen as a single intervention. It has got to be seen within the context of all the other interventions that prevent overdose deaths.

Q139 Chair: That is a debate that we have with a lot the inquiries that we hold about whether things are better provided in the community. We have heard in other inquiries that we have held—recently on sexual health services, for example—is that funding is the key issue rather than where services are provided. Do you think that you would actively prefer to see that return to being entirely NHS commissioning?

Matthew Hickman: Unless you can guarantee adequate resources, yes. There is a slight difference. Interestingly, sexual health services have taken the declining budget to innovate in a way that we have perhaps not been able to do with drug and alcohol services. Equally, we are not dealing with acute infections; we are dealing with chronic problems, and a population that you cannot diagnose and give an antibiotic to, and it is all cured. It is very different from sexual health services. Fundamentally, you have to have proper investment in the spine of opioid agonist treatment and all of the other add-ons—take-home Naloxone and needle and syringe programmes—at an adequate level that will make a difference to the population. We have not had that focus or that investment.

Q140 Chair: Josie or Yusef, do you have a view on whether it should return to the NHS or should the focus be on adequately funding something in the community because you want to reach out to people in communities?

Josie Smith: Certainly, if we are to move towards an approach where we recognise that drug use in an individual's life may be one element of their life and that there are many other issues that they wish and need to deal with as a priority for their health and welfare, we need very strong

partnership working with third-sector and community services, because the NHS alone cannot achieve that and is not expert in doing that.

Historically, there has been a focus on, “We’ll deal with one element of your life and another service will deal with another area of your life”. I would like to see a move to recognition that in an individual’s life at any one point, drug use might not be their priority. They undoubtedly, particularly if they are opioid users, need all that care—the OST, the Naloxone—but they need other care as well, which other services may be better able and suited to provide.

Certainly, NHS services need to ensure not only that OST is provided, but that it is provided in a very rapid and appropriate manner. Certainly historically we have had issues around NHS provision that has been less than rapid—waiting times, for example. We know that waiting times fail in their engagement with individuals who are ready to address their drug use at that particular time. I think there are pros and cons. Where it works well with the NHS, it is brilliant and we cannot do without them, but community-based services need to be there alongside.

Yusef Azad: The priority has to be appropriate and adequate funding and integrated and joined-up health and care services. We probably need to distinguish between provision and who commissions. It is quite possible for the NHS to commission but to commission community organisations and local providers of various kinds. I do not think we have a line other than the key outcomes that we need to secure.

On sexual health, one of the issues was that people simply did not want to go through again the disruption of reconfiguring once more the commissioning arrangements. That is an issue that will need to be thought about in terms of going back to bringing everything within the NHS.

Q141 **Diana Johnson:** I want to go back very briefly to the question about hepatitis C. Am I right in thinking that if a person goes to prison, there is automatic testing for hepatitis C?

Matthew Hickman: It is opt-out testing in most prisons.

Q142 **Diana Johnson:** That helps. Obviously, you have people there that you can then treat and that fits in with the target.

Matthew Hickman: Yes, prisons are an opportunity. Certainly, when we do infectious disease models, and we look at the role of prison, it is both a risk, primarily when people leave prison, because it can be chaotic, but equally, if you start scaling up hepatitis C treatment in prison, you will have a substantial impact on transmission in the population. I think that is happening. The difficulty is that people who inject drugs are not in prison for that long. You have to work out whether you can guarantee continuity of care if you are initiating treatment. Primarily, you have to be able to shorten the time between testing and starting treatment. In the old days, it was about four weeks. Now you could do it in a day. That is an initiation that is happening now. Once we have that, it will be an amazing opportunity.



HOUSE OF COMMONS

Chair: We can come on now to drug checking.

Q143 **Mr Bradshaw:** Yusef, you touched a little earlier on a successful model of harm reduction and a public health approach to drugs, when you talked about drug testing at festivals. Could you elaborate on that a little and tell the Committee how successful it has been, what the evidence base is for rolling it out more widely and what any potential barriers to doing that might be?

Yusef Azad: The Loop have organised drug checking at festivals over a number of years and got, as it were, letters of comfort from local police forces that there would not be any law enforcement in relation to people going to these services. The person provides a small amount of the relevant drug and it is tested. The drug isn't given back, so there is no issue around supply, but the result is provided. Similarly, Addaction has just started a year-long pilot in Weston-super-Mare, where anyone can bring drugs to be tested.

They exist in a number of western European countries. Among their advantages is not only that there is evidence that if people get adverse information around adulterance to the drug, 25% to 100% of people do not take that drug, but that it is very effective as an early warning system to the public health system about particular batches of drugs and the dangers they might pose to the wider public who might take them. There was an example in the Netherlands and Belgium where drug checking identified a dangerous adulterant in a particular pill—it was called the Superman pill—and public health messages then went out. We did not have that drug checking at the time in England, and four young people died. So there is an individual benefit from drug checking but there is also a public health system benefit. There is no evidence either that drug checking increases use of drugs, either, which is a very important point.

Q144 **Mr Bradshaw:** Loop is a charity, is it, doing all this off its own bat?

Yusef Azad: It has a lot of volunteers.

Q145 **Mr Bradshaw:** Is it at every festival?

Yusef Azad: No, I'm sure it is not at every festival. I do not know the details of how many festivals it is at.

Q146 **Mr Bradshaw:** It is not in non-festival venues such as clubs or all over the place—

Josie Smith: We in Wales run a UK-wide drug-testing service called WEDINOS, which means "after dark" in Welsh. That is a very different but complementary system. It is a web-based system where we engage with individuals who perhaps have used a substance and experienced adverse effects from taking it. They submit a self-report effects sheet along with a sample of the substance and we profile that substance in our laboratory in Llandough. We then publish the profile of that drug. For example, if a substance has been submitted as MDMA, it may contain other substances.

Q147 **Mr Bradshaw:** But that is after the event?



HOUSE OF COMMONS

Josie Smith: It is after the event. In addition to individual submissions, we also receive samples from amnesty bins, right across from festivals to all of the prisons in Wales, where they are not tied to an individual. We only test samples with no evidentiary value.

Q148 **Mr Bradshaw:** In terms of the harm reduction that Yusef referred to, avoiding four unnecessary deaths, the only restriction on that being more comprehensive is—what, funding capacity? The police are turning a blind eye, you say, for good reason.

Yusef Azad: The Home Office attitude to drug checking has changed from being hostile and suspicious to now being supportive, in effect. A lot of chief police officers and police and crime commissioners are similarly so. There were letters of comfort in the case of the Loop, as it were—

Q149 **Mr Bradshaw:** What is a letter of comfort?

Yusef Azad: It is effectively a commitment from the police force that, for example, they will not have police officers around the entrance to the drug checking to check people for possession. Would there be an attempt to claim that drug checking or testing was in some way a breach of the Misuse of Drugs Act? I do not think it is, but possibly someone could try and make that case. That would obviously worry employees and so on. Addaction was concerned to get a licence from the Home Office to put its employees beyond any risk of prosecution.

Q150 **Mr Bradshaw:** So you collectively think that it would be a very good idea if this was spread out?

Yusef Azad: Yes, absolutely.

Q151 **Mr Bradshaw:** May I move on to drug consumption rooms? We seem to have a completely different problem there, in that there do seem to be real barriers. You referred to them earlier as legal barriers, although in the preliminary meeting before the public evidence session we were told by our expert adviser that this is contested. There are some organisations that do not believe there are any legal barriers, including in Scotland, to local services initiating drug consumption rooms. Let us have a bit of a conversation about that.

Yusef Azad: In Scotland, as I mentioned previously, where there is a strong push to have a DCR—drug consumption room—in Glasgow, the Lord Advocate gave an opinion where his view was that it was a breach of section 8 of the Misuse of Drugs Act, which relates to owners and managers of premises not allowing the preparation of particular drugs to happen on the premises. What probably is needed is either a similar kind of de facto act by police forces and, indeed, the Home Office, saying “We are not going to engage and prompt the CPS to prosecute people in these circumstances”, or, ideally, a change to primary legislation. Changes to primary legislation, as you know, take some time so, more immediately, if there were some kind of comfort given to try out a drug consumption room—for example in Glasgow, where there is such an urgent need—that would be a very positive step forward.



HOUSE OF COMMONS

Q152 Mr Bradshaw: It is interesting you say that because my local police have been saying for years that they would really like this in Exeter. They think it could really help address some of the drug-related problems we are seeing blighting many of our towns and cities. Why can't the police just do this and see what happens? Do you think they are nervous of being vulnerable to legal challenge?

Yusef Azad: It is perplexing. As you say, a lot of the push for it is now coming from law enforcement services, but I think there is a lot of opposition within the Home Office. We wrote, alongside parliamentarians, to Home Office and Department of Health Ministers; we can share the correspondence with you.

Q153 Mr Bradshaw: That would be very helpful. In summary, what is the justification from the Home Office?

Yusef Azad: Victoria Atkins, who is the Minister we wrote to in the Home Office, said "We are not prepared to sanction or condone activity that promotes the illicit drug trade and the harms that trade causes to individuals and communities", which strikes at the heart of harm reduction itself. Of course, our point is that DCRs, far from promoting the harms of the drugs trade, mitigate and prevent them.

Interestingly, the response we got from Seema Kennedy at the Department of Health was very different in content and tone: "Whilst there is international evidence that drug consumption rooms can be effective at addressing problems of public nuisance and reducing health risks, there is a risk such facilities would be at the expense of other, more relevant evidence-based drugs services." It is good that there is acceptance of the evidence of its efficacy. Drug consumption rooms are not appropriate for all parts of the country. They are very specific interventions to deal with a localised problem of unsafe public injecting.

Q154 Mr Bradshaw: The international evidence shows they work.

Yusef Azad: Very strongly.

Q155 Mr Bradshaw: Are we having a Home Office Minister before this Committee? I can't remember.

You bring me on to my final point, which is a broader political point. I have a couple of questions I would like to ask all of you. Do you think that a criminal justice approach to drugs, in general, is a barrier to a proper public health harm-reduction approach? A simple yes or no will do.

Matthew Hickman: Yes.

Q156 Mr Bradshaw: What is your view, then—we will be going on as a Committee to look at these—of different models of decriminalisation, divergence, depenalisation? We are told by our expert advisers that the evidence around the world suggests that where this has happened there is no evidence of increased drugs use but significant evidence of good being done in terms of public health and harm reduction. Is that an assessment that you would all share?



Matthew Hickman: There has been no trial. You have got good observational evidence that, when policies have changed, there has been more benefit than harm, but the notion that you can then say, "This is definitive", is difficult. We want drug policy to be subject to the same as other public health policies that we should be trialling and evaluating. It is a shame that many policies have been enacted without that same evaluation. The critical thing about our drug policy is that the criminalisation has not been subject to any trial and has no evidence for its effectiveness whatsoever, so with adopting a public health approach we still have to make sure we strengthen the evidence.

Josie Smith: The experience from Portugal and elsewhere recognises that decriminalisation in and of itself is not—it is part of the picture. There was huge investment and a sea change in the provision of medical and health-based support and really high quality support. You need to take it in the round.

Q157 **Mr Bradshaw:** Arguably, if you are not spending a lot of money doing a criminal justice approach, you could use that money—

Josie Smith: It would be a move of resources, absolutely.

Yusef Azad: I agree with Matt that further trials and research are needed to work out the best way, but, as you said, we can at least say that where decriminalisation has occurred, there has not been the significant uplift in drug use that some people worried about and feared. As Josie said, decriminalisation is a key part of a holistic public health intervention, which also requires investment in other harm reduction interventions. The harms, in terms of criminal records, incarceration, barriers to harm reduction such as drug consumption rooms, and diversion of scarce public funds from health promotion into unnecessary law enforcement, are all reasons why criminalisation does not make sense from a public health point of view.

Q158 **Mr Bradshaw:** Matthew, can I come back to what you said about trials? We have this dilemma with medicinal cannabis, which is another issue we are looking at. How could you have a randomised controlled trial of a decriminalisation approach when you have to do it on a societal basis? How do you do that? Do you take people off to a desert island?

Matthew Hickman: Well, you could randomise the UK. I am being glib; you cannot do that, but you can do—

Q159 **Mr Bradshaw:** It is an observational trial.

Matthew Hickman: It is, but you can develop much better natural experiments, whereby you start collecting data prior to the change, then you have the change, and then you have control areas—some other countries or sites where there are different regulatory frameworks—and look at what happens there. It is sort of like what North America—some of the US states—should have done about cannabis. Now they are doing catch-up and saying, "What has happened about cannabis use and the population harms?"



HOUSE OF COMMONS

If we were going to do this deliberately, we would start making sure we had the longitudinal data sets now, in order to start to evaluate and define our outcomes and say, "What are we going to measure it on?" The work on Portugal was done retrospectively. It is very convincing, but it could have been much better if they had collected contemporaneous data and data prior to the intervention. That is what I mean by trial. It does not have to be randomised; it can still be controlled.

Q160 **Chair:** Just to clarify, are we collecting the data we need to be collecting now in order, if there is a policy change, to—

Matthew Hickman: Certainly on overdose, and certainly on infections. If you really wanted, we could spend another whole hour on why we do not have the right estimate of the number of injecting drug users in the population. There are some problems with the data around the size of the population, but all those could be resolved.

Q161 **Chair:** It would be helpful if you sent us some detail about what we should be collecting now, so that we have that in order to be able to evaluate it properly.

Matthew Hickman: It is sort of like what Scotland is doing with the change in alcohol policy. They are setting up those statistics and trends in A&E and through mortality data and morbidity data so they can see whether, following a sudden change in the minimum price, they see a change in the harms. We can do the same for drug policy.

Q162 **Mr Bradshaw:** You may know that Stephen Bush, who is a political commentator, wrote in *The Observer* on Sunday, in the context of the current fuss over the Tory leadership campaign: "The overwhelming evidence from around the democratic world is that countries which have legalised drugs have seen numbers of drug deaths fall and have taken billions out of the criminal economy. The UK, meanwhile, has enriched violent crooks and established itself as the market leader in drug-related deaths." That is not an inaccurate statement, is it?

Matthew Hickman: It is not the market leader in drug-related deaths. That is North America.

Q163 **Mr Bradshaw:** Right, okay. Finally, what is your view of the current classification of drugs in this country, in the context of what we have just been talking about?

Josie Smith: In relation to individuals who are using drugs?

Q164 **Mr Bradshaw:** No, in relation to policy and the message that the classification system sends. I will tell you why I am asking this question. Another article in *The Economist* this week highlights the fact that the American Food and Drug Administration has given psilocybin, which is the substance in magic mushrooms, breakthrough status for prescribing approval because of its effectiveness as a treatment for depression, anxiety, addiction, OCD and other things. Apparently, the main bit of that research is being done at Imperial College in London. I was completely unaware of that. Magic mushrooms are right at the bottom of the league



HOUSE OF COMMONS

table of harms. They cause a tiny fraction of the harm caused by alcohol, tobacco and many other illicit drugs, yet they are a class A drug. That is absolutely ridiculous, isn't it?

Matthew Hickman: Yes.

Yusef Azad: Yes.

Mr Bradshaw: It is? Good. Excellent.

Matthew Hickman: I was on the ACMD and my first meeting was regrading magic mushrooms as class A, solely because chemically it was like LSD. And because the committee never downgraded a drug or took a drug off, it just had to be the same—if it is pharmacologically the same, it should get the same grade. It is absurd.

Q165 **Mr Bradshaw:** Are there any other absurdities in the classification?

Matthew Hickman: MDMA should not be class A. That is also being used for treatment-resistant depression and PTSD.

Josie Smith: Very effectively.

Matthew Hickman: But just because a drug can be used therapeutically, that does not mean it should not be banned.

Q166 **Mr Bradshaw:** Why are we still putting out this nonsense in terms of public health messages to young people?

Josie Smith: You say "we".

Q167 **Mr Bradshaw:** We politicians—it is our fault.

Matthew Hickman: Yes.

Mr Bradshaw: So it is the politicians' fault?

Matthew Hickman: Yes.

Mr Bradshaw: Great. End of questioning.

Q168 **Chair:** I wonder whether there are any points you wanted to make to the Committee today that you have not been asked.

Josie Smith: I would like to make a point, touching on the reference I made to drug checking. You are absolutely right that, because it is retrospective, it does not have a direct and acute harm reduction effect. However, it does provide really valuable harm reduction evidence and advice for a range of people. Because it is web-based, people can have a look at the substances. To date, since 2013 we have been able to identify 345 different samples and we have reported 13 as new substances within the UK, both to the early-warning system in Europe and to the UK-wide one.

There is incredible value in drug checking to report on trends. The report is out at the end of this month, but we have seen in the past year a substantial increase in benzodiazepines. They are the largest group, for



HOUSE OF COMMONS

the second year that we have reported. Most worryingly, of those samples that we have tested, even in blister packs, they did not contain what was stated on the packaging. I firmly believe that we need to be very mindful not just of the opioids—although clearly of the opioids—but of a move away from perhaps those drugs that have been more recently controlled.

We know that cocaine, MDMA and ketamine are right up there in terms of prevalence of use, but we are seeing increasing use of benzodiazepines and other non-prescribed prescription medicines. I really urge caution and the development of appropriate harm reduction services to address perhaps the development of dependency on both prescribed medicines and non-prescribed prescription medicines.

Q169 **Chair:** Thank you very much. Was there anything you wanted to add, Yusef?

Yusef Azad: Just to re-emphasise the point that a key harm reduction intervention is the provision of OST. There have been concerns from the Advisory Council on the Misuse of Drugs about under-dosing. A high proportion of drug-related deaths are of people not in treatment, so we really need to increase the proportion of people who are in treatment by low threshold and acceptable services. In terms of the disbenefits of criminalisation, the other thing we must acknowledge is that it has a disproportionate impact on people from poorer socioeconomic groups and people from black and minority ethnic communities. We need to bear that in mind in terms of the downside.

Q170 **Chair:** Thank you. We are going to explore treatment options further with our next panel, but thank you for bringing that in.

Matthew Hickman: I will read what we have said and also the next panel, and then I can provide more information, or correct what I have said wrong.

Chair: Thank you very much.

Examination of witnesses

Witnesses: Dr Arun Dhandayudham, Danny Hames, Peter Yarwood and Professor Sir John Strang.

Q171 **Chair:** Thank you very much to our second panel. Yasmin Batliwala was not able to join us, so we are very grateful to you, Dr Dhandayudham for standing in at short notice—it is very kind of you. Could you start by introducing yourselves and telling us who you represent? Let's start with Professor Sir John Strang.

Professor Sir John Strang: I am John Strang. By background, I am a medic who became much more involved with university work on research and policy in the addictions field. I have been marinated in the addictions field for about 35 to 40 years now. I head the National Addiction Centre research group in King's College London.



HOUSE OF COMMONS

Peter Yarwood: I am Peter Yarwood, executive officer for Red Rose Recovery, which is a small charity in Lancashire that aims to create opportunities for people who have come through services of the criminal justice sector and substance misuse. I am the engagement lead, and I would say a driving force, for the Lancashire User Forum, for people who have experienced being on the receiving end of those services, as I have. I entered the criminal justice system as a 15-year-old child and spent the next 20 years using those services.

Dr Dhandayudham: I am Arun Dhandayudham, a consultant in addiction psychiatry. I work both in the NHS and in the third sector. I am a frontline clinician at Passmores House, a detox and rehab unit in Harlow. In my spare time, I am also the joint chief executive and medical director of WDP, which provides substance misuse treatment across large parts of London and Cheshire West. We do community treatment and in-patient detox treatment, and we have service provision in prisons. We also do interesting things with contingency management with the capital card.

Danny Hames: I am Danny Hames. My day job is head of inclusion, as part of the Midlands Partnership NHS Foundation Trust. We are one of the largest NHS providers of drug and alcohol treatment services across the country, in community and prisons. I am here representing the NHS Substance Misuse Provider Alliance, which is a collaboration of 15 NHS trusts that provide drug and alcohol treatment services in prisons and in the community across England. My background is that I have worked as a practitioner in drug and alcohol treatment services and as a manager of services in various locations around the country. Now, I am fortunate to have the role of head of inclusion.

Chair: Thank you all for coming. We will start off with treatment.

Q172 **Angela Crawley:** What treatments for drug addiction are the most effective in your opinion? Let's start with Professor Strang.

Professor Sir John Strang: I think it is useful to look at addiction problems that people have by the different types or classes of drugs that are there. An early distinction that needs to be made is between emergency management of crises and the treatment of someone's long-standing addiction problem, in that you have completely different of interventions. You heard earlier about Naloxone interventions with overdoses; those do not address long-term addiction problems, but they are crucial and lifesaving interventions for the emergency. You heard about the treatment of coinfections—HIV or hep C.

When you look at the drug-using population, there will be a section who have become dependent on those drugs. That is your main treatment group. First of all, as with alcohol, there will be a population using where dependence-related treatments are not applicable, but there is a population where they are hugely applicable. In that field, the strongest evidence with the illicit drugs is around heroin addiction or opiate addiction, with opiate substitution treatment—methadone or buprenorphine maintenance treatment are the two main types. There is a



HOUSE OF COMMONS

strong and well-recognised international evidence base, particularly generated by the US over the last 50 years or so.

Q173 Angela Crawley: You mentioned an example of evidence-based approaches to heroin. To what extent are the current drug treatment services evidence-based, and what barriers are there to delivering evidence-based treatment, in your opinion?

Professor Sir John Strang: The documentation that we have in the UK, both at a Government policy level and a Department of Health level, looks quite good and encouraging, in that for many decades now we have identified how crucial it is to have good quality opiates. There are various different acronyms. There is OST, which is opiate substitution treatment, or there is maintenance treatment—they are all essentially the same, though the acronyms go in and out of fashion.

Unfortunately, the reality of our provision is that a lot of the opiate substitution treatment we provide would be regarded as quite low quality on a number of measures. Some of them are very practical, concrete measures, such as whether the two main medications, methadone and buprenorphine, are prescribed in the dosage range that is regarded as optimal; whether there is then the proper monitoring and support, to check that you get a good adherence to it; or whether there is the psychosocial support and counselling that increases the engagement and the benefit. On all three of those, the picture is much worse.

Most of the prescribing that we do is probably below the bottom end of the recommended dose window. There is a diminishing investment in helping to make sure that people get engaged with the treatment. As with any treatment, whether it is treatment for hypertension, contraceptive pill or any of these things, if you are not in a routine of taking it regularly you are not going to get the benefit from it. We have a lot of low-dose prescribing.

Mindful of the questions you had earlier, it is fair to say that some of that is driven by misguided targets that are given to treatment agencies through the commissioning process, where there is an effort to get people off their medication at the earliest opportunity, whereas, from a health point of view, what we should be doing is individualising people's treatment. Of course we would not want people staying on treatment at a time when they can safely come off it, but we need to be aware that coming off the treatment prematurely carries major risks. It carries overdose risks or infection risks if you relapse and you are injecting.

Q174 Angela Crawley: Peter, Danny or Dr Arun, would you like to add to that?

Dr Dhandayudham: First, the good thing, I suppose, is that we have very sensible guidelines in the UK. We are all led by the orange book. There is robust guidance out there about what constitutes good practice. We are holistic; we are recovery-focused. As John said, though, in terms of barriers, our key performance indicators are weighted, in a sense, against what the clinical evidence would say. We know people do well when they are in contact with the treatment system: they do not die.



HOUSE OF COMMONS

However, our performance indicators say that you need to exit people out of treatment, or we will penalise you by payment by results and your funding can get taken away.

Our funding is also being reduced year on year, against a background where the costs of providing these services have increased. The prices of our key medications—in OST, as John mentioned, we have got two main drugs. The price of one of them has increased close to 500% to 600%. That is something that treatment services cannot afford.

We are also hit with two other additional double whammies. The complexity of care that we now provide was unimaginable 10 years ago. We are being hit with an ageing cohort of patients, which comes with a range of illicit drug use and prescribed medications. Their physical health status is declining, because of years of smoking, hypertension, diabetes and obesity. They are getting old-age illnesses in their brain—alcohol-related brain damage, dementias, loneliness and anxiety.

That comes on the back of a workforce with steadily decreasing skills. When I started in addiction about 10 or 15 years ago, there was a strong pool of doctors and nurses supported by a wraparound team. Those consultants and addiction psychiatrists have vanished and been replaced by what you call lead clinicians. The lead clinicians have vanished and been replaced by staff grade doctors, who call lead clinicians. Those staff grade doctors have disappeared and been replaced by nurse medical prescribers.

Chair: We're going to come on very specifically to look at the workforce issues around this later.

Dr Dhandayudham: We have a problem recruiting staff. We have a problem with staff having the right skills. We have a problem keeping staff in the sector, because of a high burnout rate. It is a very stressful sector to be working in. All of these factors constitute difficulties in providing what is actually sensible care.

Peter Yarwood: I think there is a bit of disconnect between the services and the communities they serve in some cases. I come up against service users quite a lot. The first thing they want to celebrate is the fact that they are coming down the table in their medication—they are getting off it. When I ask them, "Have you managed to secure decent accommodation yet?", the answer is often, "No, I am still in supported accommodation." When I ask, "Have you secured employment yet?", the answer is, "No, I am not employed. I'm still claiming benefits." Recovery and social capital is in no way aligned to this drive to exit treatment. Where it has worked well, some of the resources have been ploughed into bringing the service users and the community with us on this journey.

Q175 **Angela Crawley:** That is a really good point. Just moving on slightly—I am conscious that Danny will want to come in as well—where do you think the balance between substitute prescribing and abstinence-based recovery should lie?



Danny Hames: To track back, one of the most damaging narratives that has occurred in the drug treatment sector has been this quite polarising debate between abstinence and harm reduction. In terms of that question, the balance is defined by the individuals who we are working with.

To track back to the previous question, we have the guidelines and, predominantly, we have the evidence that says, "If you provide a system this way, it will function well and will give most people the best chance of achieving what they can." For some people that will be abstinence, for some people that will be different improvements, but their life will improve.

The balance needs to be defined by how we construct and commission our system. The way that we commission services currently—not just drug and alcohol services, but services across a range of other disciplines, including criminal justice—all causes fragmentation. When you get to the point of delivery of a service, it means providing a service that is integrated, so you provide a service to the end user that provides good quality pharmacological interventions and psychosocial interventions, and then wraps good, social recovery-focused intervention and peer support around that. That is what really defines where people get to.

Q176 **Angela Crawley:** My last question is specifically on opioid substitution therapy and whether it is currently adequately provided. Professor Strang, you referred earlier to the low quality and the maintenance. Is there anything else you would like to add to that point?

Professor Sir John Strang: Yes, it is probably worth pointing out that they are not particularly opinions that I have got; I am factually telling you what the records say has happened. The amount of opiate substitution prescribed over the last 10 years has reduced by about a third, while we are told that the treatment population, or the number of people deemed to be requiring the treatment, has remained constant. Those two observations need to be brought together.

There has definitely been, from one point of view, a well-intentioned wish to encourage people not to stay in treatment if treatment is not necessary. That would be something that is pretty universal to medical practice in general. You don't want somebody to be on treatment if they don't need to be on treatment. However, it has been made toxic by the fact that it has been wrapped into performance targets with competitive tendering. You win your competitive tendering exercise by giving a commitment that you will exit people from treatment with a higher rate than a different organisation. That leads to the wrong sort of work in people getting out of treatment. We need to realise that coming out of this treatment is not neutral. Coming out of this treatment, when you should still be in it, has real hazards.

This is where a health orientation is quite a comfortable territory to understand these issues. There are many examples in healthcare—it is not even worth going through them—where you would not want to be giving



HOUSE OF COMMONS

the chemotherapy any longer than is needed, but you do not want to cut it off any shorter than it needs to be. It is a difficult judgment.

Professor Hickman was referring earlier to the study of GP prescribing where there are healthy datasets through CPRD data. The disturbingly short duration of opiate substitution treatment means you have the destabilised bit at the beginning and the destabilised bit at the end, with people recycling through it, and that is a hazardous way of providing it. You were quite rightly talking about the lack of ancillary support and the lack of attention to housing. Dame Carol Black's report from a couple of years ago said what you would want within treatment is to be able to prescribe employment opportunities and other things that are essential components of what you would give somebody as part of getting back into it. That is almost non-existent.

Danny Hames: To be slightly positive, part of my role is that I am quite involved in a lot of the tendering of services. I have five or six years' experience of seeing drug and alcohol tenders. What we are starting to see now is a trend away from it being very much about successful completions recovery. It is now starting to filter into the system that that is not a helpful barometer and it does not actually help service users. That is positive. It illustrates that we have had to get so far down the line, so many years on, and we have had the perverse consequences of what was probably a well-intentioned decision. Only now are we starting at a local level for commissioners to start to say, "We can commission in a different way." There is significant damage because of that.

Q177 **Chair:** Can I just clarify? Arun, you were saying that funding is being taken away if people are not exiting treatment. Is that happening all around the country or, Danny, is it your experience that there is a great deal of variation with changes, with people recognising that the evidence base is completely the opposite?

Danny Hames: In terms of using payment by results as a measurement, there was a push towards that probably two or three years ago. It is proven generally not to be successful and, actually, if you look at the trend in terms of successful completions for opiates, I am not saying it is direct correlation but that trend has been down anyway. In terms of PBR as an approach, we are starting to see that much less.

Q178 **Chair:** We are starting to see it. Does that mean that some areas have abandoned it and some areas have not?

Danny Hames: You have such variety across the country, with such different commissioning cycles, you can only really see the general trends.

Q179 **Chair:** You cannot stop it halfway through a commissioning cycle? You cannot say, "Look, there is no evidence for this. It is actually actively leading to more people dying." In most treatments, if you could see there was evidence that people were dying as a result of your policy, you would stop prescribing the medicine, but we are still prescribing something that is actively harming people.



HOUSE OF COMMONS

Danny Hames: You can theoretically, in terms of contractual arrangements, but I have never experienced that.

Q180 **Chair:** Why isn't somebody taking responsibility for saying there is clearly evidence? Everyone seems to be agreed that this is killing people, so why isn't somebody doing something now, to say we have got to abandon this?

Danny Hames: I don't know; it is a good question.

Q181 **Chair:** Who would be directing that you should continue?

Danny Hames: Because of the way the system is commissioned, as you know at the moment we have local authorities with public health teams, within local authorities commissioning separately. You see great variation in the influence of public health within a local authority, and where a director of public health will sit and thereby influence that area.

First, you have that. Then Public Health England has worked hard to try to influence local authorities in the system. For instance, the current opiate substitution therapy and best practice programme is an attempt by them to say, "This is best practice in terms of prescribing", to influence local authorities. The issue is that you have no direct leverage between the centre, if I can put it that way, that says, "This is best practice; this is the way we should administer it," and the local authorities, who we know are under extreme stress in terms of their budgets.

Q182 **Chair:** Is it not extraordinary that nobody disagrees that this approach is actually killing people? I am trying to see if there is a consensus here about who could step in and say, "This is a harmful approach. It is killing people. Therefore, we stop doing it immediately."

Danny Hames: I do think it is extraordinary. I think it is the role that an organisation like the National Treatment Agency for Substance Misuse would have been able to influence and take on. Without that specialist arms-length agency, we lack that direct influence.

Chair: It is the lack of that direct—

Danny Hames: That would be my opinion.

Q183 **Chair:** What do you feel, Professor Strang?

Professor Sir John Strang: It was an unfortunate move of the commissioning of services outside the health arena, because it means that, for example, reference sources, like evidence from NICE, do not carry the same weight with a local authority that they would carry with the health commissioner.

Q184 **Chair:** But we have directors of public health and we have Public Health England. Should there not be an immediate response, as would we expect, for example, if we knew there was a direct harm from a drug being prescribed? There would be a directive to say that you must stop using this treatment. Should that come from Public Health England? Who should be issuing that directive that this is immediately reviewed?



Professor Sir John Strang: I am not sure who should be issuing it, so I am not sure what the answer is, but I think it is the right question. There should be somebody with both the responsibility for it and the ability to issue that statement.

When I have had similar conversations about various issues with Public Health England, their response is that these decisions are devolved to a local level and local decision makers take those decisions. My own view is along the lines of what you are saying; there are some points that are not matters of opinion—whether somebody likes the mix of this or that within the treatment—but are evidence that we wish to implement. I think it would be very good if there were ways in which you could require there to be a process, whereby those sorts of decisions could be made centrally, then the decisions about implementation are of course local.

Picking up on some of your questions earlier about drug testing in festivals, I think it is important you understand how stripped down treatment services are. Treatment services around the country do not have drug testing. Quite apart from an additional service to people attending festivals, you do not have a surveillance system within your treatment system of whether your patient is doing well or is slipping back into drug use. Colleagues will probably be able to give answers, but drug testing is very infrequent and that is one of the other short-sighted ways of saving on a budget when you are trying to put in the most competitive price.

Q185 **Chair:** Just to clarify, when you are talking about that, you are talking about testing whether people are still using drugs in addition—you are not talking about people bringing in their own supply of drugs and saying, “Is this what it says on the tin?”?

Professor Sir John Strang: Gosh, I was not talking about anything as ambitious as that. If somebody comes in and says, “I’ve got a major heroin problem; I need help getting to grips with this because I want to get out of it.”, there are two things you want to know. You want to know that they are taking the medication you are prescribing—that is one way—and you want to know whether there is anything else in their urine sample that should not be there.

It acquired a bad reputation because treatment services mistakenly used it punitively to throw people out of treatment years ago. It should be used in the same way that you would check with your diabetic whether they have sugar in their urine, or a million and one other examples where you would be able to say to somebody, “We’ve got a problem here. How do we alter what we are doing? We are not achieving what we are meant to achieve.” To do that without the laboratory back-up is possible, but it means you are working as a clinician with one hand tied behind your back.

The objective, rather than wanting people to exit treatment, is that you want them to exit the street drug use that they were involved with, so you would want to be sure that they were not showing heroin in their urine, for



HOUSE OF COMMONS

example, and if they were then tapering off to reduce, that would be good news, provided you still had the negative urine specimen.

Q186 Dr Williams: I just want to check what you are saying here: that the tendering out of services means that providers are putting in bids that are more competitive, but because of the whole process—it is not that it is their preferred model—they are putting in bids and winning contracts with services that are much lower quality than they should be, and are not following the best evidence-based management regimes for patients or clients.

Professor Sir John Strang: I would have thought that it is a sufficiently important issue that you might want to ask, through various channels, for people to provide you with that evidence, rather than my giving you the view that I have, which is obviously skewed by the colleagues I have spoken to who have described different situations. The reduction in the funding of services is public information and would be quite easy to collect, and I think would show that it has reduced by about one third.

Danny Hames: It is 28%.

Professor Sir John Strang: It is 28%, so I am exaggerating when I say one third, but not by much. You also want to look at whether there are aspects that clinically you would have thought were critical that are now only used infrequently. You would have to make a decision on how frequently urine testing should be done. Should it be every fortnight, perhaps? I am not sure, but that could be provided to you.

Q187 Dr Williams: And this reduction in quality of services has happened at the same time that drug-related deaths have increased?

Professor Sir John Strang: Yes; Professor Hickman referred to an editorial that we have coming out in the *Lancet Psychiatry*, which points out that the timings coincide.

Q188 Dr Williams: There is a temporal association; is there any suggestion that one has caused the other?

Professor Sir John Strang: Well, we can tell you that the timings look very similar. If you were stripping out those elements from the service and if services were becoming over-preoccupied with getting people off their books, your worry would be that you were placing people back in a vulnerable situation again, with relapses and overdose deaths. Those are precisely what you would worry might occur.

Q189 Dr Williams: Do you think that the cuts have caused an increase in deaths?

Professor Sir John Strang: I think it is disappointing that it is not one of the considerations of possible causes which include an ageing cohort. A number of us have made the point before that the cohort is only ageing by one year per year. It is not that the cohort gets suddenly old. It does not account for rapid changes.

Q190 **Dr Williams:** Do you think the cuts are causing the deaths?

Professor Sir John Strang: I think that should be considered much more actively as a cause. You could look at what happens in parts of the country where that has been moved faster or less. I am not aware of that having been examined.

Q191 **Diana Johnson:** I want to follow up on the issue of commissioning. We have talked about cuts to the budget, but it seems to me from what has been said that there is an issue around the quality of the commissioning that has taken place. I wondered, Professor Strang, is it that you think that because it is a local authority function they do not have the expertise or knowledge that you would find if it was being commissioned in the NHS? Is that what you are saying to us? There isn't that within local authority commissioning units?

Professor Sir John Strang: There are probably two aspects. One is whether a local authority group or a public health group or a health group would be a better commissioner. I think it depends very much on who you have in your local area. There are some excellent local commissioners.

I am more struck by the point that the Chairman is making. Would you not expect a system where there was much more given instruction from the centre about what it was that was to be commissioned? At the moment, it is more open than it ought to be about what should be commissioned. If you said: "We think that for an area with your population and your level of deprivation, we assume you would have treatment capacity for so many hundreds" then, of course, you adjust that according to what you have as your local problem.

Q192 **Diana Johnson:** So you don't think there is a particular issue around quality of commissioning?

Professor Sir John Strang: I think there are major weaknesses in the quality of commissioning. The point I was making is that is not universal. There are some very good commissioners, but some very poor decisions are made.

Q193 **Diana Johnson:** And the way you get round that is doing much more from the centre, telling people what they should or should not do?

Professor Sir John Strang: It is disappointing because, as I said at the very beginning, that the documentation and structure that we have are fairly good. Several of us have referred to the orange guidelines, and such. It is a weighty document which I shall leave behind with you. There is only a small number of collector's item hard copies, so I shall leave one with you.

They are aimed at practitioners. They do not do original research. Essentially, it says: "Here is the consensus of what guidance and research documents from around the world have said applied to a UK setting". It is the implementation of those consensus guidelines documents that seems to go badly wrong in that final stage of the commissioning. I do not know whether my colleagues differ.



HOUSE OF COMMONS

Q194 **Chair:** Can I just clarify one point? Within the orange book, does it refer to the evidence base about not having abstinence, getting people exiting from treatment, programmes? What does it say about that in the orange book?

Professor Sir John Strang: I would have to check if you wish to know exact chapter and verse. It says there should not be fixed time limits on treatment.

Q195 **Chair:** Right, so it is quite clear in the orange book, but local areas have the—

Professor Sir John Strang: And the optimal dosing is quite clear in the book and the attention to helping somebody get established into a pattern of good adherence to their medication. They are all described at length.

Q196 **Chair:** Obviously, another area that has come up is the role of heroin-assisted treatment. Which of the panel would like to talk about heroin-assisted treatment and the role of that in the mix? Would any of you like to talk about that in particular?

Professor Sir John Strang: I do not wish to hog it. Earlier, Ben Bradshaw asked, "Do you have randomised trials of things?" We actually have a randomised trial of heroin-assisted treatment that we did in this country. Just to be clear, I think this is a really small element of the treatment commissioning that is required. It is not a major aspect of provision. It is for the most severely entrenched heroin addicts where everything else has been tried many times and there seems to be no traction on their problem. The Swiss took the old British system of pretty unregulated heroin prescribing and tightened it up into a very supervised form of treatment, and that has become the model for what half a dozen countries around the world have now done trials on.

The conclusion is that for this small group, if you are willing to invest the greater intensity of services and the costs that go with that, you can turn things around for about two thirds to three quarters of them, so that they move away from their entrenched street heroin use and begin a much healthier recovery journey. That treatment cost is three to four times the ordinary treatment cost, but it is actually a cost-effective approach compared with not doing it, which is even more expensive.

We can send various papers documenting it. I say the documentation is good; the Government's drug strategy report of 2010 or 2009—I cannot remember which it was—concluded that if the trials found positive results, there should be commitment to a small capacity for this, which is a bit like intensive care in the community. That was there in the document, and the Department of Health then commissioned a small number of such clinics, until about four years ago, when, with the next wave of reduced funding, it was devolved to a local decision-making level. Local decision makers were told, "You have to make a cut and you also now have to make the decision about whether you keep this expensive treatment in your locality," and all three of the pilot clinics that had been set up were casualties of that move.



Q197 **Chair:** Even though there is a good evidence base and it is cost-effective, they have discontinued that, yet there are other treatments that we know are harmful, other approaches that are harmful, that we are continuing with—extraordinary.

Professor Sir John Strang: Yes, and the papers around the world are about as good evidence as you could imagine. They are well designed studies. They are published in *The Lancet*, *The BMJ* and *The New England Journal of Medicine*. They are not in the South London Chronicle—I say that; I don't know whether there is a South London Chronicle. There are also cost-effectiveness analyses. But it involves a different mindset: you want your commissioner to say, "We don't think that is our main treatment provision, but for four in 100"—or whatever the calculation was—"we realise we will need that intensive treatment and we hope that then we can make progress with them and move them back into more orthodox treatment."

Q198 **Diana Johnson:** Can we just ask where the three pilots that you mentioned were?

Professor Sir John Strang: One was in south London; one was in Darlington; and the other was in Brighton. And one is expected to be opening in Glasgow, probably later this year.

Q199 **Chair:** Thank you for that. Another area that it would be helpful to have your thoughts on is the place of detox and residential treatments—where they fit into the pattern. Do any of you want to speak about that at all?

Dr Dhandayudham: It is an intervention that, again, benefits a subset of our population. As the expertise in community services has declined, people now need to go in for an in-patient detox to get their treatment effectively. They need to come off alcohol and drugs, and actually this can be life-saving for them. Of course, it carries a lot of risk and it is expensive. As community funding is reduced, there is a challenge around the number of people that community services can afford to send into these units. They cannot send through all the people they want to send through.

The number of units has actually declined significantly. There is now no NHS detox unit within the M25 area. We only had two in the London area: Equinox and City Roads. City Roads just closed. We have Equinox and Passmores in Harlow doing the detoxes. Again, the clients are very complex, but it is a treatment that works very well for a certain group of patients, though it is expensive.

Danny Hames: I think the need for detox for the most complex patients is going to increase. There is potentially a significant risk on the horizon, which was just referred to. There are now four NHS in-patient detox units left in England. They estimate that by 2020 they may have to close, because of the reduction in funding that is coming through from local authorities, which is generally now given to service providers. To maintain those in-patient detox units, which deal with the most complex people, you need 24/7 medically managed care. They are becoming financially



HOUSE OF COMMONS

unviable. There is an increasing need for those types of facilities, but the way we are structuring the funding and the way that they are currently organised means that those in-patient detox units are at risk. The point that was made about there not being one in London—

Q200 Chair: Can I just clarify that? The NHS ones are disappearing. Is there still private provision that people can be referred to?

Danny Hames: You are right: there is independent provision. I would not be able to quote the number of units that can deal with the most complex clients—we are talking about people with the most complex comorbid conditions—but there are very few left.

Chair: Thank you very much. We will come on to psychological services now.

Q201 Diana Johnson: What role should psychosocial services play in drug treatment and recovery, and are there sufficient numbers of these available at the moment?

Danny Hames: The provision of psychological and psychosocial services is absolutely essential to any effective drug treatment system. If someone is in receipt of pharmacological intervention, it should be done in conjunction with that. That is absolutely essential. In any local authority area, I would challenge any service to say that that was not a central component of what is offered. There could be more investment in the evidence around effective psychosocial interventions, but I think the orange book gives us good guidance on what is effective.

One of the biggest challenges to it—I might sound like a broken record—is the funding reduction, which means that in the workforce, which is primarily there to deliver it, the number of psychologists within services is greatly reduced. The workforce that we have, in terms of recovery practitioners and the training around them, has been reduced, so our workforce has become less skilled. Those trained in psychology are the main proponents of psychological or psychosocial interventions. That is putting great pressure on the system. We will talk about the workforce later, but that is one of the big implications of that.

We have talked a lot about where treatment services are not succeeding. There are areas where there is good practice around that. The problem is that we are losing those staff with the expertise, who can then train the cohort of staff who engage with our service users to provide quality interventions. As the number of staff goes down, caseloads go up. If you used to have a caseload of 30, you now have a caseload of 60, which means you have less time to spend providing those interventions. But psychological and psychosocial services are essential to a successful system.

Q202 Diana Johnson: Is there somewhere in particular—a part of the country or an independent provider—that you could say is doing this very well?

Danny Hames: I wouldn't be able to reference specific areas, but we have strong data sets, which illustrate where systems are more successful



than others. We have that information. It is a rough barometer, but it does give an indication of where a treatment system is more successful. Also, within NDTMS, you have details of what psychosocial interventions different areas are providing. Now, I do think there are some data issues around that, but that can actually give you an indication of where certain specific interventions are being provided. If you look at that in relation to how effective a system is in terms of completions, that gives you a hint.

Q203 Diana Johnson: Does anybody else want to say anything on that?

Peter Yarwood: I suppose I could speak to the former question about commissioning. In Lancashire, it is working quite well, because our commissioner is quite close to what is going on in the community. That does not mean we have to present a set of figures based on KPIs that are sometimes unobtainable because the outcomes are really for the individual, and they are very complex. The organisations that tender for some of these pieces of work are tendering in a competitive cycle, so it is not geared up for collaboration.

What works well is where there is flexibility to meet the needs of the individuals and communities, and create real opportunities for change and to sustain that. I would say there are examples of it working well and using principles of asset-based community development and co-production, where we have brought parts of the system together in times of austerities. It has been almost like it is an opportunity to do things a little bit different and create opportunities for people who have existed on the margins and come to be all right with that. We have said, "No, that's not okay. You are just as worthy as everybody else."

We have created an opportunity for them to stand shoulder to shoulder with other organisations, other providers and peers, and really make a difference. That creates a little bit of rub, because stigma is real, but it affects the mindset of a group of people who've got no stake in society. When they start to visibly see people from their communities progressing and doing well, it addresses some of those deeply held thinking distortions, and that is when that change starts to happen on the inside.

There are examples in Lancashire of where it has worked well. I have a staff force of 28 people. The vast majority have never had a job in their life, and they are making a difference, but they are not running around collecting KPIs; they are running around and, I suppose, having purposeful and meaningful conversations. We have had to crunch data—it is public money, and we are accountable for it—but I do not know many places where people who have been perceived as the problem have been given an opportunity to have a go at becoming the solution. I suppose that has to be part of it.

Danny Hames: I think what will be helpful is Dame Carol Black's review, which has been prompted by the Home Office. Part of what she is doing is visiting treatment systems that seem to be working well, which will give us some helpful information.



Q204 Diana Johnson: Can I just move on to ask about contingency management work, and whether that should be used more often in drug treatment? Perhaps someone could just explain this to me, because I read what it was in the brief, but I wasn't quite sure. Are you giving money to people?

Dr Dhandayudham: No—well, yes and no. Contingency management is a kind of behavioural therapy. We are trying to reward people for positive outcomes and positive actions, and we are trying to reward them as close to the positive action as possible. There is no punishment here, and it works very much like a supermarket reward loyalty scheme: you know, you get more points when you go in.

We have recognised the problems facing our sector—the lack, sometimes, of effective psychosocial interventions, and these high caseloads—and we have come up with something called a capital card. There have been previous barriers to using contingency management. There is a huge evidence base and we know that it works and works really well, but some of the problems have been from a lack of understanding among staff about what contingency management actually is. We have tried vouchers, but then you get headlines in the press screaming “Junkies being given money”. The third problem is that there have not actually been that many interventions that you can easily pick up and use, but we have tried to address that with the capital card.

We give all our service users a card, and they get points when they come in for appointments, when they come in for group work or when they get the hepatitis vaccinations. We are rolling it out so that when we tell them they have a chest problem and they go to their GP, the GP can let us know that they have had it checked and we can give them points.

They then spend those points at a whole network of providers, both nationally and locally. They can redeem them at local upcycling furniture stores or go into Nando's and have a discounted meal. There are corporate partners, so they can go and have special sessions in football clubs or music lessons with City Lit. They have access to almost 7,000 courses online.

The more important thing that it does is connect our patients, a lot of whom have never saved or spent anything before, back with the community. It gets them back at the hairdresser's, saying “Can I use my points for a haircut?” In one or two instances, that has led to the hairdressing salon saying, “You know what? Now that we have a relationship, do you want to be an apprentice?”, and they have gone on to careers there. That is the way the capital card works.

Q205 Diana Johnson: Is that quite unusual, though?

Dr Dhandayudham: I think that in the sector we are the only ones who have a supermarket loyalty-type provision. It is quite cheap—it did not cost us much money at all—and we are looking at developing it for other behavioural changes such as weight management, smoking or mental



HOUSE OF COMMONS

health. There are implications across for rewarding people for positive change, and it connects to the five ways to wellbeing.

With the case system, when people spend their points, you can see whether they are using them for connecting with the community, exercise or diet—you can see what they are actually doing with their points.

Professor Sir John Strang: I think you can make a connection between the two points that you have just received. While my examples earlier were very concrete things about the medicine, the medication and how you could measure it, that has the advantage of being easy to measure so that you know whether people have or have not done it. With the content of what is being provided, the intention is that there should be much more of what you were describing with the wider holistic care and the examples you gave.

It is a huge challenge to say to somebody, “Why don’t you go and get a job?” “Well, actually, I haven’t ever had a job in the 18 years since I dropped out of school—I am not really a very employable person.” It is not an easy step, so you have to do a lot of investment.

The other point about the contingency management is that you can work with this patient population, as you can with the rest of society, and you discover that our behaviour can be shaped and nudged in particular directions. There is a strong US research evidence base studying voucher reinforcement or contingency management, and there are now a small number of UK trials. We looked at people’s hepatitis B vaccination completion. You can convert that from a 9% completion rate to a 45% completion rate with a voucher; I cannot remember if it is £5 or £10—I would have to go and check.

Behaviours are shapeable. If we think of it as an intervention within our toolkit, it should be a number of interventions that we realise can be social interventions that you can still plan to deliver. Dame Carol Black’s earlier report—not the work that she is doing at the moment, but the report that came out two years ago—wanted work to be something that you could give somebody a small dose of and then allow them to build up their capacity with. At the moment, there are some pilot schemes that are looking at building work into helping people’s recovery. We are waiting to hear the results from those.

Danny Hames: Without more defined quality standards for what you would expect as a core component of the treatment system, you are reliant on local providers or different organisations to develop an intervention like that—or not. When you have a diminishing pot of money, if you do not have those core planks that say “You have to do it this way”, each provider, often in good faith, will decide, “How do we spend the investment we have the best effect we think it will get?”, and it depends on the skills and expertise of the organisation doing that, paired with the skills and expertise of the commission.



HOUSE OF COMMONS

Peter Yarwood: And the community as well; the skills and expertise of the community are often a piece of the puzzle that is left behind. We have flipped it on its head and started to look at our service users as gifts, and started to have those conversations to challenge their internal conversations, which will amount to, "I'm worthless," with some of the colourful language that is used to describe our community. We will directly challenge that.

One of our examples is time credits. Last year, we contributed 10,000 hours-worth of volunteering; as an economic figure equated to living wage, you can add it up, but it is difficult to measure the difference that made, because we are connecting our people, who have been on the margins, in with local churches and faith sectors, parts of the community that are not beholden to the stroke of a commissioner's pen. Those are the real things that help people get and stay well.

Danny Hames: This is where the stigma is so fundamental, because you have the treatment provider, then you have the peer community that wraps around that, and for it to be successful they need to knot together, but then you have the broader community. What we have been listening to are examples of mechanisms to connect people in that peer community who have lived experiences, whether they have come through services or not, within a broader community. That starts to challenge the perception of people who use drugs or use alcohol, and that starts to unlock the doors toward employment and housing and builds social capital. Without that part of it, we have a system that sits separate, and you need that bridge.

Diana Johnson: You have just answered my next question; thank you.

Q206 **Dr Williams:** Do people who use drugs receive adequate mental health services?

Dr Dhandayudham: No.

Q207 **Dr Williams:** Why not?

Dr Dhandayudham: Previously, I think, there were sensible dual diagnosis strategies, in that people with low-level mental health needs were managed within substance misuse services, and those substance misuse services had psychiatrists and qualified doctors and nurses, who knew how to look at a patient holistically. They had the skillset to do that. Then the more complex patients went to the mental health services, to community mental health teams. It was always a challenge—even then it was a challenge—but what has happened now is that the skillset in substance misuse services has decreased, so we can no longer hold on to even those low-level mental health problems that patients have, but the threshold for referring people into community mental health services has shifted upward as well. There is a whole group of patients in the middle who cannot access mental health services unless it is in a crisis or through their GP.

Q208 **Dr Williams:** Are IAPT services appropriate for this group of people?



HOUSE OF COMMONS

Dr Dhandayudham: IAPT services are very variable across a patch. Some IAPT services will take patients who have substance misuse issues, but the majority of them will not, so patients cannot access it.

Q209 **Dr Williams:** We are talking about people with anxiety, for example, or depression, aren't we? But you are saying that there are some counselling and psychological services that will not take an individual with depression. Is that possible?

Dr Dhandayudham: No, with substance misuse issues.

Q210 **Dr Williams:** Yes, so the person may well be using substances to self-medicate their anxiety, but because of that, are they allowed to not take them?

Professor Sir John Strang: For a number of them, it is listed as part of the exclusion criteria that mean you are not eligible for IAPT.

Q211 **Dr Williams:** Does that mean that the commissioner, who has commissioned that service with the exclusion criteria, has a legal responsibility to commission an alternative service so that that problem will be treated?

Professor Sir John Strang: That is a good question; I don't know. Just to check that you have picked up on the point my colleague was making, this would have been seen as part of what addiction or substance misuse services provided. Because they were led by and staffed by people who had trained in addiction psychiatry, mental health nurses, mental health social workers, you had people who saw a broader mental health disorder as part of what they were familiar with working with. That would always have been part of what addiction services did. We have now gone down this over-specified commissioning. You will have people with a comorbid mental health problem being told, "That cannot be managed within the substance misuse service because we only deal with your substance misuse." And you go, "This is ridiculous. This is part of what someone's problem is."

Q212 **Dr Williams:** Do most people with substance misuse problems have a mental health issue?

Professor Sir John Strang: It depends where you put your cut-off, but it is very common for there to be a co-existing mental health disorder of some sort and it makes the management of the totality of their problem more complicated. In all areas of medical practice, there are some simple cases and then there are some trickier cases, and you use your workforce appropriately to work out who is treating them. Across the country, it has been a problem that those have become separated, as if the co-existing mental health disorder is a different speciality, and you think, "Well, it's actually all part of managing mental health disorders."

Danny Hames: In an area, you would have had an NHS mental health provider often having a role to play in the provision of mental health services. One of the unintended consequences of the tendering of services and the fact that the number of NHS providers has greatly diminished—



HOUSE OF COMMONS

and I think the over-specification is accurate—is basically organisational barriers between the local NHS trust and the local independent provider.

Q213 Dr Williams: What needs to be done to address this?

Danny Hames: We talked earlier about whether this should be commissioned by the NHS or by local authorities. The preference would be to look at how we co-commission between local authorities and the NHS. The way the service is commissioned encourages separation and when you have organisations competing against each other, there is always an elephant in the room.

Q214 Dr Williams: The CCG has a responsibility to provide for the physical and mental health needs of those patients in primary and secondary care. The local authority has the responsibility to commission substance misuse services. You say that if they got together—

Danny Hames: A mechanism that would make them both responsible for commissioning drug and alcohol services would greatly aid a lot of the—

Q215 Dr Williams: Is that happening anywhere?

Danny Hames: Not that I know of.

Q216 Dr Williams: Why not?

Danny Hames: You would have to ask the local authorities and local NHS. Generally, I think it is organisational boundaries. Everyone has got a lack of funds.

Professor Sir John Strang: There are some instances where there has been co-commissioning and it is healthier. I think you have a stronger system if you have the 51% responsibility in your health arena. Clearly, you have got to be working massively with your local authority partners, given the nature of what you want to do. It has lost its connection to health and it has lost its imperative in the public debate. If you look at the public debate in the UK versus the public debate in the US, for example, about how to respond to the opiate problem, the US wants to make sure there is wider provision and addresses co-existing health problems with a commitment much greater than we have here.

Q217 Dr Williams: With co-commissioning, presumably you end up getting two different commissioners but perhaps one provider.

Professor Sir John Strang: Or a consortium provision. Probably the strongest models that I would see are where, in a locality, there has been a consortium approach to the provision of the different types of interventions you want. However, that involves really strong leadership, because all of the competitive tendering process divides you. It is really difficult to do a consortium model when you know that any one of you might take the plans that seemed rather good and submit them in a single provider. There are a few examples where it has worked well.

Q218 Dr Williams: Nobody has talked about general practice—primary care—for this group of people. Usually, when you have a high-risk, vulnerable



HOUSE OF COMMONS

population, their access to primary care and its quality are essential, but my experience is that if this population of people exists within routine primary care, their outcomes are not even measured. They are not seen as a distinct population whose outcomes are measured within primary care. Are there any good primary care models for this population of people? The mortality is not just because of the substance misuse but often because of other issues that could be better managed.

Professor Sir John Strang: We have a much healthier system in this country: it is broadly accepted by most primary care practitioners that it is within the scope of responsibilities, even if it is an unpopular bit of the responsibilities. That puts us ahead of a lot of other countries, where it is completely ghettoised as being only in that special area.

Q219 **Dr Williams:** But the inverse care law would tell us that these people are the least likely to attend for screening, the least likely to have well managed diabetes, the least likely to be immunised—all the basics.

Professor Sir John Strang: Unless you have an interest in them, they may not be a rewarding patient group, so there is probably quite a lot of provision that is done to be adequate but probably not with the extras. A lot of the third sector provision has been a hybrid of GP provision, where GPs are brought in to do sessional work. It is a tricky one. Is that—doing sessional work in a third sector agency—what one meant by primary care provision, or did one actually think it was integrated into the broader provision? That is probably a different debate.

Danny Hames: There is a diminishing number of GPs interested in substance misuse. You have the Royal College of General Practitioners level 2 qualification in substance misuse. The number of GPs going through that is reducing. That is detrimental. We need those GP advocates in surgeries, advocating for our clients, but their numbers are diminishing, which is worrying.

Dr Dhandayudham: Going back a few years, shared care was quite popular. We had a lot of shared care schemes, where you would have the consultant psychiatrist in the services, supporting and mentoring the range of GPs in GP practices. We would stabilise the patients, we would move them on to the GPs, and it was okay for them to have a prescription and to maintain a quality of life. But we have moved away from that being good enough to a position where people have to exit the system.

The other criticism of shared care has been the fact that a lot of patients in shared care did not actually engage with the psychosocial provision on offer in secondary services. It has gradually whittled away over time, so it is quite hard. What has happened with the divisive commissioning is that we are now in a position in some of our London boroughs where GPs will not provide continuing Antabuse and acamprosate to stop people relapsing back into their alcohol use. In some of our boroughs, we are in a position where, if we ask for a blood test to start prescribing these medications, the GPs will say, "Well, we're not commissioned to do that, so you've got



HOUSE OF COMMONS

to pay for it yourself," whereas this would have been accepted as standard practice years ago.

Q220 Chair: Can I come on to a little more about the workforce? We have heard evidence from the Royal College of Psychiatrists that there was a 24% fall, from 95 to 72, in the number of NHS consultant addiction psychiatrists between 2011 and 2017. I wonder whether any of you would like to comment a bit more about whether that is primarily to do with recruitment, training or retention. Will you say a little more about the specialist workforce?

Dr Dhandayudham: Addiction psychiatrists do medicine and then they do psychiatry and then they have a specialist endorsement in addiction. They can only get those specialist endorsements in addiction if they work in a unit that offers them supervision and training by another addiction consultant, so as services in the NHS have disappeared—I think probably between 10% and 15% are left—

Danny Hames: It is about 30.

Dr Dhandayudham: I am talking about England. There are fewer consultant addiction psychiatrists to supervise the training of the next generation of addiction psychiatrists. That is why, fundamentally, there is a huge shortage of addiction psychiatrists who will be coming to the system. This is a serious workforce issue. I have touched on the complexity of the patients, the loss of skills in the sector, and the fact that if this generation of addiction psychiatrists goes, there will nobody to train the next generation. There is a crisis.

Danny Hames: There is nothing I can add to that. I completely agree.

Q221 Chair: In reality, we are looking at there being absolutely no facility in the near future for future training. Is it that bad?

Professor Sir John Strang: It is probably compound: there is hardly any facility for people to have the training and, for the trainee, there aren't posts for them to train to move into. Quite a number of the consultants who trained with me—I am coming to the end of my career, so it doesn't matter—really good addiction psychiatrists that I would happily know that a friend of family member was in treatment with, go through the strange process of having committed to the NHS and then being TUPE-ed out to a third sector organisation and thinking, "This isn't really what I thought I was committing to when I made this choice," and they take early retirement. You have huge losses from the treatment system.

Q222 Chair: How much is the point that you are no longer going to be employed by the NHS a disincentive to people coming in, alongside the difficulties you have raised about having a specialist there to train them? Is that a disincentive?

Dr Dhandayudham: It is a massive disincentive because people who go into training in addiction psychiatry know that the jobs over their life-cycle are going to be quite chaotic. They are going to be moving from provider to provider. Against a backdrop of cuts reducing year on year, it is not a



HOUSE OF COMMONS

pleasant environment for them to go on to because they are holding an increasingly high level of risk.

Danny Hames: You lack the infrastructure you get with an NHS trust—that depth is not there—so it is very unattractive. If you think in terms of TUPE cycles, not necessarily specifically doctors, in terms of services that we have worked with, there are individuals who have been TUPE-ed four or five times to four or five different organisations.

Q223 **Mr Bradshaw:** I know we asked you to talk mainly about treatment, but I wondered if you had anything to add to the previous panel's comments—I don't know if you heard them—about the general picture and whether we can learn from international practice. Are there any models of decriminalisation, public health approaches and so on that you think are attractive and that we might like to highlight in our report?

Professor Sir John Strang: I think we should do what we do with any other area of healthcare: we should peep over the garden fence at what good research is being done in somebody else's garden and then look at whether it is applicable to what we do here. A lot of the examples that were given in the previous session were good illustrations of that. You sometimes have to check: "Is it exactly the same in a UK context as a North American context?" and things like that. Some of them are directly transferrable.

Professor Hickman was making the point that we can be guided. Even Government decisions or criminal justice decisions could be studied better. It is exasperating when you see the changes that Government or the criminal justice system make and they won't allow you to study it. There is such a fear that, "What if the results show that we have made a mistake?" My own view is that I would vote for somebody who said, "I will change my position on the basis of the evidence that comes out."

We had it in this country with cannabis—we changed its classification and then changed it back again. What an exquisite opportunity to study the impact of that on population levels of use and the harm that resulted, and we haven't got the evidence.

You would need a commitment to the fact—Ben Goldacre has argued this much more skilfully—that you can apply science to that, but you have to be willing to suspend your judgment. You obviously have a hunch which is best, and it does not have to be a randomised trial. Your point was perfectly correct: there are some things you cannot randomise.

However, you can do one of the designs that is called a stepped wedge trial design, where you say, "Okay, we'll roll this out quarter by quarter, and therefore we expect to see the benefit appearing quarter by quarter. We can compare regions or counties that have not yet done it with counties that have." I think the more we move towards that, the better. Health is probably where we have the strongest experience—public health and individual treatment—but I thought the answers they gave were very good.



HOUSE OF COMMONS

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