

Health and Social Care Committee

Oral evidence: Drugs policy, HC 1822

Tuesday 2 July 2019

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Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Rosie Cooper; Diana Johnson; Johnny Mercer; Andrew Selous; Dr Paul Williams.

Questions 223 - 324

Witnesses

I: Jason Harwin, Assistant Chief Constable, National Police Chiefs Council; Dr Wojciech Spyt, Detective Sergeant, Thames Valley Police; Hardyal Dhindsa, Association of Police and Crime Commissioners; and Stephanie Kilili, Policy Advisor, Office of the Durham Police, Crime and Victims' Commissioner.

II: Mark Johnson, Chief Executive Officer, User Voice; Emily Giles, Policy and Communications Coordinator, ADFAM; and Kerrie Hudson, Operational Lead, The Well.

Written evidence from witnesses:

— [Thames Valley Police](#)

Examination of witnesses

Witnesses: Jason Harwin, Dr Spyt, Hardyal Dhindsa and Stephanie Kilili.

Q223 **Chair:** Welcome to the Health and Social Care Select Committee. In our first panel, we are going to be talking about drugs and the criminal justice system. Thank you all for coming. For those following from outside the room, could I ask you to introduce yourselves and who you are representing today?

Jason Harwin: I am Jason Harwin, the deputy chief constable of Lincolnshire, having moved there seven days ago. This is my day seven in Lincolnshire. I have been the national police chiefs' lead for drugs since September last year.

Dr Spyt: My name is Wojciech Spyt. I am a detective sergeant and I work in the policing strategy unit in Thames Valley police. I have been part of a team that has designed and implemented a drugs diversion scheme in one of our local areas.

Stephanie Kilili: I am Stephanie Kilili, a policy officer for the Durham police and crime commissioner. I am here today representing Ron Hogg, the police and crime commissioner for Durham.

Hardyal Dhindsa: My name is Hardyal Dhindsa. I am the police and crime commissioner for Derbyshire, and I am the Association of Police and Crime Commissioners' national lead on alcohol and drugs.

Chair: Thank you very much. Ben is going to open the questioning this afternoon.

Q224 **Mr Bradshaw:** To start with, I have a couple of general questions on the difference between a criminal justice and a public health approach. If I address my questions to a particular member of the panel, don't feel that you should not contribute.

Stephanie, I want to begin with you because your commissioner presented this Committee with some very stark evidence in which he says that the Government should seek a more evidence-based approach. What exactly did he mean by that?

Stephanie Kilili: He means that, if you were to take a public health approach to drugs and drugs policy, it should be more evidence-based. That policy is currently under the Home Office. He was suggesting that that ought to be shifted to the Department of Health, whereby we look at principles that are evidence-based and informed so that we can bring in practice in that way. He would propose the decriminalisation of drug possession, but, apart from that, a public health approach that is evidence-based that would scale up prevention, harm reduction and treatment to support the vulnerable people in our communities.

Q225 **Mr Bradshaw:** He quoted some very stark statistics from the United Nations Office on Drugs and Crime saying that nine in 10 people who use



drugs do not suffer from drug use disorders. What exactly does that mean?

Stephanie Kilili: That is the distinction between problematic drug users and people who take drugs recreationally. In our current approach, which is a whole face-value approach, we take a criminal approach towards people who are not committing an offence apart from their current drug possession. What he implies is, why focus our efforts on everyone, which is a costly operation, when we could deal with people in a different way if our policy was different.

Q226 **Mr Bradshaw:** Nine out of 10 people who take drugs at the moment are not committing crimes themselves or having any disorder as a result. We are focusing on them when we should be focusing on the 1% who are causing the problems.

Stephanie Kilili: Exactly, yes, and they are the ones who cause most demand.

Q227 **Mr Bradshaw:** The 10%, yes.

Stephanie Kilili: Yes, they cause most demand on our police forces, the emergency services, the criminal justice system and health and social care services.

Q228 **Mr Bradshaw:** What difference would it make moving the policy to the Department of Health?

Stephanie Kilili: It would shift the priorities from a criminal approach to a health approach. You would be talking about intervening in someone's life to address the underlying cause of why they were taking drugs in the first place. Such a shift would reduce a bit of the stigma associated with the criminalisation of it as it currently stands. That would enable people not to fear the law and the police, so that they can come forward and address their health issues.

Q229 **Mr Bradshaw:** Deputy Chief Constable Harwin, from a police officer's perspective, is that an approach or a view you would share?

Jason Harwin: It is fair to say that, yes, there are 10% we have more contact with, whether it be committing criminal offences or whether it is vulnerability and ultimately the consequences of drugs. We all need to be very clear that at the minute, in how the law is set, the other 90% commit criminal offences. The fact that they are not coming into contact with the police service means that there is demand and we do not understand how to respond to it.

The important piece from the NPCC side is that we are there to reduce harm. It is not just about enforcement; we are there to reduce harm, and the evidence base shows that there are ways we can approach that through a public health response that would probably have a greater impact longer term than some of the other work we are doing at the moment. Importantly, for the police service, as you will hear this



HOUSE OF COMMONS

afternoon, activities are taking place throughout the country that clearly are about an appropriate response to the needs of an individual. Ultimately, yes, they commit a criminal offence, but we are trying to make sure that they are no longer vulnerable and, just as importantly, that they do not reoffend after the first offence. There is evidence showing that some of that is working, and at the NPCC we are keen to share that practice throughout the country, as we have done. It is about how we make it more effective and make sure that we get clarity and consistency in the role of the police.

Q230 Mr Bradshaw: In your written evidence, you say that a criminal justice approach will not solve problematic drug use: "Criminalisation of drug users often creates a cycle of reoffending and does nothing to address the underlying and contributing social issues." Are you saying that in your practice you are working around that by doing other things instead?

Jason Harwin: No. First, a crime has been committed, so we are not saying it is not a crime; we are saying, what is the best outcome for that individual to stop him reoffending? Just as importantly, how do we protect the wider public, potentially the individuals who are associated with that individual—by way of example, looked-after children? A significant number of young people are going into care at the moment as a result of a family in a crisis that is being driven through drug use. We are trying to say that, with an effective evidence-based practice to manage their crisis and their vulnerability, we can reduce harm not just to those individuals but to the wider family and therefore the wider community, where there is an organised crime element committed to this that is feeding the supply of illicit drugs. That is how we need to be more effective.

Q231 Mr Bradshaw: What is the National Police Chiefs Council's attitude to moving responsibility for this policy area from the Home Office to Health?

Jason Harwin: It is everybody's responsibility; it is not just one Department. The College of Policing, working with Public Health England, has recently published some guidance on the public health response to crime and vulnerability. Importantly from our side, we recognise that, while the police service has an important role to play, we are not the solution. We are part of where we need rightly to target those who are profiting and ultimately exploiting people to commit crime, but ultimately there are individuals who are not just drug users but have other social dependencies that we need to address. The police service cannot address that. Health and other providers can, and hopefully we will hear some examples of that this afternoon.

Q232 Mr Bradshaw: Mr Dhindsa, I think you wanted to come in.

Hardyal Dhindsa: Policing has a role as long as we have the law as it is, but we cannot enforce our way out of the problem. A health-led approach is the right one, in partnership with the criminal justice system as a whole—police, courts, probation services, youth offending services. A



HOUSE OF COMMONS

health-led approach is what is needed, and I welcome the Committee's inquiry. Police and crime commissioners can play an important role in how that can be delivered at local level because of strategic thinking and joining up different agencies.

Q233 Mr Bradshaw: You say that policing has a role and that enforcement has a role as long as the law is as it is. It seems to suggest that you think there are better things that you could be doing with the resources you have in this area.

Hardyal Dhindsa: That is a debate that goes on in terms of the 10% and the 90%. There are examples. The police do a very good job in enforcing the law, but it has to be proportionate. However, in the last 40 or 50 years, that has not led to a reduction in demand, use and supply and criminality, despite the fact that people are locked up, and the police are working more and more with vulnerable groups to help divert them, through the schemes that are presented here, to get them into support and treatment and recovery and diversion. Despite all that, we are still not making an impact. We need to join up and collaborate more than we are doing now.

Q234 Mr Bradshaw: So the current policy has not worked, basically.

Hardyal Dhindsa: It cannot work on its own. It needs to be joined up.

Q235 Mr Bradshaw: Dr Spyt, do you want to come in?

Dr Spyt: Irrespective of your views on how effective prohibition is, prohibition has failed for the people the police come into contact with. The deterrent effect has not worked, otherwise those people would not be in possession of drugs. For the people with drugs that we come across, we need an alternative policy or an alternative strategy to address their drug use. The police are not medical professionals, so we are not equipped to deal with that drug use.

Q236 Mr Bradshaw: Perhaps drawing on any international models you might be aware of, how would you like to see drugs policy and the strategy change over the next five years? That is a question for all of you.

Jason Harwin: First, it has to be evidence-based, and it has to be relevant for England and Wales, for the NPCC, and obviously the wider piece including Scotland, for the Home Office. The important thing is that it is not about one element. There are lots of conversations about different elements of the evidence base, whether that be drug consumption rooms or heroin-assisted treatment, but you cannot do it in isolation. It is first about statutory responsibility in all organisations; everyone has a responsibility to address the issue across all Government Departments. Just as importantly, it is about needs assessment.

The first part of the public health response is understanding the needs of communities and then making sure that the response to that need is in line with an evidence base that will work. It is not about a universal



HOUSE OF COMMONS

approach across the UK; it is about a targeted intervention that is evidence-based, where the right partners are involved, with the right evidence and the right funding and resources to address the problem. At the minute, that is not the case.

Hardyal Dhindsa: Over the next five years, strategically, we need to see the criminal justice system working more joined up with public health departments at local level and national level. The work that has been started by the drugs working group, chaired by the Home Secretary, is important for how Departments across Government are more joined up in terms of education, awareness and diversion by public health and education, and in their work on families.

Looking ahead to the next five years, it is about strategic join-up at central Government level between different Departments, because it is not just a health and criminal justice issue; it is a social issue. At local level, there is the leadership that police and crime commissioners can give in joining up, and maybe co-commissioning with public health departments, services on the ground to provide treatment, diversion and recovery services that join up with the criminal justice system.

Q237 **Mr Bradshaw:** Would either of you like to add anything?

Dr Spyt: To echo both of those comments, the police are a gateway either to criminal justice outcomes, whether through the courts or administered by the police, or to public health outcomes. The evidence is so important. With the current policies that are being trialled, we are attempting to see whether different public health outcomes or criminal justice outcomes have greater or lesser impact, for example, on reoffending, and, from the public health perspective, on continued drug use.

Q238 **Mr Bradshaw:** Are there any foreign models, any other countries that do it better than we do?

Jason Harwin: There are a number of countries where they have decriminalised and involved other interventions. While, clearly, we need to look at what they are doing, the important bit is to relate it to here. It is not about saying that, just because they are doing it, it is going to work here. It goes back to how the whole system works.

As I said at the start, a lot of the individuals we deal with are in crisis; they are very vulnerable, and, ultimately, they feel they have no other choice but to get through the day by taking drugs. It is not just about taking drugs; it is the underlying issues about why they need to take drugs. That is the piece around which public health is better and more informed, and therefore it makes sure that there is the right outcome for the individual as well.

Q239 **Diana Johnson:** I want to understand a little bit more about the 90%. I understand the 10% that are causing the major problem. I have just sat on a Committee looking at domestic abuse, and one of the things that



HOUSE OF COMMONS

came to light was that people who suffer domestic abuse do not go to the police. They might contact the NHS before they would ever speak to a police officer.

One of the key factors around domestic abuse is substance misuse in the home, which causes problems and domestic abuse. It seems to me rather stark to say that it is just the 10%. It might be that with the 90% there are all sorts of other things going on that are very harmful, but that is not registering because it is not being brought to the police's attention. Could you explain that a bit more? Is that correct?

Dr Spyt: It is interesting in that, with the drug diversion we have had in Thames Valley police, we have been referring people to the drugs service provider who would not usually come into contact with that particular cohort of people. For example, if we stop people with cannabis, they further disclose use of other drugs. There is certainly an aspect of that. While they may not present as particularly problematic for us or for society, there may be underlying issues that we are not capturing.

Hardyal Dhindsa: Taking the analogy of domestic abuse, there has to be a robust assessment process. Some people's presentation of substance misuse or domestic abuse might not be, on the face of it, very concerning, but if the proper risk assessments are in place and screening and assessments are done—probably not by a police officer but experts who are equipped to do it better—you can decide when you need to intervene and when you do not. That is something that is probably happening in policing in many ways.

We need to uphold the law, but when you take action it must be proportionate. Police officers decide how much action to take and whether support and vulnerability referrals need to be made. It is probably wrong to say that you can forget the 90%. Screening and assessment is really important, because someone may not present as having great difficulties, but if you dig deeper there may be issues that need intervention.

Jason Harwin: I want to challenge on whether we understand the other 90%. In terms of understanding demand in relation to drugs and the criminal justice system, and the wider bit on public health and other societies and communities, we really do not know, if we are honest. We know some of it. We do not know all of it. Importantly, some of the work we are doing on serious violence at the moment, to understand better how drugs drive serious violence, is starting to help us better understand the demand. It is showing that the use of drugs, whether illicit or prescription, or both mixed together—poly-use—is a bigger issue than we are seeing in terms of recorded crime.

Q240 **Chair:** Stephanie, do you want to make a follow-up point?

Stephanie Kilili: It is in relation to drugs and domestic abuse and adverse childhood experience. Some of the people who take drugs have suffered some sort of trauma in their childhood life, and they take drugs



HOUSE OF COMMONS

as a way of coping or recovering. They are in the 90% who do not necessarily come into police contact unless they come under the vulnerability aspect or are the victim, which requires a different and more proportionate outcome rather than a traditional criminal justice sanction such as a caution or a charge. That is a different response.

Q241 Andrew Selous: I want to pick up on the term recreational drugs use, as it is a term I am rather uncomfortable with. To be fair, the Government used it in their 2017 strategy, so you can blame the Government for first using it, and I am not having a go at anyone in particular. I wondered if among any of you it has some rather worrying connotations. Diana talked about the 90%, and the links to domestic abuse, and there are links to other criminal activity. Personally, I am rather uneasy with the use of that phrase. Jason, would you rather it was a phrase that was not used?

Jason Harwin: You will not hear the National Police Chiefs Council talk about recreational use. You will probably hear the contrary—that it is illegal. If it is illicit drugs, it is illegal. That obviously fuels crime. Accepting vulnerability in individual use, the wider piece is that we recognise that even if the person is not in a service—cocaine is a prime example—it is fuelling organised crime. We can show, from production all the way through to transportation and delivery in the UK and throughout the UK, that it involves exploitation, whether that be of young people or very vulnerable people. We do not use the word “recreational” because at the moment the drugs are illegal.

Andrew Selous: Excellent. Thank you.

Q242 Chair: It is important that we do not forget the murders that are carried out overseas as part of the wider network, so to imply that it is a consequence-free choice would be worrying.

Hardyal Dhindsa: You are quite right, in that the use of the term recreational is probably inappropriate, but, if you go underneath that, we have a social problem in how we tackle drug substance misuse and who actually does that. The Home Secretary has said that middle-class white people who may be categorised as recreational users should stop misusing substances, because that would reduce supply.

The question is how you stop antisocial behaviour in terms of people taking substances such as alcohol or smoking, and what approach is the right one to tackle that problem through education, awareness of risk and giving people informed choice. We know that, despite all the efforts of the criminal justice agencies, the behaviour has not stopped, whether it is people who misuse substances and do not come before the law or people who are misusing them because they have mental health, accommodation or employment issues and they come to the attention of public services, including the police. There is a distinction between the two, but the deeper question is how we look at the social activity of individuals who make choices about taking alcohol or drugs, smoking or whatever.



HOUSE OF COMMONS

Q243 Dr Williams: I want to move our discussion to the need for a biopsychosocial approach, but can I take you back to policing and ask whether the police have enough powers to carry out their duties under the law with regard to drugs?

Jason Harwin: I suppose the question is what we are trying to achieve. In terms of enforcement, there are lots of powers; we can stop and search people, we can recover drugs, and we can put them through a process of referral, particularly if they are under arrest. As you will see, the number of arrests for drugs possession is reducing. Some of that is because the legislation has changed and we have to show necessity to arrest. We also have other outcomes, and we can deal with that individual without going through a custody suite.

When a person attends on a voluntary basis, if they are willing to do a drugs test, it would be with consent. There is no power for the police service to do a drugs test. We have a serious violence issue throughout the UK at the moment, but if you look at the legislation on the use of drugs testing and arrest, it does not involve violence. An inspector can authorise it if it is in relation to violence, but it is not set as authority for violence-related offences.

There is an important piece in terms of the rest of the legislation. To use the example of prescribed cannabis, people now quite rightly have prescriptions to access medical use of cannabis, but at the moment, because they cannot access cannabis, the police service gets involved in the middle in relation to possession of cannabis. People cannot get it legally because it is not available, and therefore, because of their medical condition, they feel the need to source cannabis by other means that are illegal.

Straightaway, the police service gets into a position where that is illegal, but, in terms of the moral position, an individual has been prescribed a cannabis substitute for their medical condition but, because they cannot access that substance, the police service gets involved. That is a real dilemma for the police service. Ultimately, we are trying to enforce the law, but we are trying to enforce the law to minimise harm longer term. It is not just about the short-term piece, as the police and crime commissioner touched on. We can arrest lots of people, as we do every day, and we can recover lots of drugs, but, while the demand is there and individuals need drugs, the supply will continue to come.

Q244 Dr Williams: Can I check what you are saying about more powers to test more people? Is that likely to identify more of the 90% for whom it is less problematic and would, therefore, be a not particularly good use of powers, or do you think it would potentially identify more of the 10% where it is problematic?

Jason Harwin: I think what it will do is give you a bigger picture than we have at the moment, because we are not testing those who are coming through voluntary attendance. Some of them will already be in



HOUSE OF COMMONS

service. Drug driving, as you know, is getting a greater profile in the country. I will use an example from my previous force. Over a six-month period, we arrested as many people for drug driving as we did for drink driving. The issue is what happens to the individuals being caught for drug driving. They may get banned, but what about referral to the system? How do we deal with the underlying issue that they have a drug need and prevent them from potentially committing other offences, not just drug driving?

Q245 **Dr Williams:** So, more biopsychosocial options, yes, but perhaps some more powers for the police to be able to act on the frontline to identify as well.

Jason Harwin: That is really important. The issue for the police service is that we are likely to increase demand for that, which is good because we are trying to address the underlying issue, but we need the provision behind it to be able to deal with the demand and make sure that there is a whole-system approach in what we do when the referral comes in.

Hardyal Dhindsa: That is the crux of it. You can have more powers, but at the end of the day, once you have them, we still come to the same point about vulnerability. What is the best action to stop that person reoffending and therefore demanding extra treatment services?

Q246 **Dr Williams:** It is not more powers to lock people up but perhaps more powers to identify situations where there may well be great vulnerability when drugs are involved.

Hardyal Dhindsa: That is the area that I am really pleased your Committee is looking at. The health-led approach has to be the way we go.

Jason Harwin: Health and wellbeing boards have a statutory responsibility to identify needs and commission services. At the minute, the police service is not a statutory partner in health and wellbeing boards. You will find throughout the country that the police are representative through relationships with both the local authority as regards their responsibility, and with wider health provision, but we need to meet around the table with statutory responsibility to influence the needs assessment to make sure that we protect vulnerable people. In law, that is not there.

Q247 **Dr Williams:** I had a very good example in my own local authority area where I met public health commissioners who are recommissioning a new substance misuse service and had not had in-depth conversations with the police and crime commissioner. I am making sure that they come together, because clearly there is a mutual interest.

Dr Spyt: One of the biggest challenges in drugs diversion was to find the funding for the additional people we were referring. The local authority worked hard to alter the KPIs that had been set in the contract for the drug service provider, to enable them to deal with the additional demand



HOUSE OF COMMONS

we were sending their way. We are a gateway, so, if that gateway becomes bigger, the services we are referring to need more resources.

Q248 **Dr Williams:** Does that mean the police and local authorities working together? It necessitates police and local authorities working together in the commissioning of services.

Dr Spyt: Yes.

Q249 **Dr Williams:** Does the UK system of drug classification help in any of this, or does it hinder?

Jason Harwin: Does it stop us doing what we need to do? No, it does not stop us doing what we need to do. Does it cause some confusion at times? It does. In terms of testing, do we know what we are dealing with? Testing is an issue for policing UK. We are having a conversation in the NPCC about our capability for provision to be able to test outside the criminal justice process. It is not just policing but looking at other providers—for example, working with prisons to identify potential vulnerability not just in terms of substance use, because substance use changes, as you know very well, but in our response. How do we respond to that differently as well?

Q250 **Dr Williams:** We have recently had the Psychoactive Substances Act. What have the effects of that been?

Jason Harwin: The evidence was evaluated and showed that premises openly selling such things had stopped doing so. The issue is the online piece where people are accessing things by other means. Online is a massive challenge for the police service, not just with drugs but in how we deal with the online challenge of criminality, in particular organised crime.

Hardyal Dhindsa: The supply of psychoactive substances has been more used by homeless people with complex mental health needs who find it cheaper than other areas, because of suppliers. That has made homeless people the focus of the antisocial behaviour you see in towns and cities, so interventions particular to that group are required. The Act has reduced usage in one area, but it has highlighted vulnerable communities and groups, homeless people in particular. We see zombified individuals taking that substance and being supplied with it more easily. There is a need to respond with interventions to help those individuals.

Q251 **Dr Williams:** Those people are getting better access to psychoactive substances.

Hardyal Dhindsa: It is easier. Psychoactive substances are more easily available because they are chemical; they are not herbal cannabis but synthetic cannabinoids. Their production and make-up can be done differently. It does not require anything massive; the chemicals can be put together easily on-site and made easily available.



HOUSE OF COMMONS

They go into prisons in the same way, as we know. They can be sprayed on to a piece of paper, for example, and sent into prison, and are less easily detectable. They are accessible and cheaper, and if people who are destitute, homeless and have fewer resources are accessing them, but then causing problems in our towns and centres, there is intervention required at that level.

Q252 Rosie Cooper: This is initially to the assistant chief constable for the first part and the second part is for all of you. First, how do the police currently contribute to harm reduction in relation to drugs? For the panel overall, what are your thoughts about the current legal and practical situation with drug consumption in the United Kingdom?

Jason Harwin: What is our contribution? I touched on it earlier in relation to health and wellbeing boards. For England particularly, we have representation on health and wellbeing boards, That is helping in the conversation about joint needs assessment but, more importantly, about the commissioning of service. It is very much a postcode lottery, if we are honest, because the statutory responsibility is not there for us to do that.

The second bit is that we want to make sure that we are referring people to treatment as soon as we possibly can in our contact with those individuals. You have examples with diversionary schemes. It may be a case of homelessness, where we come across individuals on the streets who may not be taking drugs at the time but clearly have some vulnerability. We need to get them into pathways and make sure that they get the relevant services. Again, there are examples throughout the UK. They take account of the issues with Spice, which have been well reported, and make sure that there is a joined-up response with health services, with local authority responsibility to make sure that we have joint responses to those issues in communities. It is being part of a multi-agency team realistically.

The wider bit is that we have the legislation where we need it, as I touched on earlier, and we have statutory responsibility to refer people to services at certain points in the criminal justice process as well. The issue for me goes back to the recent guidance, which is evidence-based, through the College of Policing, about the needs assessment piece. It is understanding that it is not just about drugs need but about the wider needs of the individual, hence the family and the wider community. By making sure that we influence the conversation about what we know, what the local authority knows, what treatment services know and, importantly, what the third sector knows about individuals, and involving the individual, we will straightaway have a better response because we have a more informed position.

As regards drug consumption rooms and heroin-assisted treatment, heroin-assisted treatment is evidence-based. Dr Williams will know that there is some evidence-based activity taking place in the Cleveland and Teesside area at the minute. That will have a massive impact in



HOUSE OF COMMONS

supporting individuals in crisis and a greater impact in protecting communities and stopping serious and organised crime. The issue again is around funding. At the minute, it is funded through joint commissioning, ultimately through the police and crime commissioner, the local authority and public health.

The key point is that it cannot be a postcode lottery. Whether you are an individual who has a need for an opiate-based substance or you are entrenched in treatment that is not working, and you stop that treatment and get into evidence-based treatment that works, at the minute it depends on where the funding sits whether you get the treatment or not. That cannot be acceptable in today's society.

There is an interesting debate on drug consumption rooms. There are lots of issues in understanding the difference between heroin-assisted treatment and drug consumption rooms. Drug consumption rooms have an evidence base showing that they work, but again it has to be part of a wider whole-system approach and a public health response. It has to be done with an understanding of what you are trying to achieve from a drug consumption room. It is not just about allowing people to take illicit drugs: it is about safety; it is about stopping drug overdoses; and, importantly, it is about the wraparound of other services to try, ultimately, to take the person away from illicit drugs, to manage their need for drugs and put them into other services.

It is not a universal response. Drugs misuse should not be seen as having a universal response across England. It should be considered as an appropriate response as part of a wider public health strategy for the issues a particular area faces. That links to issues around public consultation and the wider piece that some communities are suffering where drugs are being consumed in streets. I always argue that drug consumption rooms exist, without the title, in some people's houses, realistically, and people are dying there.

Q253 Rosie Cooper: Do you struggle with referring people on? It is all right talking about a partnership. If you have public opinion to get over in the first place, and then having had that row if you do not have the resources, how do you deal with that?

Jason Harwin: The first bit is influencing the commissioning. Where we clearly see and understand a need, which goes back to the point about whether we understand the demand that drugs are driving, straightaway we make sure that, through commissioning and being around the table, where we should be statutorily with the health and wellbeing agenda, we are influencing that conversation. A lot of people will say this is just to stop police demand. No, it is not: it is to stop vulnerability, the vulnerability of an individual, and potentially an impact on their family, where there are young people who could be taken into care and the associated issues when people are taken into care. Just as importantly, because that person feels the need and has no other choice but to take illicit drugs, it fuels serious and organised crime that we show is linked to



HOUSE OF COMMONS

violence. It is linked to 60% of homicides in the UK, and nearly 45% of houses broken into are linked to drug dependency.

For me, it goes back to the point that, if we do not stop the demand and need for drugs and deal with it in a different way, the supply will continue, despite lots of effort and lots of drugs being recovered through all the different law enforcement services. That is the conversation we are hopefully having on behalf of the NPCC with other partners about how we do this a little differently. That is what you see in the diversionary scheme; it is about reducing demand with appropriate pathways and therefore starting to cut off the need.

Q254 **Rosie Cooper:** Do the rest of the panel have anything to add?

Stephanie Kilili: In relation to the question about what the role of policing is in harm reduction, it is important to remember that one of the core missions of the police service is to protect human life. Many other countries around the world, which focus on a harm-reduction policing kind of approach, have seen a lot of benefits in public health and in public safety. Such initiatives include things like needle exchange and naloxone used among police forces, and heroin-assisted treatment, which our colleagues have already spoken about. They are just a few examples where the police can tap into communities that struggle to engage with mainstream services. As my colleague said, that is our way of gatekeeping and getting them into harm-reduction services.

Hardyal Dhindsa: With harm reduction, you have two very good examples. Diversion schemes can help reduce harm because you get people into treatment and recovery, as opposed to the criminal justice route. We have others. Avon and Somerset and North Wales are about to implement something similar using Checkpoint as their experience base. The problem from a police and crime commissioner strategic perspective is that it is ad hoc. In some places it is happening and in others it is not. We need a mechanism by which we understand the good practice and the evidence, and have a framework that enables it to be done consistently right across the country.

One of the things I want to take to the drugs working group is how, after the core diversion schemes, we look at the best examples and say that there is a model that should be delivered in partnership with the police, with other criminal justice services and Public Health England and public health departments. That is one approach.

The second is in terms of treatment. If you are convicted and have a treatment order, how do local public health departments commission those services? The reality is that funding has been going down and down, and therefore the number of people getting drug rehabilitation has been going down, and there is a risk that it could go further if the ring-fence for public health funding is removed in May 2020. There is a debate going on at the moment as to whether that is wise and right to do, because we need to make sure about the funding we have for health, not



just for health but how it joins up with the criminal justice system to improve harm reduction and alternative intervention, which is treatment and recovery. That is what we need to look at to build on all the good examples we already have.

Dr Spyt: From a statutory perspective, we find that youth offending teams are very well set up to intervene because they offer a very holistic service from all sorts of areas—from education to health, to housing and to social care. That system is not in place for adults. Ultimately, while we refer people to a public health outcome for drug support, diversion or education, the other underlying aspects may not necessarily be available—for example, for housing or other health or mental health issues. There could be benefit in bringing a more holistic approach that is made statutory for the care of the people we refer.

The second aspect, as has been highlighted, is that, while we make sure that we work within the law, all of these schemes are very different. We work closely with the Ministry of Justice in order to have the dispensation to try different approaches, but it is a lottery as to which one works in what area.

Chair: We have an awful lot of questions to get through, so we need to have much shorter questions.

Q255 **Diana Johnson:** In terms of harm reduction, is there a particular issue with Spice? It was mentioned by one member of the panel. In the east of England—Lincoln and Hull—there are people lying on the floor in city centres in a way that you do not normally see with people taking drugs. I wondered if there is a particular harm reduction issue there.

Jason Harwin: Obviously, I live in Lincoln now. I have done the walk-through. There have been some initiatives through multi-agencies of what works, not just to deal with the individual drug needs but the wider issue of why that person is not living in accommodation, not in work and so on.

Spice is very cheap, as the PCC has touched on already, so the reality is that it is used as a means to get through the day. I have spoken to users. We have hosted a number of workshops, and there was a national conference at the end of last year with the police service and public health on our response. There is not necessarily treatment for Spice. It is about why people are taking Spice—the underlying issue.

It continues to create an issue, particularly where it is very visible in town and city centres, but there is some evidence base for how it is effectively being dealt with. It is around peer-review and evidence-based work with the universities we have been working with, to make sure that we address not necessarily the drug-taking piece but the underlying issue of why they are on the streets and why they need to take drugs.

Chair: Thank you. We have a lot to get through.



Q256 **Andrew Selous:** Could you tell me what role the police have in trying to prevent drug use in the first place, or is that not your role?

Jason Harwin: No, it is. The police service, as my colleague said, is there to prevent crime, not just to respond to it. You will be aware that we do some joint working with local education, particularly around how we educate young people in schools.

Q257 **Andrew Selous:** What do you find effective? I was having a conversation at lunch with some young people. Older people of your and my age telling young people not to do things is not always terribly effective, is it? What works with young people?

Jason Harwin: The first thing is, what do we mean by young? We have a number of mini police schemes, which you should be aware of, where we do intervention in our most challenging communities, our most deprived communities. We start working with young people about building trust and confidence, because that is the first part, particularly if they come from a family that has very little confidence or trust in the police service.

Ultimately, it is around influence. Again, it is not necessarily the police service, where we are concentrating on the law. We work with third-party providers to understand the consequences individually. A lot of that is around peer review. Getting other people who have been involved in taking drugs talking about the impact it has had on their life, and their family life, is where we see the greatest benefit. The challenge is that we do not have enough capacity in policing to do it in all the areas where we want to target it. It is very ad hoc depending on the police capability in each force.

Q258 **Andrew Selous:** Has there been any evaluation of what is most effective in terms of prevention?

Jason Harwin: There has been of some of the work that has been done on the role of the police, working within education and working with other partners. There is some evidence base. I do not have it with me, but I am happy to submit it to you.

Q259 **Andrew Selous:** Yes. If you could send through what you think has been most effective in the prevention area, that would be helpful.

In 2011, there was roughly a 60% conviction rate for drugs offences. I see that for 2018 we have gone down to not much over 35%. That is a very big shift. What has been behind that? What is going on?

Jason Harwin: There are a number of issues. First, we should talk about the capacity of the police service to be proactive in target enforcement around serious and organised crime. There has been limited capability. If you look at the amount of drugs recovered by the police service and other law enforcement services over the last 12 months, it has continued to reduce. I think it is 2% down over the last 12 months.



HOUSE OF COMMONS

The other part is that other schemes are starting to be created where, ultimately, we are not necessarily looking to criminalise the individual. We still record a crime, but we are trying to make sure that that person's vulnerability is addressed and therefore they do not want to commit further offences. Some of the schemes talked about here are about making sure that we do not look to send people to court unless we really need to. We want to make sure that we address their issues for committing crime and therefore prevent further offending in the future.

Q260 Andrew Selous: It is still a big shift, isn't it? Was it Government-directed? Was it the police on the ground sensing that it was the right thing to do? I have these conversations with my own police force, and they tell me that sometimes these things are in fashion or out of fashion. That worries me a bit. I am not quite sure how policy is being evolved in this area, but it is a great shift, isn't it?

Jason Harwin: It is fair to say that, in policing priorities, drugs, while they are a driver of crime, are not the only thing we have to deal with. Other priorities we deal with are the newly emerging crimes around cybercrime and the wider issues around modern slavery. Clearly, quite rightly, we need to understand and address those. Again, it comes down to competing demands.

The important bit, and certainly the work I am doing with the NPCC, is recognising that drugs are a big driver of criminality, with links to organised crime. Importantly, we now have a national strategy. The national review, hopefully, will influence that strategy to get it up to date, but, importantly, in the police service we recognise that we cannot do this on our own, and that is where we are asking for public health support around a health public response.

Q261 Andrew Selous: I want to move on to the diversion schemes that the police are starting to use. We have had a briefing on three of them: from Durham, the Checkpoint scheme; Operation Turning Point from the West Midlands; and the drugs diversion pilot in West Berkshire, which is a Thames Valley initiative. First, can I establish whether we need the overlay of the criminal justice system to get people into these schemes in the first place? Am I right in my understanding of that? We say to people, "Right, it is a criminal justice route or, if you comply, you can go down this route." Is that correct? Do we need the stick as well?

Jason Harwin: Yes. The important bit is that, if people do not comply with the scheme, we put them through the courts process. That is important because there has to be some deterrent at the end if people do not comply. Clearly, after a number of stages, ultimately, it goes through a criminal prosecution.

Q262 Andrew Selous: When we talk about decriminalisation, we have to be quite careful, don't we?

Jason Harwin: We do.



HOUSE OF COMMONS

Q263 **Andrew Selous:** We need that bit of criminal law to be there in order to drive the types of schemes that I think we are all broadly in favour of. Would that be a correct understanding?

Jason Harwin: It would. Some of the schemes are slightly different, but, using Checkpoint as an example, the important piece is the amount of time people are on that scheme initially to make sure that they comply with the scheme. If they do not comply with the scheme, we can still report on summons and therefore they go through the court process. It is important to recognise that we can only give people so many choices or opportunities. At some stage, there has to be a line and, if they have gone past that, we take action.

Q264 **Andrew Selous:** As so often in this country, we seem to have three great initiatives. Are there evaluations? Do we have results? Do we know what works?

Jason Harwin: We do. I know it is rare, but actually we have. Checkpoint is evaluated; the Thames Valley piece has been evaluated; and the Bristol, Avon and Somerset, and West Midlands ones are being evaluated as well. The important bit is when the college comes in and we disseminate that information, not just in terms of the National Police Chiefs Council but across the wider partnership. That is where the public health piece comes.

Q265 **Andrew Selous:** Is the College of Policing working on that now?

Jason Harwin: They are involved in the strategic boards that we chair at the minute on drugs. As part of policing, and understanding and professionalising what works, there are workstreams about reducing harm.

Q266 **Andrew Selous:** Where I am going with this line of questioning is that we have these three initiatives and you tell me that, hopefully, there is some positive evaluation and we know they are working. When are we going to have it rolled out nationally? If we know it works and we know there is a good evidence base, presumably we are going to take the best elements of all three schemes and try to roll them out in a national programme. What is the timescale on doing that and what are the barriers in the way of doing that?

Chair: Shall we bring in someone else?

Hardyal Dhindsa: To address the point you are making, the evaluation that is most advanced is Checkpoint. There is evidence to show that there is a reduction in offending and reoffending as a result of the intervention, which is a deferred sentence of the court for four months. There is evidence on the short term, and now we are waiting for a year before we get the longer-term impact. That is the most evaluated and progressed. That model, in my opinion, is something that can be used to look at a model that we can have nationally, which can be versions of the different ones.



HOUSE OF COMMONS

Q267 **Andrew Selous:** My frustration, as always in this Committee, is that quite often we have something that works in one area, but we are pretty hopeless as a country at establishing the evidence base and then rolling it out. How are we going to do that?

Hardyal Dhindsa: The challenge to police and crime commissioners from the drugs working group and the Home Secretary was exactly what you just said. If it can work in some areas, why can it not work all across the country? That is the piece of work on which Jason Harwin, as the NPCC lead, and I, as the APCC lead, have taken one paper to the drugs working group, and the next paper will be to say that we have a model that can be delivered across the country.

The issue will come down to funding, because the funding source at the moment in Checkpoint, for example, is the police and crime commissioner and the chief constable. The element of public health in there has to be questioned. Should there be more of that? We need a model that can be funded and then we can deliver it nationally. That is the discussion we are having, and we have been charged with saying, what is the model that we can actually bring forward?

Q268 **Andrew Selous:** What is the timescale over which we could see this if we got on with it?

Jason Harwin: It has already started. There are forces not mentioned today that are starting to use the experience of Checkpoint and are looking to see how Thames Valley's project actually works. Some of that is happening. We have done some work recently, on which I can give you an update outside the meeting, on which forces are starting to use similar schemes, with an evidence base, and are seeing outcomes in the benefits it brings to individuals.

Q269 **Chair:** Stephanie wants to come in.

Stephanie Kilili: On the Checkpoint scheme, we had the same concerns as yourselves in relation to one single force going off and doing an innovative project and what follows from that, which is why we have worked in collaboration with Cambridge University. We have gone through a randomised control trial over a two-year period. We have interim findings, which obviously we are more than happy to share with the Committee, but to make sure that we align with the Ministry of Justice's proven reoffending definition we still have to wait another 12 months. The interim findings show that it is currently successful. That is our timescale.

In relation to that, nationally, the Ministry of Justice is carrying out pilots with a few other forces. The Government have acknowledged that, yes, they ought to evaluate the scheme as well, so that is ongoing at this moment in time.

Dr Spyt: To echo what the PCC said, it is not simply a case of rolling out a scheme. Even in Thames Valley police, we have to speak to each local



HOUSE OF COMMONS

authority and each care commissioning group, and obtain their buy-in to what we are trying to do. If one of them were to decide that it was not in their vision or not what they were trying to do, the scheme could not be rolled out in that area because we need the funding and the ability of people, when we refer drug users to them, to treat them or to intervene. The picture is more complex than simply adopting one approach.

Q270 **Andrew Selous:** What you are really talking about is the pooling of departmental budgets, and getting away from departmental budgetary silos, with one group saying no and having the ability to scupper the whole thing.

Jason Harwin: It goes back to the issue about needs assessment and commissioning of services and, therefore, making sure that we are at the table influencing the conversation.

Stephanie Kilili: In addition, a lot of the funding happens post court. CRC and NPS funding happens post court, whereas we have suggested trying to bring that further upstream, so that other forces are able to implement such schemes at the front end, rather than waiting post court.

Q271 **Chair:** Stephanie, could I ask you to clarify what CRC funding is?

Stephanie Kilili: They are community rehabilitation companies. They are statutory providers for low—

Q272 **Andrew Selous:** Lower-level offenders.

Stephanie Kilili: Lower-level offenders, yes. Then there is the National Probation Service.

Chair: I just wanted to clarify that for the record.

Hardyal Dhindsa: They are for medium to low.

Chair: Thank you very much.

Q273 **Diana Johnson:** I want to ask about the high rates of BAME people who appear in the arrest, prosecution and conviction statistics, and whether any of what you are talking about can start to address and tackle that.

Dr Spyt: In the scheme we are running, we worked very hard, in relation to the Lammy review, not to require an admission of guilt in the scheme. It is not simply ethnic minority groups but sections of society or different age groups that either do not trust the police or do not want to engage with the police. The point or raison d'être of the scheme is to intervene and help people, so admission of guilt does not necessarily have a bearing on that. The pluses and minuses of different schemes have to be considered before a decision is made about which scheme you would like to roll out on a national basis.

Hardyal Dhindsa: It would be fair to say that the David Lammy report highlights some gaps. There is no consistent input in monitoring how the



HOUSE OF COMMONS

criminal justice system impacts on the BAME community. We need to do more to capture that evidence and the way it is being looked at now, as a challenge from the David Lammy report. I do not think it is very well established, and we need to do something in policing and the criminal justice system as a whole to capture that evidence, and then see how we make sure that we stop any inequalities in access to interventions such as these schemes, and access to justice. There is more work to be done in this area, having looked at it across the whole of the country.

Q274 **Diana Johnson:** Does anybody else have anything to add?

Jason Harwin: Again, the important bit is not about generalisation; it is about understanding impacts on local communities. What do we mean by our local community? What are the issues around it and how is the police service making sure that we are not disproportionate in response? In the schemes that are taking place, it is about early intervention, and not criminalising unless we have to criminalise. Importantly, it is making sure that we stop vulnerability and reduce potential reoffending in the future.

Q275 **Diana Johnson:** If we are looking towards using a public health or harm reduction approach around drug abuse, I think a number of people would be very concerned. What does that mean in terms of serious organised crime, county lines and child criminal exploitation? How would that be dealt with? How would that be approached? I guess it starts with the police.

Jason Harwin: To make it very clear, it is not just about saying that we are going soft on crime. It is not that. I make it very clear. This is about being more evidence-based in how we do it. In terms of serious and organised crime, we will continue with all the powers we have, with the law enforcement services, including local authorities, to do everything that we can to address the harm that those individuals, those groups, create in communities. That is around enforcement.

As I said—hopefully, it was picked up earlier—until we stop some of the demand and address individual need, the supply will keep coming. You can still take a public health response, particularly around individual need and use, and obviously that can involve families, which links to domestic abuse. The important bit for the police service is that by reducing demand, through a public health response, the police service's powers can be focused on addressing the things that create the greatest harm, which come from serious and organised crime. That is the message we continue to give.

Hardyal Dhindsa: We all know that 90% of all serious criminality is drug related in one way or the other. Why is that? Because there is commercial benefit for serious organised criminal groups.

Q276 **Mr Bradshaw:** And because of prohibition.

Hardyal Dhindsa: The example of alcohol prohibition in America is that criminals took the opportunity to make commercial advantage. That



HOUSE OF COMMONS

continues on the basis that there is demand that is not met by other means. That leads us into all sorts of things about what else we can do to tackle the issue.

In serious and organised criminality they target vulnerable groups, so we need to work on tackling and bringing down serious and organised crime groups, and 90% of the time spent by police forces is on that. However, as soon as they take down one organised group, somebody else fills the vacuum. There are concerns about county lines, modern-day slavery and trafficking and the drug element in that. A whole lot of things feed that industry. That is where the question is. How do we try to tackle this in a different way? Just enforcement is not stopping the problem, stopping the demand or stopping serious organised criminals using the commercial benefits of drug supply to take advantage of vulnerable people.

Q277 Diana Johnson: I still think that is an important message that needs to be got across, because, if people think that this is in any way going to mean that those who are exploiting people are going to have an easier ride, it is not going to go down well with the public. The public need to be reassured that policing resources are going to go into getting the people who are serious criminals.

Dr Spyt: We have examples from the diversion scheme that we ran. Officers spent less time dealing with people caught for possession; we have examples of officers spending 20 minutes with an individual, referring them and then making arrests for supply. Diversion schemes also have the opportunity to shift resources, which are obviously limited, towards more serious crime.

Q278 Chair: Thank you. Are there any final points that any of you want to make that you have not been asked about today before you leave?

Jason Harwin: Speaking on behalf of the National Police Chiefs Council, this is a really important issue for policing and communities. We are keen to work with all providers to make sure that we have a joined-up response. The reality is that an evidence base exists, and we should be looking to do it. We need to have the conversation about how we do it. The challenge comes back to resourcing, and I include money. At the minute, that is one of the blockers that is not making it happen.

Q279 Mr Bradshaw: There was a point you made earlier about the statutory relationship that you have or do not have with the health and wellbeing boards. Is that something you would like to have?

Jason Harwin: A lot of it works because we have relationships, but there should be a statutory footing. We should have people around the table, whether that be the police and crime commissioner, because of commissioning, or the police service in relation to needs and demand. We should have that. I see examples throughout the country where it is very mixed, and if it is mixed we are not going to the table to provide the information that will help commissioning services and therefore address



HOUSE OF COMMONS

the need. If we do not address the need, we get into police enforcement, when having to enforce the law is not the solution.

Q280 **Mr Bradshaw:** What specifically would you like to see happen, the police—

Jason Harwin: From my side, first, in terms of the cross-department piece of work, bringing it all together is important. In terms of statutory responsibility, we should have a chair at the health and wellbeing board. We should have statutory responsibility to be there as well.

Hardyal Dhindsa: Police and crime commissioners in the majority are members of health and wellbeing boards. My point would be that in order to develop a health-led approach to the issue we need better joined-up co-commissioning. One of the areas where we need to do that is at national Government level, a joining-up of the different Departments, because they all have a part to play. At local level, our police and crime commissioners—not just the police, but the end crime bit, which we are talking about—can co-commission with public health departments. I think Public Health England would support that and the Home Office most likely would also support it. That would be an approach that would progress what you are looking at in terms of health-led interventions at the moment.

Q281 **Mr Bradshaw:** Stephanie said that she would like the policy to be given to Health. You talked about the cross-Government work that is going on, chaired by the Home Office. Would you rather it was chaired by the Department of Health and Social Care or Public Health England?

Hardyal Dhindsa: That is to develop from the working group. At the moment, the recommendation of the drugs strategy in 2017 was that the Home Secretary chairs and co-ordinates all the other Departments and identifies whose input is required at different levels—health, education, the CLGs and Departments. There is criminal justice—the MOJ. Everybody has a part to play if we are to tackle the drug strategy. The health element is very important, but all the others are very important as well.

Q282 **Chair:** At every level of people I meet throughout the Devon and Cornwall police service, I am told that it is not just about drug use; it is about wider vulnerability. Do you think that is also an argument for having the police on health and wellbeing boards?

Hardyal Dhindsa: Yes. I attend the two health and wellbeing boards in my county. I think most police and crime commissioners do. That should be there, but, in my experience, that is not where the work gets done. The work is about commissioning services around health and criminal justice, in mental health, alcohol, drugs and homelessness. If we can have better joined-up commissioning of those, with local leadership consistently, as opposed to being based on different health groups or others deciding whether they want to do it or not, that will make much more impact.



Chair: Thank you for that and thank you all for coming to give evidence this afternoon.

Examination of witnesses

Witnesses: Mark Johnson, Emily Giles and Kerrie Hudson.

Q283 **Chair:** Welcome to our second panel. We want you to focus on the experience of users and the families of users, and the wider impact in the community. Could I ask you each to start by introducing yourselves and who you are representing today?

Emily Giles: I am Emily Giles, the policy and communications lead for ADFAM, which is the only national charity representing the families of those with drug and alcohol use issues. I apologise for my voice. Hopefully, you can all hear me.

Chair: We can; thank you.

Kerrie Hudson: I am Kerrie Hudson. I am the service manager of The Well communities. We are a peer-led recovery organisation.

Mark Johnson: I am Mark Johnson, the founder and CEO of User Voice, a criminal justice charity.

Q284 **Chair:** Thank you. In opening this discussion, would each of you, starting with Kerrie, draw on either personal experience or the experiences of people you have been working with, and set out for us the scene of the type of harms we should be hearing about loud and clear in this Committee?

Kerrie Hudson: I am happy to wear two hats. I am in recovery. I was a heroin addict for 16 years. I am 11 years in abstinent recovery and, obviously with our organisation, I work with people who are trying to recover and achieve recovery.

I was discussing this on the way here. It is the damage to self-esteem, the damage to self-respect, the unresolved trauma, the lack of ambition, the stigmatisation, the going to places for help and getting the wrong kind of help and the wrong kind of support. That then perpetuates the feeling of uselessness and hopelessness because you cannot do what people are asking you to do or what people are expecting of you. There is the damage to your family members. It is knowing: people are fully aware of the damage that they cause when they are in addiction but they are just incapable of stopping it. You go against your conscience; you go against what you know to be right and wrong.

One of the biggest things is retraumatisation. I have yet to meet anyone who has tried to get help with a drug addiction or a drug problem who has not experienced trauma on some level. The whole lifestyle causes retraumatisation, because what it takes to actually be a drug addict—the things you do to get your money, the crimes you will commit, and the



HOUSE OF COMMONS

damage to families and communities—is very evident even through the haze of the drugs you are taking.

There is not very much support for the trauma. I liked what the guy from the police said; it is about looking at what is really the problem. It is not so much just the treatment; it is going behind it, because we can keep offering the same solutions.

My experience of coming into a service was that I left school a heroin addict; I had my first methadone script at 17 years old but not a single person ever asked me, “What’s happened?”

Q285 **Dr Williams:** Really.

Kerrie Hudson: No. They just wanted to treat what I was presenting with, and what I was presenting with was a problem. In some cases, in some forms of help, that is still done. We work in hospitals, and a lot of people, predominantly alcoholics, use hospitals rather than statutory treatment services because they can remain anonymous. I know a guy who went to hospital over 90 times to do a detox and he was never referred to a service. You can present at a hospital and what they deal with is the immediate thing, and then you are sent back out into the community and there is no support.

There is a lot of work to be done on integration. Partnership working is great, but there is a lot of work to be done to marry up all the organisations, to make it possible to work together, and to have shared respect and understanding. Using hospital as an example, I can go there with a broken arm and you will treat my broken arm, but is anyone asking why I have a broken arm, “What has happened?” Is anyone looking at the person who is going in with the injury? What we do straightaway is find out if there are any children at home. There are lots of ways we can be helping people and lots of questions we can ask, and I do not feel that the right questions are always asked.

Q286 **Chair:** Thank you. Mark, do you want to add to that?

Mark Johnson: Like Kerrie, I am in recovery—19 years. Before that, I was living on the streets of the west end. My story is very well documented. My autobiography came out in 2007. I used the money from that to set up the charity that I have now founded and delivered. It predominantly works in prisons. I have 50 employees, and we work in 30 prisons and two thirds of the probation CRCs. It is 90% led and delivered by people like Kerrie and me, which is the user perspective but on a scale that offers something directly for policymakers and opinion formers, and stuff around the data.

My own experience, the process when I got clean, was that I got off the street and went into detox—Elephant and Castle, Equinox, which is actually the only service that still exists from 19 years ago. Kerrie gave a great example of treating the problem but not the causes. I went to Equinox and I remember doing a six-week stay but breaking out of the



HOUSE OF COMMONS

window to go and get crack and heroin, because my problem was up here—in my head; as well as dealing with the physical, it was up here. There were no therapy groups then, so I used to run off and score and get in a bigger mess.

The care manager was an ex-service user and he worked for Turning Point. They were doing community action work, which they do not do now, so that job has gone. He took a risk with me, knowing I could not get clean because I was a chaotic intravenous crack and heroin user. He said, "You need to be more than a train ride away," so he relocated me. A form of confinement, relocation and longevity of support are key to a person's journey. I went to a treatment centre—one of the oldest ones—in Bognor Regis. The only things you can do there are die of old age or get clean, and I went there.

Chair: You are not selling it to me.

Mark Johnson: That guy stayed with me for 12 months. I had 12 months residential treatment. My feet never came back into society for 12 months. For the first three months, I could not walk, so it was about physical repair and sleeping and all that sort of stuff. Then in a room quite similar to this, but not as grand, in a circle of chairs with my peers, I had every deluded belief I had about myself peeled away. It was safe to unravel and be rebuilt again in that process of drug treatment. It has gone; it has closed.

The second one I went to was in Bournemouth. Closed. The third one I went to was in Weymouth. Closed. In their place, there is this veneer of treatment provision, which is a day programme or information, advice and guidance to people who are at the end of the road, who are chronically addicted and need to be away from society in order to heal, recover and get well.

Some of the problems back then were around measurement—the statutory services measuring the effectiveness of residential drug treatment. They measure it on a cycle of 90 days. Well, 90 days is the highest reconviction rate for an offender and the highest relapse rate for a recovering drug addict. We talk about evidence-based practice, and it does not look like it works, but when you look at the disruption that it causes in somebody's mind, to know there is a solution to a drug problem, it works; trust me, it works. It might take 10 times or 20, but when they recover, you get people like Kerrie, and her boss and myself, making this instrumental change with other people who were unreachable in society. The message is hope.

What has happened is over-reliance on statutory services, and there is a skills deficit. Because there is a big corporate machine delivering drug services en masse, you miss the point; you miss the human point. Actually, my case—then I will shut up—is to make direct investment in the individual and do the job really well on an individual level, and look at them long term and the contributions that they make to society once



HOUSE OF COMMONS

they get the addiction treated, because I have never committed another crime; I don't know about you.

Kerrie Hudson: No, I haven't.

Mark Johnson: All my crime was related to the drugs. In the last six months, User Voice has worked with 10,000 people on orders, in prison and probation; 75% of them have drink and drug-related issues while they are there. We work in 15 prisons, which are health-related, with the NHS, and 35% of those people said that drug treatment services improved but did not fit their need, because of the veneer. You can get methadone or a script or whatever, but all the talking therapies and stuff afterwards are just not there any more.

Kerrie Hudson: There was a study done recently on a one-year timeframe of going into service, where a service user was working with a key worker. There were only one and a half hours of therapeutic time given in all those appointments, to actually discuss what the problems might be.

Mark Johnson: We interviewed 200 children who are in the secure estate right now. It was a report for the NHS around Spice use. I know that Andrew was a Prisons Minister when it was epidemic in prison. We did a report called "Spice: The Bird Killer." We are looking at doing No. 2, in prisons and the epidemic there, but we did an intermediate one on children and Spice use.

We worked with 200 children who are locked up, which is a massive sample, because not that many kids are locked up, and 75% said that they had used cannabis. That is from 11 to 15-year-olds. That is the other factor, which is like a ticking time bomb and goes unnoticed. We focus on academic attainment and achievement and so on, but with the emotional needs and the causes—like Kerrie said about the broken arm—we are just missing the point. We are not getting it until the police catch people, and they are like a default mental health service and drug treatment service. Prison is a default drug treatment service. The number of times you hear prisoners saying, "Prison saved me from myself," because physically it was the only thing left. You go for treatment, and there is nothing there.

The last point is about NPS—novel psychoactive substances. I am not sure if it is talked about in your review, but it is at epidemic proportions, and it is a ticking time bomb because it is changing the drug user. Lots of people who stopped taking Spice because of mental disorder—you are predisposed to having a fit or a bout of psychosis, in which case you do not take drugs after that point—are not presenting as problematic drug users; they are mentally ill, and it is not being connected at all in any way. There are substance misuse services, and we talk about chronic crack and heroin use, but there is nothing, to my knowledge, that is fit for purpose for those types of users.



On the trajectory of drug use, you talk about county lines and stuff and it is polarised around that, but I think county lines have existed since drugs have existed. It is just polarised because it sounds cool, but the evidence I have read is questionable at best. You can buy NPS off the internet, so in places as remote as Cornwall kids have completely got access to it. Nobody is talking about that. Children presenting in mental health services are not problematic drug users; they have psychosis and they are mentally ill. That is an area we need to look at.

Q287 **Chair:** Thank you for pointing that out. Emily, can I bring you in to talk about the impact on families?

Emily Giles: Absolutely. While these two were talking, I was interested in how similar a lot of the impacts that we see are, but obviously they are one step removed. I can rattle off, and I will, a whole list of the most common impacts that we see, but the really important thing to make clear is that these are really interconnected, complex issues. Vulnerable individuals came up a lot on the last panel. There are often vulnerable families, before and often after these issues have come up.

I have yet to meet a family member who has not mentioned 80% or 90% of this list: relationship difficulties; family breakdown; issues with communication; severe mental ill health, which is very stressful and creates anxiety and depression; and isolation from friends and family, which is very linked to the issues of stigma that we hear about. I think everyone is aware that users themselves suffer from lot of stigma, but the families report the same thing. They might reach out to friends or family, and if they say that their loved one has a mental health issue they get empathy and support, but if they then say that they are a drug user they get shunned and stigmatised quite heavily, which is a very isolating thing to experience.

There are a lot of financial impacts, so they get into debt, whether through trying to support their loved one with an issue or through theft, being involved in some way in the criminal justice system as a result of their loved one. Physical violence and abuse are often quite common in a family; it comes along with relationship breakdowns. There are lots more day-to-day impacts, like missing work on a regular basis. A lot of people take on informal caring responsibilities. One lady pops to mind. Her son is in recovery now, as of recently. She says that even now—it has been going on for years—she gets about 30 or 40 phone calls each day from her son. It used to be to ask for money; now it is just to check in and have someone to talk to. Trying to go about day-to-day life and go to work while your phone is ringing 40 times a day and you know you need to answer it is a real challenge.

There are lots of physical health impacts as well, mostly related to the stress and anxiety that comes with all of it.

Chair: Thank you very much.



Q288 Diana Johnson: I would like to ask about problem drug use, linking it with wider issues, such as poverty, lack of educational opportunities, homelessness and employment prospects. It seems to me from what you have said already that that is probably a lot of why people go on to use drugs or alcohol. What would you say about how society could deal with it through some fundamental changes, particularly around, say, housing or education?

Kerrie Hudson: Obviously from what I see and what I have experienced, poverty comes first. That is the predominant factor. I live in a place where there are lots of council estates, and just in the last five years a lot of the funding has been cut from those estates. There is not a lot of youth support, not a lot of family support and there is not a lot of what there was. On the estate I moved from a couple of years ago, there were three stabbings in an eight-month period. It had been a relatively working-class council estate, but with the shifts in funding and there being literally nothing for youths to do—there were third or fourth generation benefit claimants—there is no aspiration and the local schools are not all that good.

There is a real hyper-vigilance as well in those areas; a lot of people are living quite anxiously. Then you look at the reasons why they might take drugs and it becomes completely obvious. Getting to school is really hard; for parents to get the kids to school is hard. By the time the kids get to school, they have experienced stress through maybe going in on an empty stomach and some of the kids know that they go in looking scruffy and they are without. Then, when they get to school, they need to stay focused and concentrated, and to have people actually take an interest in them when they get there and look behind behaviour.

It may be to do with the divorce rates or separation rates that exist in these communities. If the school knows that a divorce or a separation is happening in a family, which is one of the biggest childhood traumas, what are they doing? There is a real responsibility, because I think it is about prevention. It is not about, "Let's wait till people get to 16 and they become a problem, and they become criminals or they appear to be threatening." What are we doing for the three-year-olds who are going to nursery when we know there are obvious problems at home? Where is the provision? Where is the extra support? Where is the counselling? Where is the holistic approach, instead of looking at, "Are they at this point with their reading? Are they at this point with their writing? Tick. It looks like we are doing our job."? There needs to be more resource into eyes being opened to see the effects of the way people are living, not always through choice.

Mark Johnson: I agree with what Kerrie said. One other impact is that taking drugs is a personal choice; you have to choose to do it. That is where the debate has been, for a time, ill informed: "Well, you chose to do it." Actually, what we do know is that addiction is a phenomenon as well, so even the brightest academic mind on psychology still has to say,



HOUSE OF COMMONS

"Dunno." I look at my own drug use and my work with a lot of people over the years, and actually it is about having more informed thinking and choice.

For me, on the schools stuff, the family unit, as Kerrie said, is often unreliable for nurture, love, support and structure and so on; it is just broken, it has gone, especially with the internet and stuff as well. What do they do? They go to school, a state institution focused on academic attainment, not on emotional intelligence and being able to talk about how you think and feel in a safe environment. Whether it is there or not in the family home, the one place that does join children at a young age is school.

What happens with people who are predisposed to drug use is that they get ostracised for being abnormal, myself included. I used heroin at 11. That is because of the social network on the housing estate; it is well documented. Often in schools, you are made to feel different. With the three types of abuses—sexual, mental or violence—it is not the event that does the damage; it is the feeling of isolation that comes with it. Then you get a driver for self-medication, because nobody really wants to feel shit—sorry. That is the driver to make you want to change how you feel.

Then you go into that lifestyle and that network, and I would say that even the people the police are calling criminals—the people they are playing cops and robbers with on the housing estates—are vulnerable, because all they are doing is economic behaviour: "I know somebody with a bigger parcel than you, so I am just going to supply my own habit to do that." There is that as well. With young offenders in Aylesbury, for something like 50% of the people in there, the serious knife crime and violent crime stuff is attributed to drugs and alcohol. When you ask them, "What were you doing?", self-medication was the reason. Their choices are completely diminished through the chemicals they are putting inside their body, and nobody is reaching them. Nobody is reaching them to say, "What's going on?"

I think the police are a large part of the problem, because they are the ones who are there and probably more funded than all of the social care services. I did a documentary for Radio 4 where I interviewed street users and the police. The police are getting really well funded to give PCSOs and all these orders for people who literally have no choice other than to sit begging. They have lost their benefits, they have no house, they have anxiety and depression, they cannot use the local housing services because they get bullied when they go—the day care centres and stuff—and they are literally just concertinaed. For them, society does not have a consequence. How much more can you punish somebody who is sat in a shop doorway or taking such high risks with their own health with an unknown substance? How can we punish people like that? Yet we attempt to.



Chair: We are now going to come to the prevention angle with Johnny.

Q289 **Johnny Mercer:** You say the police are partly to blame, but what do they do?

Mark Johnson: We criminalise ill people.

Q290 **Johnny Mercer:** I understand that, but what should we be doing differently to get away from that? It kind of leads into my question, if that is all right, Chair. Clearly, these issues are hugely multi-factorial across many areas of society and an individual's life and family and so on, so what are the things we can really do? We can talk about money and investment in addiction, and I would be the first to champion that. It is a real source of pain for me, the way that has happened, particularly in Plymouth in some of the areas I work in, but what would you do differently if you were the Home Secretary's special adviser at the moment on drugs?

Mark Johnson: If you are asking me, I will try to answer quickly.

Johnny Mercer: You, Kerrie and then Emily.

Mark Johnson: Kerrie's story and my story are not unique.

Johnny Mercer: No, I know.

Mark Johnson: We have navigated it. In 20 years, I have been to over 70 funerals of people I have worked with. Within four years of getting abstinence, I employed over 200 people—on drugs and out of prison—in my first business and I won loads of awards for it. Now I have 50, but probably there have been about 500 people.

What Kerrie has got, and what people with lived experience of the problem have got, we need to bottle. We need to follow the story from beginning to end and invest in each of the steps. As I said, the journey starts with an unreliable family structure, so do we do that with the state, do we focus schooling on actual emotional wellbeing rather than academic achievement? I do not know about you—am I middle class? No, but the kids go to school and that sort of stuff, and with the pressure they are under to achieve and go through the statistics, I can see the stress, never mind if you have a predisposition to being an addict or have some emotional unmet need. There is nowhere for them to go; they are completely isolated, in which case drugs and the need to escape become very attractive. It is there.

On the policing side of it, there is an assessment to be had. I am not a prison abolitionist, believe it or not, because, as I have said, if you are an addict and you commit a crime, you pay for that by being removed from society. That is an ideal opportunity to treat someone—ideal—and it never gets done, because we do drug treatment services en masse in prison; it is just corporate machine box-ticking, with short duration, information advice and guidance programmes and so on.



HOUSE OF COMMONS

We need to go back to probably 2000—that level—and have that kind of investment in residential drug treatment services, literally having people welded to the police for referral in police cells, to divert people from being charged with a criminal offence if they are known to be a problematic drug user. It is about removing the stigma behind people, ex-prisoners or ex-drug users, and welcoming them back in and then having the industry—the people with lived experience—actually integrated in all sorts of services, which we are seeing more and more, though not in the police and not in prisons.

- Q291 **Johnny Mercer:** What is a bit frustrating about that solution—the whole sort of integration of addiction into all of these touchpoints where the state is going to touch you, whether it is in your family, your school or when you first go to prison, or whatever it may be—is that for a long time people have been saying, obviously, that that relationship needs to be very close together. I read parts of your books, and when you started doing this in 2007 you had that event at Clarence House and John Reid came to it and things like that.

Mark Johnson: A good memory, yes.

- Q292 **Johnny Mercer:** When you meet these people, where is the disconnect between saying to the Home Secretary at the time “This is what needs to happen,” and then it does not happen? I think I know where it is—local authority funding and things like that, okay—but what is not getting through from your message, do you think, and why is it not getting through?

Mark Johnson: For me, it is being led by the end-user perspective.

- Q293 **Johnny Mercer:** What do you mean?

Mark Johnson: The person, the patient or the offender or whoever is looking at the world from that perspective and not the siloed approach that the state has. If we put them at the front of it, you would start to see the journey. I call them the dos, the don’ts and the haves—the “do engage”, the “don’t engage” and the “have engaged”. All of those people can offer a 360° view of the problem, or the solution funnily enough. There is a piece of work called ReConnect with the NHS around people returning to society from prison, and it has just started its second meeting. That was front and centre of the whole thing around putting the person’s journey at the front: follow the journey, not the state institutions, because that is where we miss it.

One thing I want to add is about where policy exacerbates the problem or actually creates it.

- Q294 **Johnny Mercer:** In what way?

Mark Johnson: It is best to give you an example.

- Q295 **Johnny Mercer:** Yes, go on.



HOUSE OF COMMONS

Mark Johnson: Mandatory drug testing in prison was introduced in 2010; I am sorry if I upset you, Andrew. It was, "Drugs will not exist in our prisons. We are going to test for them." Cannabis was the drug of choice in prison, but then there was an immediate spike in heroin use. There is a belligerent denial that intravenous drug use exists in prison, so possibly nobody knows because there are no reports on it, but I know the word on the wings, and that is a spike in blood-borne illness transition through people sharing needles. Heroin stays in your system two days in prison, so you could take it on a Friday and it is out of your system by the Monday. With that policy, you have created an escalation in somebody taking higher-risk drugs.

Point two is NPS and the rise of it. You get treated punitively if you get caught with heroin and you are not treated, so you do not want to get caught. Somebody comes in with an unknown substance for which there is no testing parameter that is fit for purpose and it gets through MDTs, so you start taking this stuff from China that is in liquid form, and sprayed on something that looks like weed but is not. You have one inhalation and you can go into psychosis for the next two years, and it has taken over the prison.

All that is through the MDTs. That is what has literally created the funnel of people taking higher risks with their health. Somebody quite senior in HMPPS asked, "What is the answer?" I said, "You're not going to want to know." They said, "What is it?", and I said, "Stop MDTs." Well, that is not going to happen, so drug use is not going to stop happening.

The second part of that is that prisons have gone smoke-free, which, in a real middle-class way—sorry to be politically incorrect—is a good thing. I actually agree it is a good thing because smoking is bad for your health and stuff. However, there is a cohort of people entering our prisons with chronic heroin and crack use and so on who are not getting treated, and the state comes over and says, "By the way, you are stopping smoking as well, and we'll provide cessation programmes, but you can't get them for two weeks." In that time, you have gone cold turkey off the fags, not had your drugs and alcohol treated, but you don't smoke in prison. You have a situation where tobacco is more costly than Spice and heroin. It is mad. That is all policy.

If you put the service user, or the prisoner, and their experience at the front of that—however unpalatable that is politically, around being seen by the press to be pandering to offender needs or drug addicts' needs—and if you had done a robust consultation before implementing policy, we might see something a bit different. We need to analyse the people at the sharp end if we want a real solution to the problem.

Q296 **Johnny Mercer:** Thank you. Kerrie, we have talked about the broader solutions. What would you add to that, particularly around prevention?

Kerrie Hudson: I think it is about healthy communities. The one thing we focus on is trying to establish healthy communities that are full of all



the support that people need, and for us to have access to that support and know the roles of the different organisations. One of the things we do particularly well, for example, is that we take the person who enters our service and look at all the organisations they would likely need that are going to be involved in their recovery, and do our level best to build up relationships with them. I think quite often what is missing between statutory and the third sector is that relationship, and healthy respect.

The one thing we believe in as an organisation is that you do not need to go 100 miles or 200 miles away to a rehab. I never got offered that. That was a privilege for people who had money. When I was in treatment service, it was not for everybody, so I got clean in my own community and I really believe in people being able to stick around their own community, because either you go away or people die. You never really knew whether anybody ever recovered. You need to know that there is some supported housing, that there is a day-hab facility, and that there is sufficient mental health support. What happens when people stop taking drugs is that, essentially, you are lifting the lid on a lot of the trauma and mental health problems that exist underneath, and I do not think services can run without mental health provision alongside.

There are lots of drug treatment programmes that are very effective in stopping people using drugs in the short term, but they do not offer a long-term solution. The long-term solutions reside in resolving the trauma. It needs to be localised as well. We are very active in several different communities across different counties. The drug problems you might find somewhere like Fleetwood are completely different from what you might find in Barrow or in Lancaster, so I do not think it is one size fits all. It is about an assessment of that community and an assessment of need; it is important to have those people with lived experience.

I still run into people I used to use heroin with and it is, "What have you done? How have you managed this? Wow, what's happened?" You need to see living, breathing examples and have people who can speak to you in a way you understand. We never try to fix anybody and we understand that it is a relapsing condition—addiction, alcoholism. You will go into relapse and that is okay, but you are not shoe-horned out of a service; it is not, "Right, our time is up. We are done." We create communities and you are always a part of that community, so whether you relapse, take a dip in your mental health, or perhaps move somewhere else, you can always come back. It is about resourcing communities effectively.

Q297 Johnny Mercer: There were two in-depth answers there. If you could be concise, why do you think the UK currently has its highest ever levels of drug-related deaths?

Kerrie Hudson: Wow.

Johnny Mercer: Briefly.



HOUSE OF COMMONS

Kerrie Hudson: Briefly. Why does it? I think there is a lot of poly-drug use. Recently, I got to hear about a coroner's report where there were 15 drugs in someone's system, and 13 of those were prescribed. It could be irresponsible prescribing; pregabalin has been mentioned a lot in drug-related deaths. It is the latest for people experiencing pain.

We have an ageing heroin population. We are getting 50-year-old heroin addicts. In a sense, they are casualties of harm reduction; they have just been plied with methadone, with no real vision of what recovery is or that you can do better optimally dosed. You find that a lot of people do not want to be optimally dosed. Nobody wants 120 ml of methadone. You look like you belong in Madame Tussauds; you cannot think, you cannot speak, you cannot function. A lot of people just want about 30 ml and then they can go about their lives. A lot of heroin addicts work.

Q298 **Johnny Mercer:** Why are they over-prescribed like that?

Kerrie Hudson: Because it is safe; it is harm reduction, and then they won't use on top.

Mark Johnson: And providers could call it treatment.

Kerrie Hudson: Yes.

Mark Johnson: When we say we have been in treatment, that is what treatment is.

Kerrie Hudson: Yes, that's right, but the funny thing is that, if you speak to anyone who has been on methadone for 25 years, they say, "I've never been to treatment." They don't even know that they are in treatment, so that is about the message between treatment provider and service user. There is a lot of that.

Q299 **Johnny Mercer:** There are a lot of reasons. Emily, why do you think drug deaths are at the highest they have ever been?

Emily Giles: To be honest, that is not a question we have an answer to. We are focused on the family side.

Q300 **Johnny Mercer:** What about you, Mark?

Mark Johnson: The economic climate is a massive factor, and the need that drives people to want to get off their head and take a higher risk for themselves.

Q301 **Johnny Mercer:** Can you expand on that a little bit—the economic climate?

Mark Johnson: Basically, the removal of so many people—

Q302 **Johnny Mercer:** The safety net.

Mark Johnson: And creating more poverty than has ever been seen before. I do not know how many of you guys frequent some of the places



HOUSE OF COMMONS

where you actually live—the town centres and certain estates, and so on—but it is visibly different. Homelessness is probably getting on a par with when I got off the streets. In Westminster, you are literally stepping over bodies—half-dead bodies—all the time. We see that daily now, and so do the public.

People who experience poverty have more of a driver to want to get off their head, and that is what Kerrie just talked about with driving their drug use and stuff, to which they are more predisposed. There is also health—wider health. There are older crack and heroin users; people do not last very long. With User Voice, we work in prisons, and we talk about offenders being vulnerable. This is not palatable at all, but my definition of vulnerable people are those who are more predisposed to die from their psychological illness and their lack of awareness of their health and their unhealthy choices. That group is a prime target.

Can I just mention one thing about families? We have done two reports. One was for the previous Prisons Minister, which is the 10 Prisons Project. I do not know if any of you have heard about that; it is under embargo at the Ministry of Justice. The recent one, which is out in six weeks, is on the impact of smoke-free prisons. It is quite a substantial report. Before those, the previous one was on Spice use.

All of them indicate the impact on the family. The thing we do not acknowledge is the escalation in violence, debt and bullying among this group as well, where the criminal fraternity get involved. In prison particularly, that impacts on the family more than anybody else. I am talking about phone calls when people owe extortionate amounts of money and there are pressures. The phone call says, "Your son's going to get shivved if you don't send regular payment." It pushes a vulnerable group even further, and the pressure is on the family. I call them the unseen victim in all of this. We see victims as people who have crime perpetrated against them, not as relatives of the perpetrator. That probably needs to be put in there as well.

Johnny Mercer: Thanks, Mark.

Q303 **Andrew Selous:** Mark, can I take you back to something you said about your own journey? If I understood you correctly, you were saying it was the fact you were taken to residential rehab, out of the area where you had been involved in drug use, that had been quite critical. Is that a correct understanding of what you said?

Mark Johnson: Absolutely: 100% removal. Kerrie's experience is a little bit different. There is this thing, "Well, I experienced poverty and I never took to drug use." It is about the person's moral faculties, or emotional and mental abilities and that sort of stuff. For me, I was living in a doorway and I had reached the end of the road. I would inject myself probably 10 to 15 times a day with a snowball—crack and heroin together—and I think that any drug addict would say that is probably the end of the road with drug use. You cannot get higher.



HOUSE OF COMMONS

I had to be removed from society. I had to go somewhere that literally could care physically. I remember having the socks peeled away from my feet on the first visit to the nurse. The physical stuff is done pretty quickly. I think I put on 4 stone in six weeks and then all of the recovery started in a room. If you left, you could not go back, so that kept you there.

Q304 Andrew Selous: I am interested a little bit in the policy towards residential rehabilitation, because it seems to have gone in and out of fashion a bit. People like Iain Duncan Smith and Oliver Letwin were very keen on it at one stage. Has it faded away because it is more expensive and budgets are under pressure, or are there people who disagree with it as a form of treatment? What is your analysis as to why there are so many fewer residential options?

Mark Johnson: The whole area is so politically charged. Even for people in recovery, there is abstinence versus harm reduction, or controlled drug use. When you ask a group of people how they have done it, Kerrie's story will differ from mine. I think, economically, they are more expensive, with fewer people getting through.

Then there is the measuring. I completely question the measuring used that shows that it is ineffective and that day programmes are better. We need a closer look at that. Westminster Council paid £20,000 for my drug treatment. I am so grateful. My first tax bill was £50,000 after recovery. There is an investment. There is an investment case to be had. I have employed hundreds of people like me. There is a real investment case for working with one person; you could put in a real quality focus, with real professionals who understand the complete nature of addiction and then start to build around that.

Q305 Andrew Selous: I understand the cost pressures, and it is not a secret that budgets have been under pressure because tax income always struggles to meet demand for public services, but I am interested that you said that it is a politically fought-over area. You speak as an ex-user and it worked really well for you, so I guess you are a bit mystified as to why it is a matter of political debate. It was just something that worked for you.

Mark Johnson: Kerrie said she has two hats on. I run an organisation that has worked with 10,000 offenders in the last six months. I have had 20 years of working—hand-to-hand combat—with deluded, very ill people. I have watched, and I have worked, and designed interventions, with people who are getting through. For me, the best, the cherry on the cake, is abstinence, because, if you take drugs to change how you feel, I would say that the best version of a human being is one who can change how they feel in a very healthy way without the need for chemicals. But the political driver with this sometimes might be commercial: it is cheaper to whack people over the head with some methadone than it is to invest.



Then there is the skills deficit involved. If we get a company saying, "Oh, we can deliver drug services across 10 prisons," or even two prisons, where are you going to get those people? How are you going to employ them and train them in the complex nature of drug addiction? There is a resource element as well. If we dilute the quality a little bit, we can deliver this en masse, but what we lose is the quality of real experts in treating the problem of addiction.

Q306 Andrew Selous: Thank you for speaking so frankly from your own experience. It is really valuable.

There is just one other area from me, if I may. You were talking very powerfully at the start about dealing with the causes and not the symptoms. I was very pleased to hear you say that. You talked a bit about the collapse of supportive family relationships and then you said there was not the emotional support within schools. Do you think the family piece is really important? We are a bit of an outlier as a country in terms of couple separation and so on. We seem to do worse on the international statistics than elsewhere in the EU. Do you think that would be an area where it would be worth us politicians focusing on trying to strengthen some of those family relationships? Would that contribute towards reduction in drug usage?

Mark Johnson: Yes, but the understanding of family is massively different depending on where you go. I do not have reference points to what a healthy family is. I learned my thinking skills and emotional stability and maturity through therapeutic intervention, because it was not there before. I did a project in South Africa, on the silence of violence, around nurture groups in schools where you mimic what is in the family. What does a child get in its development in the family?

Q307 Andrew Selous: Close emotional support and committed relationships.

Mark Johnson: Exactly, talking about how you feel in a warm, loved and supported environment. You can actually mimic that in a school setting or a state setting. You take the components and mimic that. That is not around support groups, because of how they are perceived; it is built into the school. To be honest with you, every human being could do with that. It creates empathy with each other, and that is what is missing as a whole—the haves and the have nots.

Q308 Andrew Selous: It is the lack of empathy that drives people to take drugs, to dull the pain of not having that empathy. Would that be a reasonable summary?

Mark Johnson: No. I think on lack of empathy, you are talking psychopathic, the real criminals who have lack of empathy. With the drug addict, it is about actually understanding growing up in toxic environments under narcissistic abuse and being repeatedly subjected to various trauma. It is kind of knocked out of you, but parts of it can be learned from people who really understand the nature of it and how to get out of it by arming people, children, with the facts about themselves.



HOUSE OF COMMONS

There are so many young offenders we work with where social services have documents and dossiers that thick. We have academic researchers saying, "Statistically, 40% of this group is going to be dead, single parents, drug addicts and underachievers." We know that, but nobody actually talks to the kids themselves to say, "Hey, we know that you're in this group. Do you want to go there?"

Then there is outrage. We harbour the dysfunction instead of arming people with the facts about themselves to say, "If X, Y and Z has happened to you, you are going to be predisposed to this, and this is potentially what's on offer to you. You need to work." This is what I say to people: "Your life chances are pretty poor." There is a shock, but at least somebody can do something or start to focus on it.

Q309 **Chair:** Mark, some of the witnesses to this inquiry have said that they think the abstinence approach is causing significant harm, and possibly increasing deaths of people who have been using drugs. Is that something you would recognise?

Mark Johnson: No.

Kerrie Hudson: No.

Mark Johnson: I would say it is the other way around. I went to visit Bournemouth. Bournemouth has, or had, the second biggest recovery community in Europe, London being the first, but Bournemouth is a concentrated area and lots of drug rehabs were set up in the 1980s or late 1970s/1980s. Now they are negligible and the ones that exist only take paying clients. They do not take referrals from other local authorities, and even if they do, which I am not aware of, there is an issue around local connection, so people do not stay there. The abstinence-based recovery communities are being decimated. The most you can hope for is the thing where they are redefining what "treatment" is. There is a redefinition of it, because it is easier. It is easier to give methadone.

Q310 **Chair:** If you have the gold standard of residential programmes outside the area, that is one thing, but if you do not have access to those, where people are on programmes where they are being taken off their methadone—

Mark Johnson: Sorry. A particular area is release from prison. They are doing this horrible thing, which I do not agree with but they are doing it, with retoxing. If somebody goes to prison who is a drug user, they go on substance-harm reduction, so they take methadone and they get clean, but before release they ask them if they want to go back on methadone, because of the spike in people who are predisposed to overdose because of being abstinent.

For me, drug use is a choice and if you do the intervention well—the therapeutic intervention about being clean—and you get all of the different things involved, like somewhere to go, the link with the



HOUSE OF COMMONS

community, the GP and the housing, what impact does that have? Your choice is, do you have a long, slow death, as Kerrie talked about, with long-term methadone use? I do not have any teeth at the back of my head through long use of methadone—horrible stuff. Or do you have the risk of somebody overdosing because they take too much? That is the choice.

Chair: That is your point of view. Right.

Kerrie Hudson: It has been an unfair analysis to say that abstinence is not working, because what we have tried to do is introduce abstinence with a workforce that has been 25-years harm-reductionist, and it is a completely different culture; it is a completely different mindset. It means something completely different.

As to the upskilling, I do not think the right people have been trying to deliver that message. In some of the treatment services where I am, it is the same key workers as when I was there 20-odd years ago. They have never been to mutual aid meetings, and they are not active in the communities. They have their NHS training, so they deal with something medical that requires a prescription. That does not look at the social aspects. It does not look at the spiritual and the emotional, and we are still using that workforce to try to introduce a concept. Now we are saying it has not worked, but the right people were not delivering it.

Mark Johnson: Good point.

Q311 **Dr Williams:** Mark, what do you say to people who say that recovery can best be sustained if it happens within the community where people actually live, and that to take someone with substance misuse problems to a different place to detox them and have a series of interventions and then put them back into the environment they were in before is like taking somebody with cholera away to a hospital to treat them and then putting them back into the place with the contaminated water supply?

Mark Johnson: It is subjective. It is down to the individual, the point in time and the people around them. Kerrie said that for her she did it in the community. For me, when I got clean, I did not have a community—it had gone. It was the removal from society to a safe environment. I know that for a fact. That is my story. At the Elephant and Castle, I literally could not get clean in that place. I had to go far enough away, just in the early stages, to contain it. I think it is about either/or. I think it is a choice, but I think removal and moving on allows the extra benefit of starting again.

Kerrie Hudson: I do not think there is any harm in coming back. Maybe some people need removing because of levels of criminality or breakdowns in relationships; they may need to be moved away. But if the community is fertilised and it has everything that somebody might need, we do not really need to be moving people around the country, with that dislocation. Essentially, that is all people have ever known: "We're going



HOUSE OF COMMONS

to move them there.” How great that you can move them back and there are lots of adequate resources in place.

Moving people to a different town or a different county is not without its problems. It is all well and good when it goes well, but then you have also got the argument about releasing people into areas and creating a completely different group of drug users. That is the argument about rehabs and which communities they can let people back to. While it is working well it is okay.

Q312 Mr Bradshaw: When you were talking about young people’s experience, you basically gave the impression that by the time young people come into contact with the criminal justice system it is too late.

Mark Johnson: Yes.

Q313 Mr Bradshaw: I do not know whether you meant to give this impression, Mark, but you sounded a bit critical of the role of the police earlier. We heard from the police in the evidence session before, and we have heard in written evidence from them, that they are very keen on different approaches, a more health-based approach to drugs policy. They would like to see that, but it is quite difficult for them operating within the current criminal justice framework. Do you have some sympathy with what they are trying to do and understand the constraints they are operating under?

Mark Johnson: The devil is always in the detail. From a policy level, it is one thing; from a reality level, there is the other. This guy Luke that I interviewed—it is on Radio 4, the documentary I did; I am not plugging it or anything—had been arrested 17 times by the police, and the police said there was nothing wrong with that.

The reality is that often we have to look at the detail to get the full picture. The illness, an addiction, is criminalised. Kerrie said it around amalgamating long-term harm reductionists with abstinence-based people. It is the same with the police; they do not get enough training mental health-wise. I am not attacking the police; I am saying there is a skills deficit. They are the default mechanism to pick up society’s most vulnerable and that is not right, because what happens then is that you open a whole door of stigma as well; once you have a criminal conviction it affects your life chances. You go into prison and you come out: “I’ve got a criminal conviction. Nobody’s going to employ me and I might as well go back into the world that I know,” and that is selling little bits of whatever, or larger bits if you find somebody who has got it.

Q314 Mr Bradshaw: Time and again during this inquiry we have heard from witnesses, whoever they are and wherever they are from, that this is an area of policy where policy does not follow the evidence. Why is it? What is it about drugs and drugs policy? Why are we so uniquely bad at establishing policy based on evidence, in your view?



Mark Johnson: It is the same as the law, the courts or whatever. We have the presumption that people commit crime out of the moral choice to do so, and there is no factoring in the absolute wave of mental health and psychological disorders. We do not do it. If you want to have a look at it, and I am sure you have heard about it, there is Portugal. I sit on the Europe drug monitoring group.

Chair: We are going to visit.

Mark Johnson: Are you? I sit on that group. They have the most progressive model and they have reduced criminality and drug use as a result, if we wanted that. Here we have a very archaic view of people. It is exactly the same as the law: you come in front of the court because you have made the moral decision to do it. There is no view of the mitigating circumstances behind it.

Q315 **Mr Bradshaw:** You are a fan of the Portugal model, are you?

Mark Johnson: Yes, and I was a real anti-everything. I thought the fact that there is a criminal element in drug use would stop a number of children coming through, and I have turned. In 19 years, I have turned around because I have seen it and witnessed it and been quite close to it.

Mr Bradshaw: Fascinating, thank you.

Q316 **Dr Williams:** My questions are mainly to Emily. I have spent many hours listening to, and being educated by, families and people who are not only carers but grandparent carers as well in the town where I am an MP. I am interested in the wider picture of what role families can play in helping people with recovery, how well they are supported to do that and what further support families might need.

Emily Giles: My starting point would always be that families should be supported in their own right, no matter the status of the family member who is using drugs. First, it has benefits for the individual if the family's mental health is supported and if they are given some sort of education in what is going on for their loved one, things like boundary setting and basic awareness about the effects of these drugs. A lot of parents deal with their child's drug use with no idea what the drug is; they have never heard of it until this happened to their child. Support for the families in their own right is vital for the individual's recovery.

The main thing for the individual is that the family is well enough supported to be able to support them, but the key thing is that families are supported in their own right to deal with the plethora of issues that I talked about before. One of the biggest issues that we see is that support is very inconsistently available. It used to be much more available. That is basically due to cuts. Lots of small local community-led services that supported families have been cut in stages over the last 20 or so years.

Where support is available, often families are only eligible for that support if their loved one is actively engaging in treatment, often within



HOUSE OF COMMONS

the same service at the same time, which obviously is not always the case. Some families are still dealing with the issues even if their loved one is in recovery. Some are dealing with issues before their loved one has got to the point where they are able to engage in recovery or in treatment. Family members are in real crisis and have absolutely nowhere to turn for support.

There are a huge number of different models that work. We do not advocate any one particular model. The basic argument is that services need to exist in some form in every area, which they currently do not.

Q317 Dr Williams: Is there any evidence that money is being cut from those services?

Emily Giles: Yes. I do not have any numbers for you, but I am sure I could try to dig something out. I would be happy to come back to you with that. Anecdotally, we hear that most of the long-standing services were set up—they are community-led—by a family member, often a mother. I do not have any statistics, but it most commonly seems to be a mother who is dealing with their child's substance abuse, and they set up, basically, peer-support groups. They meet in a town hall once a week, or once a fortnight, and as many people as want to can come along and share stories and support each other. The impact of something as simple as that is huge. It is anecdotal, as I said, but I am sure I can find more evidence.

The other model is services that take place in a treatment centre. Again, as I said, we do not advocate either one or the other. They all seem to be pretty effective. I can dig around to see if I can find you some better evidence.

Q318 Dr Williams: Finally, on developing policy, and being involved in the commissioning process, how effective are people, the policymakers and commissioners, in involving families and service users when they are commissioning and designing services and policy?

Emily Giles: They are pretty poor, unfortunately. Again, it is an inconsistent picture. We work with a couple of local commissioners and, off the top of my head, I cannot think which areas they are in, but again I could follow up. We work with a couple of local commissioners who really get it. Even if you remove any moral argument, they get the investment argument that these people need support and it reaps its benefits in society. The contracts for these things come up relatively quickly; there are three to five-year-long contracts on average. The commissioners see that there was a family support service involved in the last one, but it maybe took up a tiny amount of the budget and they need to cut that tiny amount of the budget. It is not seen as a central part; it is seen as a "nice to have" by most commissioners, and when they have to cut something that is what often gets cut.

Q319 Dr Williams: Thank you. Can I ask Kerrie and Mark about service user



involvement in design of services in commissioning?

Kerrie Hudson: Service user experience is imperative. Quite often what services think they are delivering and what is being received at the other end are two completely different things. Services for the people they are going to cater for should be designed by those people.

Q320 **Dr Williams:** Are people involved, in your experience?

Kerrie Hudson: To a degree, they are involved, but I do not see that they are massively involved. I do not see communication between commissioner and service user. By the time you get to commissioner, you might go to a manager and then to staff, and then you might get to someone who will find a service user and you get to the service user. The message that is being received by commissioner and service user is completely different.

If there is going to be a redesign, there needs to be some kind of levelling where the service users can sit and talk freely with commissioners. I also think it is about getting the right service user reps. Predominantly, it is not always the best people who come forward and can speak on behalf of the population. It is about communication between them.

Q321 **Dr Williams:** Presumably, families can sometimes be good representatives as well.

Kerrie Hudson: Yes, absolutely.

Q322 **Dr Williams:** Mark.

Mark Johnson: That is the reason I set up User Voice. It was because of what Kerrie has just talked about and the dysfunction of it all. There are commissioners, providers and the end user—those three—and I often give talks on that. We listen to a lot of providers, and you guys, if you are the commissioner. There is me and Kerrie with direct experience, and I am sure there are lots more people who are more relevant than us today who could share that, but there is no link.

Commissioners are often educated through the provider—organisations—and their agenda is to protect their market interest before any delivery. Nobody ever admits that they have failed in delivering a service. Everybody has been really successful. The three biggest housing charities, for instance—I won't mention them—had something like a 40% increase in profit over the last 10 years. Yet you see the degradation of services that are offered or the rise in street homelessness. We need a mechanism to get the end user insight to the commissioner. As I said before, that drives everything. It should be driving policy, and so on.

There should be robust consultation. How we do it is by setting up democratically elected councils of prisoners. I think you visited them, Andrew, when you were Prisons Minister. We have them in 30 prisons. You do wide participation, the community self-selects their own



representation, democracy is the key—the dirty word, democracy—and they are issue-based, not personality-based. They sit for a term and then they do the engagement again. They sit with the commissioners and co-design together, so it gets rid of the idea, which we see all the time, and Kerrie just talked about it, that you are politically motivated to want to sit at the table. Sometimes the commissioners are incredibly powerful, with money, so everybody gravitates with every agenda known to sit around that commissioner. I work at national level, and in some regards there is a little bubble, from my world of MOJ and probation, of services that just sits around the bubble of the commissioners, and it is questionable whether they actually do anything.

Q323 Dr Williams: On a very practical level, local authorities commission services. Does User Voice know when all the contracts are coming to an end or when services are being redesigned?

Mark Johnson: In 15 prisons in the south, we run a health council, a hybrid of the main one, and I think what has happened in those 15—don't quote me—is that in the last two years we have done seven procurements of services. Sometimes, those are £20 million health provider contracts. What we have managed to negotiate is that service users—the prisoners—get 10% of the procurement score, which is equal to finance. In two of those seven, the prisoners have been the king makers. That is the model we need to replicate more widely; it is at that level, where the money is going.

Q324 Dr Williams: That is a really good practical example. When somebody is doing the specification and when they are setting the criteria by which they will award a contract, 10% of the points, those scores, are awarded by service users, and therefore they have power.

Mark Johnson: Yes. The other point of that is this. The state has inspectorates. Are there nine? I can't remember. I met the new probation one yesterday. There are nine inspectorates and often they go into a service, inspect and write a report of what is failing, what the recommendations are, and often it is out of date before it has actually been released. Everybody gets frustrated, with the provider saying, "We have implemented all of these changes before." If you had the democratically elected participation model, service providers should be sat at the table every month at management meetings saying what is not on offer and what is not being done, and literally co-producing the solutions. That changes the model by which the state holds its inspections. It should be done regularly, as a service improvement, not a kind of cosh.

Dr Williams: Not in a pejorative way, yes.

Chair: Thank you. That was really helpful. Thank you very much for coming this afternoon.