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Home Affairs Committee

Drugs

Third Report of Session 2022–23

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Home Affairs Committee

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Summary

Drugs can have a significant and negative impact on people who use drugs, their loved ones and society. Trends in drugs may vary over time but this consequence is constant. Concerningly, drug misuse deaths across the UK continue to increase with opiates playing a significant role in this, and 'street' benzodiazepines and polydrug use also playing an increasing role. There were 250 drug misuse deaths per million population in Scotland in 2022—significantly higher than in England, Wales and Northern Ireland. In her Independent Review of Drugs, Professor Dame Carol Black estimated the total cost of drugs to society to be more than £19 billion per year—more than twice the value of the illicit drugs market (an estimated £9.4 billion).

In recent years, the response by the international community and devolved nations to drugs has increasingly focused on responding to drugs through a public health lens. UK policy should ensure that an approach originally and primarily based on criminal justice principles continues to adapt to achieve a proper balance of public health interventions that may reduce illicit drug use in the longer term rather than aiming simply to disrupt demand. We believe that this approach would be best supported by making drug policy the joint responsibility of the Home Office and the Department of Health and Social Care, with a minister sitting across both departments.

The main piece of legislation controlling drugs in the UK—the Misuse of Drugs Act 1971—is more than 50 years old. It is in need of review. Further, a full review by the Advisory Council is required on whether the most commonly controlled drugs in the UK are correctly classified and scheduled (under the Misuse of Drugs Regulations 2001), based on the evidence of their harms.

The Government's latest drugs strategy, 'From Harm to Hope: A 10-Year drugs plan to cut crime and save lives' (the 10-Year Drugs Strategy) signals a shift towards recognising the need for a holistic response to drugs that not only aims to tackle the illicit drug market but also supports people who use drugs, their loved ones and society. However, the Government's response could go further by adopting a broader range of public health-based harm reduction methods in tandem with its support of law enforcement efforts to tackle the illicit drugs market.

We support the use of diamorphine assisted treatment supported by psychosocial support as a second-line treatment for people with a chronic heroin dependency. We visited a centre in Middlesbrough and saw the dramatic and positive effect this treatment had on the lives of a small group of people who had used drugs and, albeit on a small scale, to local crime reduction. Disappointingly, such treatment programmes are few and controversial, and the Middlesbrough programme lost its funding. The Government should provide centralised funding for such programmes.

Safe consumption facilities, where people who use drugs may do so in safe, secure surroundings, may also reduce harm and deaths, but the status of such facilities is uncertain because of the restrictive regime in place under the 1971 Act. We recommend that the Government support a pilot facility in Glasgow and create a legislative pathway to enable more.

A national drug checking service in England could enable people to anonymously test samples of drugs, again preventing harm and potentially death. We recommend the Government establish a drug checking service, taking into account the experience of Wales. We also recommend the expansion of on-site drug checking services at temporary events such as music festivals and in the night-time economy through the creation of a dedicated licensing scheme. The power to issue such licences could include the devolution of power to grant licences to local authorities.

These public health and harm reduction interventions must be balanced with the role of police in applying the law. The police can also have a role in aiding prevention of drug use and treatment of harms. Scotland's pioneering programme of having all police officers carry naloxone (a nasal spray or injection that can be administered immediately to reverse the effects of an opioid overdose) should be rolled out elsewhere in the UK as a straightforward means of saving lives. The police can also play an important role in diverting young people who have committed low-level drug-related offences away from the criminal justice system. We support greater standardisation of police-led diversion across England and Wales, to avoid a 'postcode lottery' in the treatment of such offenders.

1 Introduction

1. In recent decades, UK drug law and policy have been considered by previous iterations of this Committee and by other Select Committees.[1] Over that time, responses to drugs have shifted in some respects. For example, some countries, like Uruguay, have legalised and regulated cannabis.[2] In addition, the adoption of a 'public health approach' to drugs has increasingly gained traction.[3] This involves evidence-based health and social interventions that aim to prevent drug use and improve the health of people who use drugs by reducing drug-related harms and supporting treatment and recovery. It can include interventions that seek to reduce harm, such as the exchange of used needles and syringes for clean ones to help reduce the transmission of blood-borne viruses.

2. The UK's legislative framework on the control of drugs is largely contained within the Misuse of Drugs Act 1971, which is more than half a century old. It is supported by the Psychoactive Substances Act 2016. This framework applies to the whole of the UK and responsibility for it is reserved to the UK Government. In England—and Wales in relation to policing and justice—the legislative framework is supported by the UK Government's latest drugs strategy: From harm to Hope: A 10-Year drugs plan to cut crime and save lives (the 10-Year Strategy).[4] Each of the devolved administrations have their own drug strategies which are relevant to their responsibilities under the devolution settlement. As health is a devolved matter in Scotland, Wales and Northern Ireland, the provision of drug treatment is a key example in which UK drug policy may differ across the four nations.

3. In her Independent Review of Drugs, Professor Dame Carol Black estimated the total cost of drugs to society to be more than £19 billion per year—more than twice the value of the illicit drugs market (an estimated £9.4 billion).[5] This significant cost demonstrates the impact of drugs, which can also be evidenced through data on drug-related offending, drug use and drug misuse deaths.

4. Regarding drug-related offending in England in Wales, 38,381 people were convicted for drugs offences in the year ending December 2022. Since 2010, the number of convictions in England and Wales has fallen by around two fifths. The conviction rate for drug offences is typically high (over 90%).[6] In Scotland, 2,094 people were convicted for drug offences in 2020/21.[7] This made up 11% of all people convicted of a crime. The number of people convicted was lower than in previous years and may be a result of court

1 See, Home Affairs Committee, Third report of Session 2001–02, The Government's drug policy: Is it working?, HC 318-I; Science and Technology Committee, Fifth Report of Session 2005–06, Drug Classification: Making a Hash of it?, HC 1031; Home Affairs Committee, Ninth Report of Session 2012–13, Drugs: Breaking the Cycle, HC 184-I; Home Affairs Committee, Eleventh Report of Session 2013–14, Khat, HC 869; Home Affairs Committee, Twelfth Report of Session 2013–14, Drugs: New Psychoactive Substances and Prescription Drugs, HC 819; Home Affairs Committee, Fifth Report of Session 2015–16, Psychoactive Substances, HC 361; Health and Social Care Committee, First Report of Session 2019, Drugs Policy, HC 143; Scottish Affairs Committee, First Report of Session 2019, Problem Drug Use in Scotland, HC 44.

2 United Nations Office on Drugs and Crimes, World Drug Report 2022, June 2022.

3 United Nations Office on Drugs and Crimes, World Drug Report 2022, June 2022.

4 In Wales, policing and the justice system are matters reserved to the UK Government. HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, December 2021.

5 This total estimated cost took into consideration the health harms, costs of crime and winder impacts of society, including to families. Professor Dame Carol Black, Review of drugs: Executive summary, February 2020, p.5.

6 Ministry of Justice, Criminal Justice System statistics quarterly: December 2022, 'Outcomes by offence data tool', Prosecutions and convictions table.

7 Scottish Government, Criminal Proceedings in Scotland 2020–21 - Final Main Bulletin tables (06–04–2023), Table 4b.

backlogs due to the Covid-19 pandemic. However, convictions had already been falling since 2015/16 (which had 7,144 convictions for drug offences).[8] In Northern Ireland, 2,798 people were convicted for drug offences in 2022. It was the third largest group of offences after motoring offences and violence against the person offences.[9]

5. Regarding drug use, there has been an increasing trend in drug use in England and Wales since 2014/15, albeit with some fluctuations. In the year ending June 2022, an estimated 9.2% of 16 to 59 year olds had taken illegal drugs in the past year, equating to around 3 million people.[10] Young people aged 16 to 24 years old) in England and Wales are more likely to take drugs. However, since 1995, there has been a declining trend in drug use among this age group from 30% to 18.6% in the year ending June 2022.[11] The latest survey data available for Scotland indicates that for the years 2018–20, 13.5% of people aged 16 and over reported taking one or more drugs in the past year–an increase from 9.5% in 2017/18.[12] The latest survey data available for Northern Ireland from 2014/15 found that an estimated 5.9% of people had taken an illegal drug in the previous year.[13]

6. Concerningly, the number of people who have died as a result of drug misuse has continued to rise across the four UK nations. There is also a rise in the number of reported deaths involving more than one drug, indicating a rise in polydrug use, which means the consumption of more than one drug at a time or sequentially. We consider drug misuse deaths data across the UK further in Appendix 1.

7. It is within this global and domestic context that we commenced our inquiry. We have considered UK drug law and policy. We have also considered the international response to drugs and the impact that drugs can have on people who use, or used, drugs and their loved ones. However, the subject of drugs is large and complex, and it often overlaps with other issues. There are therefore limitations to what we have been able to consider. Such issues include dependency on alcohol, the use of stop and search for drug-related offences, and drugs and prisons.[14] Finally, we are limited to considering drug policy that is reserved to the UK Government (hereafter referred to as 'the Government').

8. We received a large number of written submissions and held six oral evidence sessions. We also held roundtables with people with lived experience of drugs and family members, an engagement event with drug treatment and recovery organisations, and a meeting with international stakeholders, including the United Nations Office on Drugs and Crime. We also visited Middlesbrough, Glasgow and Belfast, in addition to Uruguay. With the exception of Northern Ireland, we also met the UK ministers responsible for drug policy.[15]

8 The meaning of 'crimes' in Scotland is roughly equivalent to the meaning of 'indictable offences' in England and Wales. Scottish Government, Criminal Proceedings in Scotland 2020–21 - Final Main Bulletin tables (06–04–2023), Table 4b.

9 Northern Ireland Statistics and Research Agency, Court prosecutions, convictions and out of court disposals statistics for Northern Ireland 2022, June 2023.

10 This includes data from year ending December 1995 to year ending June 2022. Office for National Statistics, Crime Survey for England and Wales, year ending June 2022, December 2022.

11 Office for National Statistics, Crime Survey for England and Wales, year ending June 2022, December 2022.

12 Scottish Government, Scottish Crime and Justice Survey 2019/20: main findings, 16 March 2021.

13 Northern Ireland Department of Health, Prevalence of Drug Use and Gambling in Ireland and Drug Use in Northern Ireland 2014/15: Bulletin 2, 23 February 2017.

14 We have, however, considered stop and search for drug-related offences in our report: Home Affairs Committee, Third Report of Session 2021–22, The Macpherson Report: Twenty-two years on, HC 139.

15 At the time of taking ministerial evidence, Northern Ireland was without a functioning Executive.

9. Finally, we take this opportunity to thank everyone who contributed to this inquiry. We extend a particular and sincere thanks to those with lived experience of drugs and the loved ones of people who use, or have used, drugs. Each individual's story was different but common threads emerged regarding the trauma, stigma, grief and sadness they had experienced, or continue to experience. But the stories also highlighted resilience, humanity and the positive change that can occur when people receive appropriate support. It was a privilege to hear each story.

2 The UK's drugs legislative framework

The Drug Control Conventions

10. The UK's approach to drugs is underpinned by its obligations under three United Nations (UN) conventions, collectively known as the Drug Control Conventions (the conventions). Primarily, the conventions prohibit the production and supply of narcotic and psychoactive drugs except for specific purposes like medical treatment or research.[16] The International Narcotics Control Board (INCB)—a quasi-judicial United Nations body that monitors the implementation of the conventions by member states—has explained that intentional possession of drugs (but for excepted purposes) is contrary to the conventions and liable to punishment. It has explained that punishment should be proportionate, and that incarceration should only be applied to serious offences. It has advised that punishment:

> should be adequate and directly proportionate to the seriousness of the actual offense committed, and all three conventions explicitly allow measures of treatment, education, after-care, rehabilitation and social reintegration as alternatives or in addition to conviction or punishment.[17]

International and domestic response to a public health approach to drugs

11. In 2013, the Executive Director of UNODC, Yury Fedotov, stated that a "health-centric approach" to implementing the conventions produces the most effective results.[18] He also said that the "original spirit" of the conventions focused on health, and that "[t]he conventions are not about waging a 'war on drugs' but about protecting the 'health and welfare of mankind'".[19] In 2016, the UN General Assembly recognised drug dependence "as a complex, multifactorial health disorder characterized by a chronic and relapsing nature with social causes and consequences that can be prevented and treated …" through, for example, evidence-based drug treatment, care and rehabilitation, and social reintegration.[20]

12. A number of countries have sought to embed public health interventions in their response to drugs. The Portuguese model decriminalises controlled drugs "as part of a broader approach designed to deter drug use and promote measures directed to public

16 The UN Single Convention on Narcotic Drugs 1961 was signed by the UK on 30 March 1961 and ratified on 2 September 1964. It prohibits substances including cannabis, coca and opium-like drugs. The UN Convention of Psychotropic Substances 1971 was signed by the UK on 21 February 1971 and ratified on 24 March 1986. It prohibits substances that have a psychoactive effect including psychedelics like LSD. The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988. The UK signed this Convention on 20 December 1988 and ratified it on 28 June 1991.

17 INCB, Letter from the President of the INCB to Chair-Rapporteur of the Working Group on Arbitrary Detention, 23 April 2020, p.2.

18 UNODC, Contribution of the Executive Director of the United Nations Office on Drugs and Crime, 6 December 2013, para.43.

19 UNODC, Contribution of the Executive Director of the United Nations Office on Drugs and Crime, 6 December 2013, para.50.

20 UNODC, UN General Assembly Special Session on the World Drug Problem, 2016, p.6.

health concerns".[21] In Switzerland, harm reduction is one of four legally enshrined pillars of Swiss drug policy.[22] Likewise, in Canada, the Canadian Drugs and Substances Strategy pursues harm reduction initiatives as part of a public health approach to drugs.[23]

13. The UK devolved administrations have also moved towards a public health approach. The then Scottish Minister for Drug Policy, Angela Constance MSP, told us that the "serious and significant public health challenge" in Scotland required "a fully-fledged public health approach".[24] The Welsh Government told us that its approach is very much health-led and focused on harm reduction, with responsibility for substance misuse lying with the Deputy Minister for Mental Health and Wellbeing, Lynne Neagle MS, whom we spoke to during our inquiry.[25] In Northern Ireland, the Department of Health leads on the Executive's response to tackling substance misuse and related societal harms. The then Northern Ireland Minister for Justice, Naomi Long MLA, told us that she supported holistic interventions "primarily based on therapeutic and early interventions".[26]

14. During our inquiry, the adoption of a public health approach, including the adoption of harm reduction responses, received widespread support.[27] President of the Association of Directors of Public Health and Director of Public Health for Hertfordshire County Council, Professor Jim McManus, argued that "it is right that we take a public health approach to drugs".[28] There was support for a holistic response to drugs that recognised both the role of public health in tackling drug use and dependency through treatment and support and law enforcement in tackling the production, possession and supply of drugs is important.[29] Indeed, the National Police Chiefs' Council Drugs Lead and Chief Constable for Dyfed-Powys Police, Dr Richard Lewis, told us that law enforcement previously saw drug use and dealing "through a narrow lens of enforcement" but that this was changing and law enforcement "would like as much as possible to ensure that those who are using drugs are diverted into treatment services—very much a public health approach as opposed to the narrow lens of enforcement".[30]

15. The Home Office has told us that the Government "remains firm that [its] approach is the right one" which is focused on providing a:

21 Dr João Goulão, Statement of the Portuguese National Coordinator on Drugs, Drug Addiction and the Harmful Use of Alcohol, Dr João Goulão at the 65th Session of the Commission on Narcotic Drugs General Debate, 14 March 2022, p.1.

22 In addition to prevention, treatment and law enforcement. Federal Office of Public Health, The four-pillar policy.

23 Government of Canada, Harm Reduction: Canadian Drugs and Substances Strategy, August 2018.

24 Q345.

25 Welsh Government (DRU0081) and Welsh Deputy Minister for Mental Health and Wellbeing, Lynne Neagle AS (DRU0124).

26 Justice Minister for Northern Ireland, Naomi Long MLA (DRU0113), para.2.

27 Norman Baker (DRU0005); Alliance for Rights Orientated Drug Policies (DRU0010); Professor Alex Stevens, University of Kent (DRU0014); West Yorkshire Combined Authority (DRU0018); Dr Felipe Neis Araujo, University of Manchester (DRU0019); Amber Marks, Queen Mary University (DRU0020); Anyone's Child (DRU0044); The Hepatitis C Trust (DRU0065); The Faculty of Public Health and The Association of Directors of Public Health (DRU0096); Transform (DRU0097); North Yorkshire Police and Crime Commissioner (DRU0099); Q119.

28 Q122.

29 Association of Police and Crime Commissioners (DRU0078); Q270.

30 Q286.

> balanced, whole-system response which brings together police, health, community and global partners to tackle the illicit drug trade, protect the most vulnerable and help those with a drug dependency to recover and turn their lives around.[31]

16. **There is increasing support for public health responses as a tool to respond to drugs, and the adoption of such responses are within the spirit of the Drug Control Conventions.** ***We recommend that the Government balances its criminal justice response to drugs with an increased public health response that seeks to prevent and treat drug use and tackle the root causes of drug use through, for example, a broad range of harm reduction approaches.***

The UK drugs legislative framework

The Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001

17. The Misuse of Drugs Act 1971 (1971 Act) gives effect to the UK's obligations under the conventions. It makes it an offence to produce, possess, supply, export or import drugs, except as permitted by the Home Secretary. The 1971 Act is supported by the Misuse of Drugs Regulations 2001 (2001 Regulations) which outline the circumstances in which it is lawful to possess, supply, produce, export or import controlled drugs.

18. Since the 1971 Act came into force more than 50 years ago, numerous Select Committees—including previous iterations of this Committee—have recommended a review of the Act, elements of it.[32] In 2000, an independent review led by Viscountess Runciman DBE on behalf of the Police Foundation (the Runciman Report) also concluded that reform of the Act was required.[33] However, successive UK Governments have largely rejected these calls.[34]

19. The majority of evidence we have received on this issue has argued that reform is needed. Some have argued the 1971 Act has failed to prevent drug use and has failed to reduce drug-related deaths and drug-related offending.[35] Some have argued that it has a disproportionately negative effect on black, Asian and minority ethnic people, particularly in relation to the stop and search of people for suspected drug-related offences.[36] We have also heard arguments that it contributes to the continued stigmatisation of people who

31 Home Office (DRU0080), para.1.2, para.6.6.

32 Home Affairs Committee, Third report of Session 2001–02, The Government's drug policy: Is it working?, HC 318-I; Science and Technology Committee, Fifth Report of Session 2005–06, Drug classification: Making a hash of it?, HC 1031; Home Affairs Committee, Ninth Report of Session 2012–13, Drugs: Breaking the cycle, HC 184-I; Scottish Affairs Committee, First Report of Session 2019, Problem Drug Use in Scotland, HC 44.

33 Police Foundation, Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971, 2000.

34 Home Affairs Committee, Second special report of Session 2000–2001, Government response to the 'Police Foundation's Independency Inquiry into the Misuse of Drugs Act 1971', HC 226; Home Affairs Committee, Third report of Session 2001–2002, Government response to 'The Government's drug policy: Is it working?', HC 318-I; Science and Technology Committee, Fifth Report of Session 2005–06, Government response to 'Drug classification: Making a hash of it?', HC 1031; Home Affairs Committee, Ninth Report of Session 2012–13, Government response to 'Drugs: Breaking the cycle', HC 184-I; Scottish Affairs Committee, First Report of Session 2019, Government response to 'Problem Drug Use in Scotland', HC 44.

35 See Appendix 1 for an overview of drug trends in the UK. Professor Alex Stevens, University of Kent (DRU0014); Dr Felipe Neis Araujo, University of Manchester (DRU0019); Law Enforcement Action Partnership (DRU0052).

36 Release (DRU0075); Transform (DRU0097); Q19.

use drugs.[37] However, the Home Office has argued that the current approach seeks to provide a balance between the legitimate use of controlled drugs and drug-related harms.[38] The Combating Drugs Minister, the Rt Hon Chris Philp MP, told us that the 1971 Act "provides a framework that is sufficiently flexible that we do not need to revisit it, at least just at the moment".[39]

20. **We conclude the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001 require reform.** ***We recommend that the UK Government reform the 1971 Act and 2001 Regulations in a way that promotes a greater role for public health in our response to drugs, whilst maintaining our law enforcement to tackling the illicit production and supply of controlled drugs.***

The classification and scheduling of controlled drugs

21. Under the 1971 Act, controlled drugs are placed within a class—Class A, B and C—based on their perceived harms.[40] The class within which a drug is placed will determine the extent of the criminal penalties attached to offences committed under the 1971 Act (for example, possession of a controlled drug). The greater the harm, the higher the classification, with Class A attracting the greatest restrictions and most severe criminal penalties.

22. Separately, the 2001 Regulations permit the lawful possession and supply of controlled drugs in particular circumstances, such as for medical and scientific purposes. Under the 2001 Regulations, controlled drugs are placed into one of five schedules. Drugs under Schedule 1 are the most restricted; they are not authorised for medical use and can only be supplied, possessed or administered in exceptional circumstances under a licence from the Home Office. MDMA, LSD and psilocybin are contained in Schedule 1. Drugs under Schedule 5 are the least restricted and include, for example, the painkiller codeine.

23. We have heard that the classification system does not reflect the scientific evidence on the harms of drugs.[41] This conclusion has also been drawn following other inquiries on the 1971 Act—including an inquiry by a previous iteration of this Committee.[42] The Chair of the ACMD, Professor Owen Bowden-Jones, told us that the Government has not commissioned the ACMD to review the classification system, nor has the Council self-commissioned such work.[43] He accepted a review of the classification system would be within the Council's remit.[44] The Combating Drugs Minister told us that the legislative framework "gives flexibility to allow evolution as time goes on".[45]

37 Professor Alex Stevens, University of Kent (DRU0014); Anyone's Child (DRU0044); Criminal Justice Alliance (DRU0090); Transform (DRU0097); Q5; Lived experience roundtables (DRU0121); Engagement event with drug treatment and recovery sector (DRU0122).

38 Home Office (DRU0080).

39 Q378.

40 Misuse of Drugs Act 1971, Schedule 2.

41 Professor Alex Stevens, University of Kent (DRU0014); Peter Reynolds (DRU0050); Drug Science (DRU0056); National Police Chiefs' Council (DRU0079); Green Party (DRU0087); Transform (DRU0097); Faculty of Public Health and Association of Directors of Public Health (DRU0096); Q37.

42 The Police Foundation, Drugs and the Law: Report into the Independent Inquiry into the Misuse of Drugs Act 1971, March 2000; Home Affairs Committee, Third report of Session 2001–02, The Government's drug policy: Is it working?, HC 318-I; Science and Technology Committee, Fifth report of Session 2005–06, Drug classification: Making a hash of it?, HC 1031.

43 Q65–68.

44 Q65–68.

45 Q378.

24. We have heard that the scheduling of drugs does not reflect the scientific evidence on the harms of drugs. Professor Joanna Neill, Dr Sara Tai and Dr John Gig from the University of Manchester noted that psychedelic drugs are subject to more stringent conditions under Schedule 1 than more harmful drugs like heroin, which is placed in Schedule 2.[46] Professor Bowden-Jones, accepted that it would be helpful to have a "more systematised approach" to reviewing the scheduling of drugs, which could be possible to action under the existing operational framework of the ACMD and was something he was willing to discuss with the Council.[47]

Barriers to researching controlled drugs under Schedule 1

25. A Home Office licence is required to research drugs controlled under Schedule 1 to the 2001 Regulations. Professor of Neuropsychopharmacology at Imperial College London, David Nutt, and Professor of Psychopharmacology at the University of Manchester, Joanna Neill, told us that Schedule 1 licensing requirements place bureaucratic and costly burdens on researchers and medical professionals, coupled with delays to the licensing process.[48] This can create barriers to researching Schedule 1 drugs, particularly psychedelic drugs.

26. A growing body of evidence suggests psychedelic drugs may have wide-ranging therapeutic benefits, including treating depression and post-traumatic stress disorder.[49] In particular, psilocybin—a naturally derived compound found in certain fungi—has received increasing scientific attention. As Professor Neill has suggested, the therapeutic potential of psychedelic drugs could be significant because "we have not enabled patients to access better medicines than the standard drugs, so I would say that psychiatry research has hit a brick wall".[50] Indeed, we have received evidence of the transformational effect of psilocybin in helping a veteran and cancer survivor overcome their mental health conditions.[51] On 12 May 2023, an open letter by the Royal College of Psychiatrists and others was sent to the Combating Drugs Minister urging him to consider rescheduling psilocybin in light of the increasing mental health burden in the UK.[52]

27. Beyond the potential benefit psychedelics may have to health, these barriers may also prevent the UK from developing its own psychedelic research industry, which has an emerging and growing global market.[53] The barriers researchers face may therefore stymie our understanding of controlled drugs, undermine innovations in medical treatment and undermine the UK as a global leader in science and medicine.[54]

28. Both the ACMD and the Combating Drugs Minister told us that they were aware of the barriers researchers face regarding Schedule 1 drugs. The Combating Drugs Minister told us he was "very, very sympathetic" to making it less bureaucratic and burdensome

46 Professor Joanna Neill, Dr Sara Tai, Dr John Gig, University of Manchester (DRU0062).
47 Q83–86.
48 Q46; Q48.
49 Other conditions may include anxiety, addiction, obsessive compulsive disorder, anorexia nervosa. Medical News Today, What to know about psychedelic therapy, 30 June 2021; European Commission, Psychedelics paired with therapy could treat chronic mental health conditions, 24 October 2022.
50 Q46.
51 Anonymised (DRU0111); Anonymised (DRU0112).
52 The letter was also signed by the Conservative Drug Policy Reform Group, CALM, SANE, Heroic Hearts Project UK, Clusterbusters and Drug Science. Psychedelic Health, UK Minister of State urged to champion psilocybin access in Parliament, 17 May 2023.
53 Professor Joanna Neill, Dr Sara Tai, Dr John Gig, University of Manchester (DRU0062).
54 Professor Joanna Neill, Dr Sara Tai, Dr John Gig, University of Manchester (DRU0062); Q47.

for researchers, "and then for doctors to prescribe where there is a medical need".[55] The ACMD are reviewing the barriers to researching Schedule 1 drugs, and ways to reduce such barriers. On 18 May 2023, the House of Commons was told during a debate on psilocybin treatments that the ACMD's considerations were at a "well advanced" stage and that the Home Office should "expect its advice in the near future" for it to consider.[56] The House was told that the UK Government's ambition was to tackle the barriers to research across Schedule 1 but that the Government:

> [M]ust keep a firm focus on the need to tackle drug misuse, which causes such harm across our society. Both are vitally important aims, and we will continue working to strike the right balance in the interests of the public.[57]

29. **We welcome the ACMD's work reviewing the status of drugs controlled under Schedule 1 to the 2001 Regulations. However, we conclude a wider review is required. *We recommend that the Home Office commission the ACMD to review whether the most commonly used controlled drugs in the UK are correctly classified under the 1971 Act and correctly scheduled under the 2001 Regulations based on the scientific evidence available. The Home Office must reform the classification system and the scheduling system based on the findings of that review. We recommend the ACMD conduct updated assessments every 10 years, or in circumstances where a review is required, to take into account the emerging scientific evidence on controlled drugs.***

30. ***We welcome the UK Government's commitment to reducing barriers to researching psychedelic drugs under Schedule 1 to the 2001 Regulations. Pending the outcomes of the ACMD's ongoing review of Schedule 1 controlled drugs, we recommend the UK Government urgently moves psychedelic drugs to Schedule 2 in order to facilitate research on the medical or therapeutic value of these drugs.***

The Psychoactive Substances Act 2016

31. New Psychoactive Substances (NPS) tend to mimic the effects of controlled drugs. However, because they hold a chemically different structure to controlled drugs, they are not covered by the 1971 Act. Common examples of NPS include synthetic cannabinoids like spice, 'street' benzodiazepines like etizolam and flubromazolam, and synthetic opioids like fentanyl analogues and nitazenes. In the late 2000s, there was a rise in the use of NPS in the UK and internationally. The 1971 Act struggled to keep pace with the rate at which NPS were emerging.[58] In response, the UK Government introduced temporary class drug orders (TCDO) in 2011 to provide an expedited mechanism for controlling NPS.[59] However, even the TCDO regime could not keep pace with the rising prevalence of NPS and the Psychoactive Substances Act (2016 Act) was enacted in January 2016.[60]

55 Q82; Q379.
56 HC Deb, Psilocybin treatments, 18 May 2023, col.1038.
57 HC Deb, Psilocybin treatments, 18 May 2023, col.1038.
58 Home Office, Psychoactive Substances Bill Factsheet: Background to the Bill, August 2015.
59 Once a TCDO is in place, the ACMD can assess the temporary class drug and the Government can consider whether it ought to be controlled under the MDA regime. All offences under the MDA — but for the offence of possession for personal use — apply to a temporary class drug. Home Office, Temporary Class Drug Factsheet, November 2011.
60 It is still possible to make a TCDO, however, they have reduced in appeal because they involve removing the offence of possession in custodial settings (unlike the PSA). Home Office, Review of the Psychoactive Substances Act 2016, November 2018.

32. The 2016 Act places a blanket ban on substances that "are capable of producing a psychoactive effect".[61] Certain activities, such as approved scientific research, can be exempt. Under the Act, it is not an offence to possess NPS unless possession occurs in a custodial setting.[62] However, if the Government chooses to control a NPS under the 1971 Act, it will become an offence to possess it regardless of the setting.[63] Marcus Starling, Deputy Director of the Drug Misuse Unit at the Home Office, told us that the purpose of the 2016 Act was to provide a mechanism to deal with the adaptability of criminal gangs to change the chemical structures of drugs so as to evade the 1971 Act regime.[64] The Combating Drugs Minister noted that the 2016 Act has "a more general approach" and that "by virtue of being more general, obviously you want to be careful before you criminalise individual possession".[65] It nonetheless means that a criminal and non-criminal response to the possession of drugs for personal use operate in parallel in the UK.

33. In 2018, the Home Office held a review of the 2016 Act. It concluded that:

> most of the main aims of the 2016 Act appear to have been achieved, with the open sale of NPS largely eliminated, a significant fall in NPS use in the general population, and a reduction in health-related harms which is likely to have been achieved through reduced usage. However, some areas of concern have remained or emerged since the Act, such as the supply of NPS by street dealers, the continued development of new substances, the potential displacement from NPS to other harmful substances, and continued high levels of synthetic cannabinoid use among the homeless and prison populations.[66]

34. Some have submitted to us that, since the enactment of the 2016 Act, NPS-related harms have increased among the prison and homeless populations, the potency of NPS has increased, and deaths involving NPS have also increased.[67] In 2022, the UNODC reported that benzodiazepine-type substances continued to be a primary NPS threat and synthetic opioid NPS were the second biggest threat in relation to drug-related deaths and drug driving cases.[68]

Benzodiazepines

35. Legally prescribed benzodiazepines—diazepam (Valium) and alprazolam (Xanax)—can be used to help treat anxiety or insomnia. However, there has been a rise across the UK in drug-related deaths linked to benzodiazepines (as well as other prescription medicines like gabapentin and pregabalin).[69] When illicitly purchased they can be referred to as 'street benzos'. Examples include etizolam, which is often referred to as 'street valium',

61 Psychoactive Substances Act 2016, section 2. However, section 3 and Schedule 1 to the Act state that a number of substances are exempt on the basis that the substances are controlled by existing legislation (e.g., tobacco) or because the psychoactive effect is negligible (e.g., caffeine).

62 Psychoactive Substances Act 2016, section 9.

63 The Home Office may commission the ACMD to review the harms of a psychoactive substance with the view to making recommendations on whether the substance ought to be moved to the MDA regime.

64 Q396.

65 Q396.

66 Home Office, Review of the Psychoactive Substances Act 2016, November 2018, p.7.

67 See Appendix 1: Drug misuse deaths. Professor Alex Stevens (DRU0014); Drug Science (DRU0056); Cranstoun (DRU0067); Release (DRU0075).

68 UNODC, Current NPS Threats: Volume V, October 2022.

69 See Appendix 1.

and flubromazolam. Street benzos can be particularly harmful, or fatal, because the true substance of the pills can be different to that advertised or it can be mixed with other (potentially more harmful) substances. The harms of benzodiazepines can also increase when consumed with alcohol and/or opioids.[70]

36. In January 2023, the Home Office opened a consultation on a new offence to better enable law enforcement to prove the illicit use of pill presses. The aim of the proposed offence is to address the increasing reports of illicit benzodiazepine manufacturing in England and Wales.[71] The then Scottish Minister for Drugs Policy, Angela Constance MSP, told us the Scottish Government was engaging with the Government on how to respond to pill presses.[72]

Synthetic opioids

37. Synthetic opioids are man-made drugs that mimic the effects of opiates, such as heroin.[73] They are highly potent. The most commonly encountered type is fentanyl and its analogues (compounds that are structurally similar, such as carfentanil). Fentanyl is up to 50 to 80 times stronger than heroin and up to 100 times stronger than morphine.[74] As little as 0.002 grams is potentially fatal.[75] It is a controlled substance that can legally be prescribed for severe pain.[76] Other harmful and potent synthetic opioids include nitazene and its analogues (such as isotonitazene) and brorphine and its analogues.

38. Synthetic opioids have contributed to North America's opioid epidemic. In America, more than 150 people die from overdoses related to synthetic opioids each day.[77] In Canada, more than 34,400 people have died due to opioid-related deaths between January 2016 and September 2022.[78] Synthetic opioid use is considerably lower in the UK, but the ACMD has reviewed the harms and use of these drugs.[79] Following the ACMD's 2022 report on nitazene and brorphine, the Government announced in February that it would make 11 synthetic opioids Class A drugs and place them under Schedule 1 of the Misuse of Drugs Regulations 2001.[80]

39. In June 2022, the National Crime Agency told us that the threat of fentanyl remained low but that it was something law enforcement was alive to.[81] However, we have heard concerns that the reduced production of opium poppies (used to produce heroin) in Afghanistan will impact the availability of heroin and in turn increase the use of synthetic

70 ACMD, Novel benzodiazepines A review of the evidence of use and harms of Novel Benzodiazepines, April 2020.
71 Home Office, Strengthening the law enforcement response to serious and organised crime, 24 January 2023.
72 Q348.
73 An opiate is a naturally derived drug that interacts with opioid receptors in the body. For example, heroin is derived from opium poppies. Opioids is a broader term that includes opiates in addition to synthetic or semi-synthetic drugs that interact with opioid receptors in the body.
74 European Monitoring Centre for Drugs and Drug Addiction, Fentanyl drug profile; United States Centre for Disease Control and Prevention, Fentanyl Facts, 12 Mat 2023.
75 Crown Prosecution Service, Drug Offences, 21 December 2022.
76 In the UK, Fentanyl is a Class A controlled drug under the Misuse of Drugs Act 1971 and Schedule 2 to the Misuse of Drugs Regulations 2001. However, some of its analogues are not controlled in this way and may be controlled as psychoactive substance under the Psychoactive Substances Act 2016. Crown Prosecution Service, Drug Offences, 21 December 2022.
77 United States Centre for Disease Control and Prevention, Fentanyl Facts, 12 May 2023.
78 Canada Centre on Substance Use and Addiction, Opioids.
79 ACMD, Misuse of fentanyl and fentanyl analogues, January 2020; A review of the evidence on the use and harms of 2-benzyl benzimidazole ('nitazene') and piperidine benzimidazolone ('brorphine-like') opioids, July 2022.
80 Home Office, Synthetic opioids to be banned as government acts to stop drug deaths, 3 February 2023.
81 Q268; Q269.

opioids.[82] This is because the opium produced in Afghanistan makes up to 80% of the world's opium supply and contributes to 95% of Europe's heroin market.[83] In April 2022, the Taliban supreme leader, Haibatullah Akhundzada, prohibited the production of opium.[84] The ban was not applied to the 2022 harvest, which was up 32% compared to 2021.[85] The ban has now been applied. Reports indicate that this year's production in Helmand province has fallen by 99% and that the country's 2023 harvest may be down by 20% on 2022 levels.[86] UNODC said that a long-term sustainable reduction in opium production in Afghanistan may:

> [L]ead to a displacement of opium production to other countries, to overall decreases in opiate use or replacement of heroin or opium by other substances at the user level, some of which may be even more harmful than heroin or opium (such as fentanyl and its analogues).[87]

40. Professor Dame Carol Black, independent advisor to the Government on drugs, told us that it needed to be monitored closely.[88] Professor David Nutt argued that fentanyls would be the biggest threat if there were a heroin drought as a result of the reduced production of opium in Afghanistan. He said:

> In fact, we might not be able to stop it, anyway, because the economic returns from making the fentanyls are so much greater than from making heroin.[89]

41. Niamh Eastwood, Director of Release, said that "if we have the synthetic opioids in this country, it will be catastrophic. We need to have a strategy in place now to be prepared for that".[90] She argued that the risk could be mitigated through drug checking, opioid substitution treatment (OST) and diamorphine assisted treatment (DAT).[91] Concerningly, we were told that data indicates OST and DAT do not seem to retain the same number of people in treatment for fentanyl dependency.[92]

42. **We recognise that the Psychoactive Substances Act 2016 was enacted to deal with the surge in new psychoactive substances (NPS) and the related health harms. We note that it was successful in removing the open sale of NPS but are concerned with the use of NPS among vulnerable populations, such as homeless people and people in prison, and with the increasing potency of NPS.**

43. **We are concerned about the increasing prevalence of benzodiazepine use, and its implication in drug misuse deaths, across the UK. We await the outcome of the Home**

82 Baroness Meacher and Neil Woods (DRU0105).
83 UNODC, Opium cultivation in Afghanistan: Latest findings and emerging threats, November 2022; BBC News, Inside the Taliban's war on drugs - opium poppy crops slashed, 6 June 2023.
84 Financial Times, Drug prices rise in Afghanistan after Taliban outlaws trade, 31 October 2022.
85 The 2022 crop was the third largest area under opium cultivation since monitoring began. UNODC, Opium cultivation in Afghanistan: Latest findings and emerging threats, November 2022.
86 BBC News, Inside the Taliban's war on drugs - opium poppy crops slashed, 6 June 2023.
87 UNODC, Opium cultivation in Afghanistan: Latest findings and emerging threats, November 2022, p.21.
88 Q185.
89 Q26.
90 Q27.
91 We discuss these approaches in chapter 6.
92 Giovanna Campello, Professor Matthew Hickman and Dr Jane Philpott (DRU0123).

Office's consultation on the creation of a new offence to better enable law enforcement to prove the illicit use of pill presses. *The Combating Drugs Minister must write to us with an update on the outcome of the consultation before 18 December 2023.*

44. **We are alarmed by the health and social harms of synthetic opioids, such as fentanyl. We are concerned that a reduction in the global supply of heroin will have the effect of people with an opioid dependency turning to even more potent and harmful synthetic opioids, which have contributed to the ongoing opioid crisis in North America.**

45. ***To mitigate this risk, we recommend the Government, in partnership with the devolved administrations, increase its monitoring of synthetic drugs being trafficked in, and around, the UK, and prioritise supporting people with a chronic heroin dependency into treatment and recovery.***

46. ***We recommend that the Government must prepare a strategy to mitigate the risk of an increase in the supply and availability of synthetic opioids in the UK before the end of this Parliament.***

The Advisory Council on the Misuse of Drugs

47. The ACMD was established by the 1971 Act as the UK Government's independent, advisory body on drugs.[93] Experts in the fields of medicine, pharmacy and social science (among others) are appointed to the Council. The Home Office regularly commissions work from the ACMD, such as advice on the classification and scheduling of drugs. The Council also self-commissions its own work, such as its 2022 review of naloxone implementation in the UK.[94]

Government implementation of advice

48. Some have noted that the advice of the ACMD is regularly implemented by the UK Government when it recommends substances should be subject to increased restrictions, but less so when the ACMD recommends that controls on a substance should be less restrictive.[95] For example, following reviews by the ACMD, ketamine and GHB (along with GBL and closely related substances) were upgraded from Class C to Class B in 2014 and 2021 respectively.[96] However, the Government chose not to adopt the ACMD's 2008 recommendation to reclassify MDMA from Class A to Class B; it remains a Class A drug.[97] In 2009, the Government reclassified cannabis as a Class B drug despite recommendations by the ACMD in 2005 and 2008 for cannabis to remain a Class C drug.[98] In 2013, khat was

93 Misuse of Drugs Act 1971, section 1 and Schedule 1.

94 Q67; ACMD, Review of the UK Naloxone Implementation: Availability and Use of Naloxone to Prevent Opioid-Related Deaths, June 2022.

95 Professor Alex Stevens, University of Kent (DRU0014); Cranstoun (DRU0067).

96 ACMD, Ketamine: A review of use and harm, December 2013; Minister for Crime Prevention, Letter to Chair of the ACMD: Response to review of ketamine, 12 February 2014; ACMD, An assessment of the harms of gamma-hydroxybutyric acid (GHB), gamma-butyrolactone (GBL), and closely related compounds, November 2020; Home Secretary, Letter to Chair of the ACMD: Response to review of GHB, GBL and closely related compounds, 30 March 2021.

97 ACMD, MDMA ('ecstasy'): A review of its harms and classification under the Misuse of Drugs Act 1971, February 2008; British Medical Journal, UK Government rejects advice from drugs adviser to downgrade ecstasy, 13 February 2009.

98 ACMD, Further consideration of the classification of cannabis under the Misuse of Drugs Act 1971, December 2005; Cannabis: Classification and Public Health, May 2008; HC Deb, 7 May 2008, col.705.

classified as Class C despite the ACMD concluding that "the evidence of harms associated with the use of khat is insufficient to justify control and it would be inappropriate and disproportionate to classify it under the [1971 Act]".[99]

49. Further, on 6 March 2023, the ACMD recommended that nitrous oxide should not be controlled under the 1971 Act but that the risks posed should be managed through a range of harm reduction measures.[100] However, contrary to the ACMD's recommendations, the UK Government announced in its Anti-Social Behaviour Action Plan (published 27 March 2023) that it would make nitrous oxide a Class C drug "with potential prison sentences and unlimited fines for unlawful supply and possession" when parliamentary time allows.[101] The Government took the decision due to concerns regarding "anecdotal reports of an increase in social harms such as drug driving and littering of discarded canisters … and the risk of neurological harm it presents to users when consumed in extreme volumes".[102] On 2 May 2023, the Home Office launched a public consultation on how to classify nitrous oxide whilst continuing to enable its use for legitimate purposes, such as in the medical, industrial and catering sectors.[103]

50. The Home Office is not bound by the ACMD's advice. Professor Bowden-Jones recognised that some recommendations are accepted, and some are rejected. He said that the Working Protocol between the Home Secretary and the ACMD is clear that the Government must explain why it is rejecting a recommendation.[104] Professor Bowden-Jones told us that:

> When we [the ACMD] function well, we are providing the science and synthesising that in a way that Ministers can clearly understand what the science says. It is very much for the Government then to decide what to do with those recommendations.[105]

Unpublished 2016 report

51. In November 2021, an article reported the existence of an unpublished report by the ACMD in 2016.[106] The Home Office had previously rejected a freedom of information request from a journalist on the basis that it was exempt under the Freedom of Information Act 2000 because it related to the formulation or development of government policy.[107] In September 2021, the Information Commissioner upheld the Home Office's reliance on that exemption.[108] That decision was appealed to the First-Tier Tribunal (General Regulatory Chamber; Information Rights). In January 2023, the Tribunal decision upheld that the exemption applied; the contents of the report could be withheld but for a recommendation

99 ACMD, Khat: A review of its potential harms to the individual and communities in the UK, January 2013, p.4; HC Deb, 3 July 2013, col.57WS [Commons written ministerial statement].
100 ACMD, Nitrous oxide: Updated harms assessment, 27 March 2023.
101 HM Government, Anti-social behaviour action plan, 27 March 2023, para.22.
102 Home Office, Nitrous oxide: Legitimate uses and appropriate controls, 2 May 2023, Foreword.
103 Home Office, Nitrous oxide: Legitimate uses and appropriate controls, 2 May 2023.
104 Q72; ACMD, Working Protocol between the Home Secretary and the ACMD, 15 November 2011.
105 Q70.
106 Vice, The UK Government Ignored Its Own Experts' Advice to Decriminalise Drugs, 21 November 2021.
107 Freedom of Information Act 2000, section 35(1)(a); ICO, Freedom of Information Act 2000 Decision Notice, 30 September 2021.
108 ICO, Freedom of Information Act 2000 Decision Notice, 30 September 2021.

that the Working Protocol be reviewed. It noted that the Home Office had accepted that the report was the only ACMD report that has not been published and that it was self-commissioned by the ACMD.[109]

52. In written evidence to this inquiry, Professor Alex Stevens—a member of the ACMD in 2016—told us that the report was titled 'Interactions and relationships between the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016' and did include recommendations relating to the offence of the possession of drugs for personal use under section 5 of the 1971 Act in order to align with the 2016 Act.[110] We asked the ACMD and the Home Office about the 2016 report. Marcus Starling told us that:

> It was a piece of advice that was provided by an outgoing chair of the ACMD to Ministers. It was marked as confidential, so the Home Office has not disclosed that report, partly to protect the safe space between Ministers and our expert advisers in which they can have those conversations. We have chosen not to publish the report […].[111]

53. As the Committee with oversight of the Home Office, we asked that the report be shared with us confidentially, but this request was refused.[112]

54. **The ACMD seeks to provide scientific, evidence-based recommendations to support the development of evidence-based drug policy. We note that the Home Office appears more likely to adopt advice to increase the classification of a controlled drug than it is to adopt advice to reduce the classification of a controlled drug. For example, we note that in the cases of cannabis, MDMA, khat and nitrous oxide, the ACMD recommended a lower classification, or no classification based on a review of the evidence. We acknowledge that scientific evidence should remain a key driver but not the main driver in the development drug policy in all cases, including when the scientific evidence supports reducing the level of control placed upon a drug.**

55. **We are disappointed that the Home Office has repeatedly refused to publish the ACMD's 2016 report, including to this Committee on a confidential basis. No other ACMD report remains unpublished and withholding this one contravenes established practice and undermines the ACMD's transparency. *We, once again, request that the Home Office publish the ACMD's 2016 report. At the very least, we request that the Home Office provide us with a confidential copy of the document within one month of receiving this report. Failing that, the Government must explain in its response to this Report why this ACMD paper, and no other, deserves to be withheld from public view.***

109 Busby v Information Commissioner & Home Office [2023] UKFTT 305 (unreported).

110 Professor Alex Stevens (DRU0014). As noted above, the PSA only criminalises the possession of NPS in custodial settings.

111 Q409.

112 Q414–416; Combatting Drugs Minister (HUM0118).

3 The 10-Year Drugs Strategy

Professor Dame Carol Black's Independent Review of Drugs

> I tried very hard in my review to make it a health issue. Drug dependency is a chronic disease. It is a bit like diabetes or rheumatoid arthritis: you have relapses, you have remissions. It is simply that we do not treat it like that. We treat people who have a drug dependency as a stigmatised population who get a very inferior service from both the health service and, in fact, the treatment and recovery service. […] I made it very clear in my review that you need six Departments of State at the centre with their feet held to the fire, otherwise we will fail.

Source: Professor Dame Carol Black[113]

56. In February 2019, the Government appointed Professor Dame Carol Black to conduct an independent review of drugs in England. Part one found that the estimated total cost of drugs to society is more than £19 billion per year—more than twice the value of the illicit drugs market (an estimated £9.4 billion).[114] Part two concluded that prevention, treatment and recovery were not fit for purpose. It recommended increased cross-departmental working and national and local accountability to improve treatment, employment and housing support; increased funding; rebuilding the treatment sector workforce; recognition that drug dependency is a chronic health problem; and recognition of the harms caused by recreational drug use.[115]

Overview of the 10-Year Drugs Strategy

57. The Government sought to action Dame Carol's recommendations through the 10-Year Drugs Strategy (the strategy), which was published on 6 December 2021.[116] Announcing the strategy, the then Prime Minister, Boris Johnson, said:

> It's clear that the old way of doing things isn't working. So this plan is different. It's not a short-term fix but a long-term, 10-year strategy, one that treats drug abuse not just as a law enforcement issue but as a problem for all of society that all of government must deal with.[117]

58. The strategy is a partnership between six departments: the Home Office, the Ministry of Justice, and the Departments of Health and Social Care, for Levelling Up, Housing and Communities, of Education and for Work and Pensions. Overarching responsibility for the strategy rests with the Combating Drugs Minister. Implementation is supported by the Joint Combating Drugs Unit (JCDU), established in July 2021.[118] At a local level in England, the strategy will be driven forward by multi-agency Combating Drugs Partnerships,

113 Q168.
114 This total estimated cost took into consideration the health harms, costs of crime and winder impacts of society, including to families. Professor Dame Carol Black, Review of drugs: Executive summary, February 2020, p.5.
115 Professor Dame Carol Black, Review of drugs part two: Prevention, treatment and recovery, August 2021.
116 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021.
117 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021, Forward.
118 The JCDU sits within the Home Office and staffed by officials from across the main departments involved in implementing the Strategy.

which may extend across multiple local authorities.[119] Partnerships should have a senior responsible owner to oversee local progress and be accountable to Government and people with experience of drug-related harms, who are recognised as playing an "essential" role.[120]

Actions and commitments in the 10-Year Drugs Strategy

59. The strategy is wide-ranging and seeks to provide a "whole-system approach" with actions relating to each of the six departments. It has a focus on three strategic priorities: breaking drug supply chains; delivering a world-class treatment and recovery system; and achieving a significant reduction in demand for illegal drugs over the next generation. Over the life of the strategy, the Government's ambition is "to reduce overall drug use towards a historic 30-year low".[121] By the end of 2024/25, the Government has committed to:

- preventing nearly 1,000 deaths,
- increasing treatment capacity by 20% with at least 54,500 new treatment places,
- preventing nearly 750,000 crimes, including 140,000 neighbourhood crimes through increases in drug treatment,
- closing more than 2,000 county lines, and
- delivering 20% more major and moderate disruptions against organised criminals.[122]

60. Across the 10-year period, the success of the strategy will be measured against three strategic outcomes—reducing drug use; reducing drug-related crime; and reducing drug-related deaths and harm—under the National Combating Drugs Outcomes Framework.[123] The strategy states that the Combating Drugs Minister will present an annual report to Parliament to monitor progress.[124] We understand it is expected to be published around the time of this report's publication.

Extent of the 10-Year Drugs Strategy in Wales

61. The strategy extends to policing in Wales (which is a reserved matter) and Welsh policing partners are tasked with meeting outcomes under the strategy.[125] The Deputy

119 Membership of a Combating Drugs Partnership should include, for example, local politicians, local authority officials, the NHS, the police and Police and Crime Commissioner, and drug treatment providers. HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives: Guidance for local delivery partners, June 2022.

120 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives: Guidance for local delivery partners, June 2022, p.20.

121 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021, p.6.

122 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021.

123 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives: Guidance for local delivery partners, Figure 1.

124 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021. The implementation of the Strategy is also being monitored by the National Audit Office, which is expected to report in autumn 2023. National Audit Office, Reducing the harm from illegal drugs — a review of early implementation.

125 Those outcomes are: to reduce drug use, drug-related crime and drug supply, and to increase engagement in treatment. HM Government, National Combating Drugs Outcomes Framework: Supporting metrics and technical guidance, 22 May 2023.

Minister for Health and Wellbeing, Lynne Neagle MS—with whom responsibility for the Welsh Government's health response to drugs rests—told us that a number of approaches in the strategy have already been operating in Wales. For example, the partnership-working approach under Combating Drugs Partnerships has been operating for some time through Welsh Area Planning Boards, which bring together relevant partners and which commission substance misuse services.[126]

62. Beyond the relevant elements within the strategy, the Welsh Government's response to drugs is based on the Substance Misuse Delivery Plan 2019–2022. It is a cross-government plan that focuses on the prevention of harm, supporting people who use drugs into recovery, supporting families, and tackling the availability of drugs. The Welsh Government argues that its work is "very much health-led" with the inclusion of initiatives like naloxone, buvidal and WEDINOS.[127]

63. In October 2022, Public Health Wales reported that drug deaths had increased the previous year; there were 210 drug misuse deaths in 2021, an increase of 41% from 2020. The Head of Substance Misuse at Public Health Wales, Rick Lines, said that a number of policies such as the Welsh Take Home Naloxone programme had been effective in preventing or reducing drug deaths, but that

> "[In] light of the scale of drug deaths in Wales, evidence on the impact and influence of different level policies, and their role as barriers or facilitators to reducing drug deaths, is required to inform change".[128]

64. Beyond the relevant elements within the strategy, the Welsh response to drugs is "very much health-led" and based on the Substance Misuse Delivery Plan 2019–2022.[129] The plan focuses on the prevention of harm, supporting people who use drugs into recovery, supporting families, and tackling the availability of drugs. It is a cross-government approach that aims to embed tackling substance misuse in other policy areas. The Deputy Minister told us about a number of initiatives that have been rolled out quite successfully in Wales, including naloxone, buvidal and WEDINOS.[130] We discuss these approaches in chapter 6.

65. ***In line with the spirit of the partnership approach in the 10-Year Drugs Strategy, we recommend that the Government make the Department of Health and Social Care and the Home Office jointly responsible for drug policy. We recommend that the Combating Drugs portfolio be held by a minister that sits across both departments. There is already precedent of Home Office ministers sitting across other departments such as the Ministry of Justice. The Home Office and law enforcement authorities would continue to respond to the illicit production and supply of drugs.***

66. **We welcome the Government's efforts to recognise and respond to the issues in Professor Dame Carol Black's Independent Review of Drugs and we welcome**

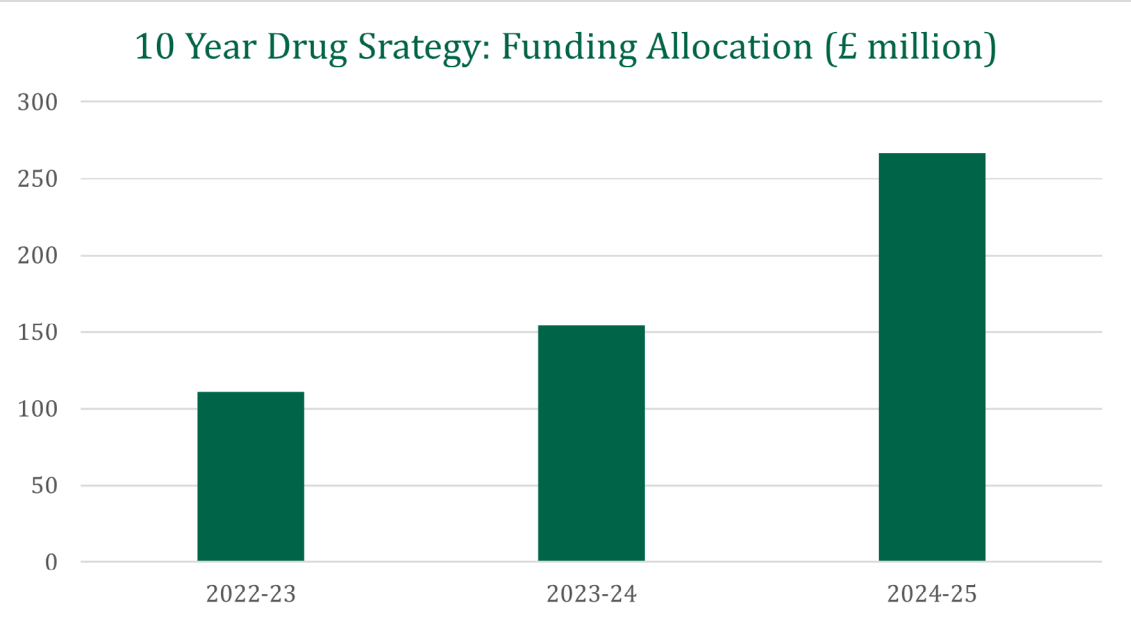
126 Welsh Deputy Minister for Mental Health and Wellbeing, Lynne Neagle MS (DRU0124).
127 WEDINOS is the Welsh Emerging Drugs and Identification of Novel Substances. Welsh Deputy Minister for Mental Health and Wellbeing, Lynne Neagle MS (DRU0124).
128 Public Health Wales, Wales' drug deaths a complex picture, 19 October 2022.
129 The Plan was updated in January 2021 in response to the Covid-19 pandemic. Welsh Government (DRU0081), para.2.1; Welsh Government, Substance misuse delivery plan 2019–2022: Revised in response to Covid-19, January 2021.
130 WEDINOS is the Welsh Emerging Drugs and Identification of Novel Substances. Welsh Deputy Minister for Mental Health and Wellbeing, Lynne Neagle MS (DRU0124).

the ambition of the 10-Year Drugs Strategy. In particular, we welcome the cross-departmental and partnership approach and the increase in funding for the drug treatment and recovery sector. We believe the strategy is an important step in the right direction.

Funding

Funding via the 10-Year Drugs Strategy

67. The strategy committed to providing around £900 million over the first three years, taking cross-government funding to more than £3 billion.[131] A significant proportion is committed to rebuilding drug treatment and recovery services with local authorities in England receiving a ringfenced £780 million over the first three years. Funding for drug treatment and recovery has been prioritised in areas with the highest need, with full coverage across England by the end of 2024/25. Following the initial tranche of funding (£110.9 million), the Government announced £154.3 million for 2023/24, and indicative funding of £266.7 million for 2024/25.[132]



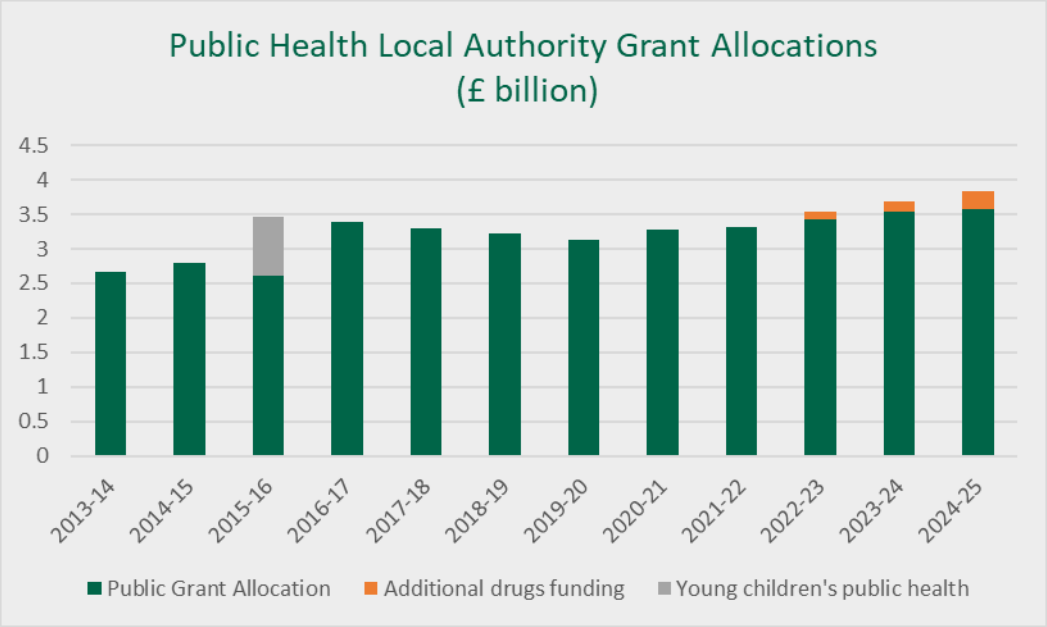
Source: Office for Health Improvement Disparities, Additional drug and alcohol treatment funding allocations: 2023 to 2024 and 2024 to 2025, 16 February 2023.

Funding via the public health grant

68. The funding available under the strategy for drug treatment and recovery services in England is in addition to that allocated to local authorities via the annual public health grant. Since April 2013, drug treatment services have been funded through the public health grant following the coming into force of the Health and Social Care Act 2012. It is a condition of the grant that local authorities have regard to improving the take up of,

131 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021.
132 Department of Health and Social Care, £421 million to boost drug and alcohol treatment across England, 16 February 2023.

and outcomes from, drug and alcohol treatment services.[133] The strategy states that the Government will "ensure that local areas maintain their existing investment in drug and alcohol treatment".[134]



Source: Public health grants to local authorities from 2013–14 to 2023–24.[135]

69. In 2015/16, the public health grant amounted to £63 per person (£3.465 billion).[136] In 2023/24, it amounted to £64 per person (£3.529 billion).[137] This is a nominal increase of 1.6% compared to 2015/16 but is a real terms reduction of 18% when adjusted for inflation.[138]

133 Department of Health and Social Care, Public health ring-fenced grant 2023 to 2024: local authority circular, 15 March 2023, Annex A.

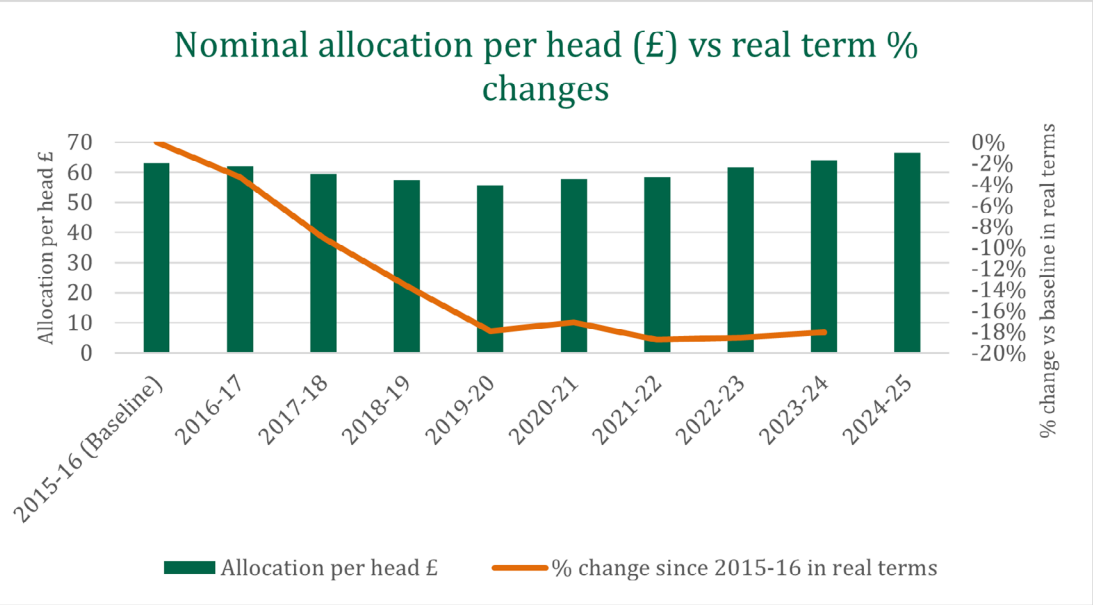
134 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021, p.34.

135 The public health grant for 2015–16 increased significantly as young children's public health services were transferred in from the NHS. Because of this, real term funding analysis is done from a 2015–16 baseline to ensure services are comparable. Department of Health and Social Care, Public health grants to local authorities: 2013–14, 2014–15, 2015–16; 2016–17; 2017–2018; 2018–2019; 2019–2020; 2020–2021; 2021–2022; 2022–2023; 2023–2024.

136 This was the first year where allocations under the public health grant fell compared to the previous year. Department of Health, Local authority allocations and allocations per head 2016 to 2017, February 2016, 2015–16 baseline & allocations tab; The Health Foundation, Public health grant: What it is and why greater investment is needed, 17 March 2023.

137 Department of Health and Social Care, Public health ring-fenced grant 2023 to 2024: local authority circular, 15 March 2023.

138 Population and grant allocation data is gathered from the Department of Health and Social Care data (see above footnotes). This figure is calculated using the whole population for England and the GDP deflator series. See: HM Treasury, GDP deflators at market prices, and money GDP March 2023 (Spring Budget), 16 March 2023.



Source: HM Treasury, GDP deflators at market prices, and money GDP March 2023, 16 March 2023; Public health grants to local authorities from 2015–16 to 2023–24.[139]

70. The Local Government Association (LGA) has expressed disappointment that the latest public health grant allocations were published two weeks before the start of the financial year because it would "make it extremely difficult for councils to plan effectively".[140] It has asked that the timing of allocations be aligned with the local government finance settlement.[141]

Responses to funding

71. In her Review of Drugs, Dame Carol said that "funding cuts have left treatment and recovery services on their knees".[142] The impact of these cuts was repeatedly noted in our inquiry—particularly its impact on shrinking the skilled workforce.[143] Indeed, some argued that re-building the workforce could be the most important long-term change to ensure services can meet demand.[144] The commitment to re-building drug treatment and recovery services and the increase in funding has received widespread welcome.[145] So too

139 Department of Health and Social Care, Public health grants to local authorities: 2015–16; 2016–17; 2017–2018; 2018–2019; 2019–2020; 2020–2021; 2021–2022; 2022–2023; 2023–2024.

140 Public health grant allocations for 2023/24 were published on 15 March 2023. Local Government Association, Public Health Grant allocations to local authorities 2023/24, 27 March 2023.

141 The local government finance settlement is the annual determination of funding to local government. The settlement for 2023/24 was published on 19 December 2022. Local Government Association, Public Health Grant allocations to local authorities 2023/24, 27 March 2023; Department for Levelling Up, Housing and Communities, Final local government finance settlement: England, 2023 to 2024, 6 February 2023.

142 Professor Dame Carol Black, Review of drugs part two: Prevention, treatment and recovery, August 2021, Introduction.

143 Cranstoun (DRU0067); Volteface (DRU0073); Release (DRU0075); Q26; Q122; Event with drug treatment and recovery sector (DRU0122).

144 Collective Voice (DRU0060); Sharon Grace, Professor Charlie Lloyd and Dr Geoff Page, University of York (DRU0074); Changing Lives (DRU0082).

145 Ben Corken, Change, Grow, Live (DRU0009); Professor Alex Stevens (DRU0014); Dr Felipe Neis Araujo, University of Manchester (DRU0019); The Company Chemists' Association (DRU0025); Dr Jack Spicer, University of the West of England (DRU0027); Peter Reynolds (DRU0050); Collective Voice (DRU0060); The Hepatitis C Trust (DRU0065); APPG for Drug Policy Reform (DRU0070); Sharon Grace, Professor Charlie Llyod and Dr Geoff Page, University of York (DRU0074); Release (DRU0075); Association of Police and Crime Commissioners (DRU0078); Changing Lives (DRU0084); Faculty of Public Health and the Association of Directors of Public Health (DRU0096).

has the strategy's prioritisation of funding areas that are disproportionately affected by multiple disadvantages because "this rightly approaches substance misuse through the prism of social disadvantage".[146]

72. However, Changing Lives expressed concern that the increase in funding under the strategy could result in other funding streams reducing, such as from police and crime commissioners, because those funders may see their contribution as unnecessary in light of the strategy.[147] Others questioned how the aims of the strategy would be achieved "within the funding envelope committed, especially in the context of the wider cuts to public services in the past few years".[148] As the initial three-year tranche of funding will end in 2025, Collective Voice argued that the sector may need to use this time to "demonstrate it is capable of absorbing the new funding to support a vastly increased number of people and to produce the results the government expects".[149] It said "there are significant challenges that will not be solved quickly–at least not in a way that provides long-term stability and sustainability".[150]

73. We also heard concerns about the allocation and timing of funding. In particular, some argued that yearly distribution of funds did not provide services with sufficient time to plan or recruit and train skilled staff and that structural changes to short-term funding streams were needed.[151] The Combating Drugs Minister sympathised with these concerns and told us that Government had worked to allocate funding for both the 2023/24 and 2024/25 financial years. The Minister went on to say:

> In fact, that is a point we might take on board more generally in Government, because particularly when you are funding charities or third-party bodies, giving them funding just for a year makes it quite hard to plan. Giving people funding for two or three years in one go makes it much easier to plan and organise services, particularly in the voluntary sector and the charity sector.[152]

74. **We are concerned about the long-term sustainability and security of funding for the drug treatment and recovery sector.**

a) **We welcome the Government's latest funding announcement, which provides funding in England over a two year period. However, we question whether this is a sufficient length of time for service providers to utilise the funding to embed change. *We recommend that the UK Government provide funding throughout the 10 year lifespan of the strategy in three year cycles.***

b) ***In relation to the public health grant in England, we recommend that the Government go further than placing a condition on local authorities to have regard to drug and alcohol treatment by requiring local authorities to ringfence funding allocated under the public health grant for these services.***

146 Centre for Justice Innovation (DRU0068), para.1.
147 Changing Lives (DRU0082).
148 Barrow Cadbury Trust Transition to Adulthood Alliance (DRU0059), para.12.
149 Collective Voice (DRU0060), para.16.
150 Collective Voice (DRU0060), para.16.
151 Sharon Grace, Professor Charlie Lloyd and Dr Geoff Page, University of York (DRU0074); Association of Police and Crime Commissioners (DRU0078); Event with drug treatment and recovery sector (DRU0122).
152 Q382.

c) ***We recommend that the Government give service providers a minimum of three months' notice of forthcoming funding allocations under the strategy and public health grant to enable them time to plan appropriately.***

Responses to the 10-Year Drugs Strategy

75. The strategy has been broadly welcomed in our inquiry, particularly the increase in funding. The LGA said councils shared its ambition.[153] Collective Voice and others said it represents "a serious chance to transform our treatment and recovery system".[154] The National Police Chiefs' Council (NPCC) told us there was "widespread, almost universal support" among police forces.[155] The Association of Police and Crime Commissioners (APCC) welcomed the strategy's approach, which recognises that drugs are both a criminal justice and health issue.[156] The North Yorkshire Police, Fire and Crime Commissioner agreed and argued that there is a "significant role" for enforcement regarding supply and that its role is in "line with public expectations".[157] The APCC also welcomed the tone of the strategy because it considers the issue as one where progress can be made.[158]

76. Some welcomed the strategy's support for out-of-court disposals, which enable the police to deal with low-level offending without the involvement of the courts. Diversion schemes are an example of an out-of-court disposal. These schemes seek to direct offenders away from the criminal justice system to, for example, treatment and support services.[159] This commitment reflects Dame Carol's recommendation to divert drug users from the criminal justice system and into treatment.[160] However, Cranstoun—a social justice and harm reduction charity—argued that there was a "missed opportunity" to enable criminal justice partners to co-commission diversion services, such as its Cranstoun Arrest Referral Service.[161] Others welcomed the commitment to preventing and reducing drug use among children and young people but argued that more prevention is needed—particularly in relation to addressing Adverse Childhood Experiences, poverty and deprivation.[162]

77. In addition, though most have welcomed the health-based elements of the strategy, others have criticised the criminal justice elements as a continuation of punitive policies which, in their view, have failed to address drug use and drug misuse deaths.[163] Others have argued that the strategy could have gone further in how to support people with a drug dependency who, for example, are from disadvantaged or marginalised backgrounds or have a learning disability or are neurodiverse.[164]

153 Local Government Association (DRU0084).
154 Collective Voice (DRU0060), para.12.
155 National Police Chiefs' Council (DRU0079), para.3.6.1.
156 Association of Police and Crime Commissioners (DRU0078).
157 North Yorkshire Police, Fire and Crime Commissioner (DRU0099), para.33.
158 Association of Police and Crime Commissioners (DRU0078).
159 We discuss diversion schemes in chapter 7. Dr Felipe Neis Araujo, University of Manchester (DRU0019); Barrow Cadbury Trust Transition to Adulthood Alliance (DRU0059); Faculty of Public Health and the Association of Directors of Public Health (DRU0096); Transform (DRU0097).
160 Professor Dame Carol Black, Review of drugs part two: Prevention, treatment and recovery, August 2021, Recommendation 15.
161 The service operates across the West Midlands Police, seven local authority areas and seven different local drug and alcohol treatment providers. Cranstoun (DRU0067).
162 Association of Police and Crime Commissioners (DRU0078); Changing Lives (DRU0082); APPG on Drugs, Alcohol and Justice (DRU0093).
163 National Aids Trust (DRU0094); Transform (DRU0097).
164 Q122.

78. Finally, some have welcomed the strategy's commitment to building a world-leading evidence base and investing in research to "ensure that treatment meets the needs of people accessing services because this is core to ensuring treatment is attractive to people".[165] However, the Faculty of Public Health and the Association of Directors of Public Health argued that:

> Although the Strategy states that evidence is "at the heart" of its approach, this is not always the case. Research investment is focused on only two of its four pillars of drug policy: treatment and prevention, whilst drug law enforcement remains largely unevidenced, and legislation creates barriers to building the evidence base for innovative harm reduction approaches.[166]

Law enforcement

79. The strategy's recognition of the complexity of the illicit drug market has been welcomed.[167] The APCC said that it fully supported the government's 'tough consequences' agenda.[168] South Wales Assistant Chief Constable, David Thorne, and Merseyside Chief Constable, Serena Kennedy, said the strategy's ambition to prevent three quarters of a million crimes by 2024 would be challenging for police forces to meet.[169] ACC Thorne nevertheless said that the police can make a "significant difference in the amount of harm caused" but argued that tackling the problem was about more than the supply of drugs and would "take longer to deal with in its totality".[170] The NPCC suggested that a gap within the strategy could be the insufficient resources available for Regional Organised Crime Units to tackle the mid-market drugs supply, which is left to forces with limited capacity to respond to.[171]

80. Dr Jack Spicer from the University of West England questioned whether objectives in the strategy, such as placing a "ring of steel" around the UK and eliminating the presence of drugs "from our cities, towns and villages" were realistic and whether outcomes regarding the supply and control of drugs would remain the same.[172] Dr Giulia Berlusconi from the University of Surrey argued that the long-term effectiveness of law enforcement approaches can be limited due to the resilience and flexibility of drug markets. She said that, while more research on drug law enforcement was needed, available evidence suggested a focus on prevention and treatment might be more effective and, ultimately, have a positive impact on drug supply, too.[173] In part one of her review, Dame Carol said that:

> "even if [police forces, Border Force and the National Crime Agency] were sufficiently resourced, it is not clear that they would be able to bring about a sustained reduction in drug supply, given the resilience and flexibility of illicit drug markets".[174]

165 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021; Release (DRU0075), para.31.
166 Faculty of Public Health and the Association of Directors of Public Health (DRU0096), para.21.
167 APPG for Drug Policy Reform (DRU0070).
168 Association of Police and Crime Commissioners (DRU0078).
169 Q200.
170 Q200.
171 National Police Chiefs' Council (DRU0079).
172 Dr Jack Spicer, University of the West of England (DRU0027).
173 Dr Giulia Berlusconi, University of Surrey (DRU0076).
174 Professor Dame Carol Black, Review of drugs: Executive summary, February 2020, para.8.

81. The National Crime Agency told us that law enforcement plays an important role in seizing drugs and preventing a greater amount of drugs filtering into the country but that:

> It is right to say that law enforcement alone, no matter how well resourced, cannot solve this problem because it is about demand and treatment and education as much as law enforcement.[175]

Methods of treatment and recovery

82. Dame Carol Black said in her review, and to us, that drug dependency is a chronic disease.[176] The Government recognised this in the strategy and said it would treat addiction as such, which we welcome.[177] The strategy says that promoting recovery is a key aspect of the approach taken and that Government "will support local areas to expand and improve the quality of a full range of evidence-based harm reduction and treatment interventions".[178] Its commitment to building a world-class treatment and recovery system that seeks to provide holistic support has been welcomed.[179]

83. Police and Crime Commissioner for Dorset, David Sidwick, argued that the "focus with the new investment needs to be targeted at abstinence and also across drug types" because a focus on opioids would not address problems relating to cocaine and other drugs.[180] However, we have heard concerns that the strategy places more emphasis on abstinence-based approaches over harm reduction approaches. Though the strategy recognises approaches like long-term injectable buprenorphine, naloxone and needle and syringe programmes, it was argued that the strategy does not consider other approaches including diamorphine assisted treatment and safe consumption facilities.[181]

84. Drug Science argued that a primarily abstinence-focused approach may be problematic as recovery through abstinence may not be achievable for everyone.[182] For example, the ACMD noted in its 2016 report on reducing opioid-related deaths that recovery from heroin dependency has a very high rate of relapse and that "Many people who become abstinent will not sustain it but will relapse to opioid use. This is a known risk for overdose and death, as users lose tolerance to opioids during periods of abstinence".[183]

85. The Criminal Justice Alliance also noted that harm reduction services can be beneficial in acting as " a vital springboard to detoxification and abstinence" and that thresholds for people to access abstinence-based recovery programmes are often too high for people to meet because they need to have abstained from drugs for several weeks.[184] Professor Jim McManus told us that "there is a good focus on harm reduction [in the strategy], but it doesn't go far enough".[185]

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175 Q270.
176 Professor Dame Carol Black, Review of drugs part two: Prevention, treatment and recovery, August 2021; Q168.
177 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021.
178 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021, p.35.
179 Centre for Justice Innovation (DRU0068); Volteface (DRU0073).
180 Police and Crime Commissioner of Dorset, David Sidwick (DRU0100), p.2.
181 Ben Corken, Change, Grow, Live (DRU0009); Professor Alex Stevens, University of Kent (DRU0014); Dr Felipe Neis Araujo, University of Manchester (DRU0019); Volteface (DRU0073); Criminal Justice Alliance (DRU0090); National Aids Trust (DRU0094); The Faculty of Public Health and The Association of Directors of Public Health (DRU0096).
182 Drugs Science (DRU0056).
183 Drug Science (DRU0056);
184 Criminal Justice Alliance (DRU0090).
185 Q122.

86. **The 10-Year Drugs Strategy recognises some harm reduction approaches but could go further. Abstinence-based recovery may not be an effective form of treatment for everyone. A broader range of harm reduction treatments are therefore required to help as many people into recovery as possible.** ***We recommend that the Government update the strategy to increase the range of harm reduction approaches available to support a person's treatment and recovery from drugs in line with the approaches outlined in this report.***

People with lived experience of drugs

Stigma

87. The impact of stigma associated with drugs has been repeatedly raised during our inquiry. Dr Karenza Moore told us that stigmatising language is unhelpful, particularly as a means of deterring young people from using drugs.[186] Stigma is a key concern among people who use, or have used, drugs, their families and loved ones, and the organisations that support them. They argued that stigma can have a negative impact by inhibiting people from accessing treatment and, beyond treatment, affect their housing and employment prospects.[187]

88. During our roundtables with people who used drugs and with people whose loved ones had experience of drugs, we were told that the stigma of addiction can follow a person, even when that person enters long-term recovery. We were also told that people from different ethnic, cultural and religious backgrounds can face different, and sometimes intense, forms of stigma, which in turn may act as a barrier to accessing support, particularly from within one's own community. Participants told us that the social consequences can be permanent and severe, and that stigma can have a negative effect on more than just the person who uses drugs; stigma can affect their families too.[188]

89. We were told how important language is in perpetuating stigma and shame. Terms such as 'drug addict' can, for example, dehumanise an individual by reducing their identity to their struggles with drug use, or implying that their situation is fixed. This may create a sense of shame within that individual and prevent them seeking support.[189]

90. The strategy states that it "will create a system where no one falls through the gaps, where there is no stigma attached to addiction and [drug dependency] is treated as a chronic health condition".[190] However, the strategy provides no specific actions to support this ambition.[191] A national programme to tackle stigma was suggested to us.[192] Some have argued that language in the strategy itself, such as the use of the term "addict", runs counter to its ambition to tackle stigma.[193] Others argued that the 'tough consequences'

186 Q14.
187 Event with drug treatment and recovery sector (DRU0122). Lived experience roundtables (DRU0121).
188 Lived experience roundtables (DRU0121).
189 Lived experience roundtables (DRU0121); Visit to Glasgow and Belfast (DRU0119).
190 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021, p.31.
191 Collective Voice (DRU0060).
192 APPG on Drugs, Alcohol and Justice (DRU0093).
193 DRU0053 (Anonymous); Collective Voice (DRU0060); Volteface (DRU0073); Release (DRU0075); National Police Chiefs' Council (DRU0079); Scottish Government (DRU0100).

language throughout the strategy may also have a stigmatising effect and undermine efforts to get people into treatment.[194] This perceived contradiction has been noted by other academic and public health commentators.[195]

91. The Welsh Government's Substance Misuse Delivery Plan outlines that a key aim is to support people with a drug dependency to improve their health and support their recovery. In doing so, people with a drug dependency must be treated with dignity, fairness and respect by, among other things, reducing negative perceptions of people with a drug dependency. To achieve this, Welsh Area Planning Boards are required to work with community groups and the local media to support people who have experienced recovery to raise awareness of recovery.[196]

Barriers to treatment and support

92. During a roundtable with treatment sector stakeholders, we were told that treatment and recovery services can fail to account for the specific needs of women, particularly women who are pregnant or who have children. We were also told that many women may find accessing treatment an intimidating experience.[197] We also heard how black, Asian and minority ethnic people may face additional barriers in accessing treatment and support.[198] Professor Jim McManus told us that access to treatment should be "culturally sensitive, appropriate and non-stigmatising" for people from black, Asian and minority ethnic communities.[199] It has been argued that more research is needed on how best to support women and marginalised groups who use drugs.[200]

93. Other barriers noted by people with lived experience included stigma and logistics—for example, a person may not be located near support or unable to travel to it.[201] Maggie Boreham, Senior Public Health Specialist at Hackney Council, suggested that the criminalisation of people who use drugs can also act as a barrier to accessing treatment.[202] However, Dame Carol questioned the extent to which this contributed to the problem. Instead, she argued that a lack of high-quality, good treatment was a key factor in why fewer people were accessing and remaining in treatment.[203]

94. At a local level, the strategy recommends that the voices of people with lived experience are included in the work of Combating Drugs Partnerships. Maggie Boreham argued that it was important to bring in people with lived experience to co-develop treatment and support services, particularly because they can help local authorities to understand the barriers preventing people from accessing treatment and support.[204] However, we note that the strategy does not recommend the inclusion of the voices of people with lived experience at national level.

194 Barrow Cadbury Trust Transition to Adulthood Alliance (DRU0059).
195 Holland et al, Analysis of the UK Government's 10-Year Drugs Strategy—a resource for practitioners and policymakers, Journal of Public Health, 29 October 2022.
196 Welsh Government, Substance Misuse Delivery Plan 2019–2022: Revised in response to Covid-19, January 2021.
197 Event with drug treatment and recovery sector (DRU0122); Lived experience roundtables (DRU0121).
198 Lived experience roundtables (DRU0121).
199 Q129.
200 APPG on Drugs, Alcohol and Justice (DRU0093).
201 Lived experience roundtables (DRU0121).
202 Q119.
203 Q190–191.
204 Q146.

Families and loved ones of people with lived experience of using drugs

95. Our discussions with people with lived experience of drugs, their families, and the organisations that work with them made clear the important role that families can play in supporting their loved ones into treatment and recovery. Though family may in some cases be part of the root cause of drug dependency, in other cases, family can be a motivating factor in a person's recovery. Family can, for example, provide a social and emotional support network and can help to provide a person with stability during their treatment and recovery.[205]

96. However, it can be a difficult, upsetting and traumatic situation for families. We were told that there can be a lack of support, particularly mental health support, that charities supporting families are often oversubscribed and that receiving support can be a matter of luck.[206] We were told that the level of support available can vary across local authorities in England, with some running family outreach programmes, some using external services but in others only be one person being employed to provide support. Yet we were also told that investment in a family and alcohol team can save a local authority money within a year.[207] In addition, we were told that there is little bereavement support for people whose loved ones have died as a result of drugs. One organisation suggested that bereavement support services ought to be commissioned to support families in these cases.[208]

97. The strategy recognises the role of families in treatment and recovery while also recognising the impact that drugs can have on families and that they have support needs separate from their loved ones. It also places a particular focus on the treatment of young people and of parents, which it states ought to be trauma informed and family based if necessary. The strategy's commitments in relation to the family are primarily directed towards early intervention and prevention. For example, it commits to investing in the creation of family hubs in half of the council areas across England, to providing further investment in the Supporting Families Programme and further investment in secure and open residential children's homes.[209] Though this investment has been broadly welcomed, some have argued to us that the strategy could have done more to support the families, carers and loves ones of people who use drugs, who "deserve support in their own right—and will continue to play an essential role in supporting loved ones into and through recovery".[210]

98. **The strategy states a commitment to breaking down stigma but provides little detail on how this commitment would be actioned. Stigma is a key issue for people with lived experience of using drugs and for their loved ones. Tackling stigma in all its forms must be a priority in the Government's entire response to drugs.**

99. ***We recommend that the Combating Drugs Minister leads on devising a cross-departmental action plan to tackle stigma. In devising the action plan, the Government must engage with people with lived experience of drugs and stakeholders in the drug treatment and recovery sector to understand fully how stigma can affect people and how***

205 Changing Lives (DRU0082); Event with drug treatment and recovery sector (DRU0122); Lived experience roundtables (DRU0121).
206 Lived experience roundtables (DRU0121).
207 Event with drug treatment and recovery sector (DRU0122); Lived experience roundtables (DRU0121).
208 Event with drug treatment and recovery sector (DRU0122); Lived experience roundtables (DRU0121).
209 The programme aims to support vulnerable families to address multiple disadvantages. HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021.
210 Collective Voice (DRU0060), para.18.

best to tackle it. The action plan must be published before the end of February 2024. We further recommend that the Government work with the devolved administrations to roll-out a coordinated, UK-wide campaign to tackle stigma.

100. **We were concerned to hear about the barriers people, such as women and black, Asian and minority ethnic people, can face when accessing treatment. No-one should be unable, or feel unable, to receive treatment and support.**

101. ***We recommend that Combating Drugs Partnerships prioritise identifying the likely barriers to treatment and recovery for people within their local area and take steps to address these barriers as part of fulfilling their commitments under the 10-Year Drugs Strategy.***

102. **We welcome the strategy's recommendation that the membership of local Combating Drugs Partnerships should include people affected by drug-related harm because it gives people with lived experience a platform to help reduce barriers to treatment and recovery at a local level. However, we question whether this is reflected at a national level.**

103. ***We recommend that the Government explain how the voices of people with experience of drug-related harms are being recognised and included in national efforts to implement the strategy.***

104. **We welcome the strategy's commitment to supporting families. It focuses on the important role of the family in preventing drug use, particularly in relation to young people. However, it does not recognise the role that families can play in the treatment and recovery of family members who have already developed a dependence on drugs. Our discussions with families also made it clear that the level of support available for families, particularly mental health support, could be improved.**

105. ***We recommend that local authorities use the funding allocated under the 10-Year Drugs Strategy to embed specialist practical and mental health support within drug treatment and support services for the families and the loved ones of people who use, or used, drugs.***

Swift, certain, tough White Paper

Overview

106. To meet one of the strategy's core commitments—achieve a generational shift in demand for drugs—the Government committed to "applying tougher and more meaningful consequences".[211] As part of this, it committed to publishing a White Paper considering "a series of escalating sanctions" for recreational drug use.[212] On 18 July 2022, the Government published the White Paper: 'Swift, certain, tough: New consequences for drug possession' and launched a public consultation on the policy.[213]

211 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021, p.9.
212 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021, p.6.
213 The consultation ended on 10 October 2022. At the time of writing, consultation feedback was still being analysed. Home Office, Swift, certain, tough: New consequences for drug possession, July 2022.

107. The White Paper proposes three tiers of escalating sanctions for adults found in possession of low levels of recreational drugs. The tiered framework would apply in England and Wales and may also apply to Scotland and Northern Ireland. The tiered framework would not apply to people with a drug dependency; such individuals would instead be directed into treatment. However, the White Paper does not provide further details on how these individuals would be identified and directed into treatment. The three-tiered framework is summarised below.

Table 1: Three-tiered framework of escalating sanctions

Tier 1	Tier 2	Tier 3
For a first offence, an offender would be required to attend, and pay for, a drug awareness course as an alternative to prosecution (unless prosecution is considered more appropriate). A person would be issued with a newly proposed fixed penalty notice called a Drug Enforcement Notice. Failure to attend the course would require a person to pay this fine. Failure to pay would result in enforcement proceedings or prosecution for the original offence.	For a second offence, a person would be offered a diversionary caution. This may include attending, and paying for, another drug awareness course or a longer-term intervention. This would be coupled with a period of mandatory drug testing (not exceeding three months) during which the testing appointments will be randomised, albeit providing the person with 24 hours' notice. Failure to comply with the conditions (including a positive drug test result) could render a person liable for arrest and charge for the original tier 2 offence.	For a third offence, a person would be charged. If convicted for the offence, the court would have discretion to impose a newly proposed civil Drug Reduction Order if it could reasonably prevent further drug possession offences and/or associated harms. A person would attend, and pay for, a drug awareness course. Further conditions may, where appropriate, be attached for specified periods: an Exclusion Order, Drug Tagging, the confiscation of a person's passport or disqualification of their driving licence.[214]

Source: Home Office, Swift, certain, tough: New consequences for drug possession, July 2022.

Responses to the White Paper

108. We took most of our evidence on the White Paper shortly before it was published. Some questioned whether the proposals would be effective and expressed concern that they could have a stigmatising effect and discourage people from seeking out treatment.[215] Transform argued that drug testing on arrest is coercive and unethical.[216] Dr Karenza Moore from Newcastle University argued that "a crackdown on recreational drug users is a crackdown on young people" as overall drug use tends to be higher among people aged 16 to 24 years old.[217]

109. After the publication of the White Paper, over 100 individuals and organisations—including the Faculty of Public Health, the Association of Directors of Public Health,

214 The maximum period a condition can be attached to an Order is 24 months. A breach of an Order would be considered as a separate criminal offence, which may result in a custodial sentence.

215 Professor Alex Stevens, University of Kent (DRU0014); Dr Felipe Neis Araujo, University of Manchester (DRU0019); Release (DRU0075).

216 Transform (DRU0106).

217 Q23. See also Appendix 1.

the British Medical Association and the Police Federation—wrote to the Home Secretary opposing the proposals as "punitive". They argued that the proposals will further stretch police capacity; further undermine the trust of communities in policing; fuel stigma; and create barriers to health and social interventions.[218] The Scottish Government has expressed opposition to the proposals extending to Scotland. It has argued that criminal sanctions "have not proven successful in preventing drug deaths" and that the approach in Scotland is based on public health.[219] This has been echoed by the Chair of the Scottish Drugs Deaths Taskforce, David Strang CBE.[220] The Welsh Deputy Minister for Health and Wellbeing also expressed concerns over the policy. She was concerned that the proposals did not consider the underlying reasons for why a person may use drugs and could disproportionately impact deprived and marginalised groups, and people from black and minority ethnic backgrounds. She also said the Welsh Government did not want the cost of the policy to become the responsibility of the devolved services or for it to increase the burden on those services.[221]

110. Others have argued that people need to be discouraged from using recreational drugs. West Midlands Police Chief Constable, John Campbell QPM, and South Wales Assistant Chief Constable, David Thorne, argued that some punitive element may be necessary, though ACC Thorne said its efficacy would need to be evidenced.[222] CC John Campbell and Police and Crime Commissioner for Dorset, David Sidwick, argued that even the term 'recreational' drugs is misleading and minimises the associated harms.[223] PCC Sidwick added that to be effective, the policy needed to extend to all drugs on focus on a broader range of people who use drugs recreationally.[224] The APCC agreed and said it "would like to see a shift in the language that we use away from the sharp distinction between 'problem' and 'recreational' use and towards something that recognises that there can be a continuum of harm".[225]

111. The Combating Drugs Minister said the proposals were not "unreasonable" in the sense that they seek "to have a clearly pre-defined set of escalatory measures". He argued that Parliament has legislated for the possession and consumption of classified drugs to be illegal and that it is therefore right that "proportionate and calibrated consequences" follow. He said that the Tier 1 interventions were not dissimilar to those for driving "40 [miles per hour] in a 30 [miles per hour] zone".[226] In October 2022, the then Combating Drugs Minister, Jeremy Quin MP, requested the ACMD establish a working group to consider the implementation of the proposals, with "targeted commissions" on areas of the policy's implementation to follow.[227]

112. **We welcome the Government's ambition to reduce demand for drugs including recreational drugs. However, we have heard concerns that the three-tiered framework**

218 Release and Transform, Letter to the Home Secretary: Organisations and Experts Call for Rethink of Drug Possession Proposals, 16 December 2022.
219 Scottish Government, Letter from the Minister for Drugs Policy to the Combating Drugs Minister, 22 July 2022.
220 Scottish Drug Deaths Taskforce (DRU0102).
221 Welsh Deputy Minister for Mental Health and Wellbeing, Lynne Neagle MS (DRU0124).
222 Q205.
223 Q205; Police and Crime Commissioner for Dorset, David Sidwick (DRU0110).
224 Police and Crime Commissioner for Dorset, David Sidwick (DRU0110).
225 Association of Police and Crime Commissioners (DRU0078).
226 Q383.
227 At the time of writing, details on targeted commissions had not been published. Home Office, Letter from the Combating Drugs Minister to the ACMD on new consequences for drug offences, 4 October 2022.

of escalating sanctions under the Swift, Certain, Tough: New Consequences for Drug Possession White Paper may have a negative impact in, for example, perpetuating stigma and in relation to young people.

113. ***Though we await the outcome of the consultation on this White Paper, we ask that the Home Office further explain:***

a) ***How people with a drug dependency—to whom this policy will not apply—will be identified and directed into treatment.***

b) ***The extent to which the policy is likely to affect young people aged 16–24 years old—among whom recreational drug use tends to be higher—and what analysis it has done on how effective the policy is likely to be among this age group compared to police-led diversion schemes.***

c) ***To what extent the cost of implementing the policy would fall to the devolved administrations.***

4 County lines

The extent of county lines

114. The Home Office defines 'county lines' as:

> [A] term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.[228]

115. Dame Carol's review concluded that county lines activity has fuelled an increase in drug use, drug-related harms and violence in every area of England, and that the involvement of vulnerable children and young people in the supply of drugs was "widespread".[229] Indeed, British Transport Police (BTP) Assistant Chief Constable, Charlie Doyle, told us that of the people dealt with by his force in relation to county lines, 38% are aged 10–19 years old and 40% aged 19–29. He said that young people are managing even younger people to transport drugs across the country.[230]

Responses to the problem of county lines

116. In November 2019, the Government launched its County Lines Programme. Among other things, it increased the police response on the rail networks and in the Greater Manchester, London, Merseyside and West Midlands force areas.[231] It also expanded the National County Lines Coordination Centre—which monitors county lines at a national level and coordinates the response of law enforcement. The NPCC said that the centre has enabled Regional Organised Crime Units to improve the coordination of police activity across force areas.[232]

117. The strategy committed to strengthening this programme through £145 million of funding.[233] The programme will support dedicated County Lines Taskforces established in London, Merseyside and the West Midlands, as well in the BTP. The strategy's overarching county lines commitment is the closure of more than 2,000 lines by March 2025.[234] Since the programme's launch in 2019, 3,588 county lines have been closed, 10,209 people have been arrested, and 5,727 people have been referred by the police to safeguarding services.[235]

118. In 2019, a previous iteration of this Committee concluded that the safeguarding of children needed to be prioritised; that demand for drugs needed to be reduced; and

228 Home Office, County lines programme overview, 14 March 2023.
229 Professor Dame Carol Black, Review of drugs part two: Prevention, treatment and recovery, August 2021, para.2.2 and 3.3.
230 Q269.
231 Home Office, County Lines Programme overview, 14 March 2023.
232 National Police Chiefs' Council (DRU0079).
233 This funding built on over £65 million invested in the County Lines Programme since 2019. HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021.
234 This funding built on over £65 million invested in the County Lines Programme since 2019. HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021.
235 Latest figures as of March 2023. Home Office, County Lines Programme data, 14 March 2023.

that increased cross-border working and data-sharing between law enforcement and safeguarding agencies were required.[236] During this inquiry, we have heard evidence to suggest that law enforcement alone will not solve the problem. The NPCC told us that forces have reported county lines being quickly re-established despite significant activity and funding to help roll them up.[237] Dr Jack Spicer from the University of West England argued that an increased law enforcement response can make the problem of 'cuckooing' worse.[238] Dr Spicer argued that a primarily criminal justice response would have limited success and that public health responses, including a well-funded treatment system and a range of harm reduction measures, were needed.[239]

119. The Strategy has committed to reducing demand for drugs and re-building drug treatment and recovery services. The need for a more holistic response has also been noted by law enforcement. Though supportive of the County Lines Taskforces, Dr Richard Lewis, NPCC Drugs Lead and Chief Constable for Dyfed-Powys Police, recognised that reducing demand for drugs is an important element in tackling the issue but that:

> It is only in conjunction with agencies such as health boards and local authorities, who fund a lot of drug treatment services, that we can truly effectively tackle drug abuse in our communities.[240]

120. Nicky Hill, Head of Services at Abianda—a social enterprise that works with young women and girls affected by criminal exploitation and violence—argued that the issue of county lines ought to be reframed primarily as a safeguarding issue rather than as a law enforcement issue, particularly given the number of people under 18 who are exploited.[241] She said that good practice is occurring in areas, like Shropshire, that have aligned drug and alcohol services with exploitation services. She also argued that early intervention and diversion away from the criminal justice system are important tools in tackling county lines.[242] Business Development Manager at St Giles Trust, Junior Smart OBE, supported well-funded programmes that support children and young people in areas where county lines is most prevalent.[243] He referred to the Rescue and Respond project that has been operating in London since 2018. It is a multi-agency partnership overseen by the Mayor's Office for Policing and Crime. Its aims are threefold: to develop a 'rescue plan' for the child or young person; to develop intelligence on emerging county lines; to upskill frontline professionals in London to identify and divert young people away from county lines.[244]

121. In addition, Junior Smart support adopting a statutory definition of child criminal exploitation because, without one, "it has been left down to regional areas to define who they see and how they treat [people]". He said that organisations like his could be working

236 Home Affairs Committee, Sixteenth Report of Session 2017–19, Serous youth violence, HC 1016.
237 National Police Chiefs' Council (DRU0079).
238 'Cuckooing' refers to a situation where county lines dealers take over a property for county lines activities, such as to store or supply drugs. It is often properties that belong to vulnerable people that are targeted.
239 Dr Jack Spicer of the University of West England (DRU0027); Q344.
240 Q308; Q309.
241 Q344.
242 Q328.
243 Q344.
244 Mayor's Office for Policing and Crime, Rescue and Response County Lines Project: Supporting young Londoners affected by county lines exploitation — Year 3: Strategic Assessment 2021, December 2021.

with someone who could be a victim, a perpetrator or even a witness but that, without a statutory definition, it was difficult to determine. He argued that the lack of a definition was ultimately hampering efforts to tackle county lines.[245]

122. ACC Charlie Doyle told us that there was a need to "improve availability, access and capacity of practical support for children and their families who are, or are at risk of, exploitation by criminal gangs".[246] He said that the increased funding via the County Lines Programme had enabled the secondment of two Prevention Officers from the Children's Society to BTP. The officers shared knowledge on safeguarding with BTP and took responsibility for the force's 'Look Closer' campaign. The campaign aimed to raise awareness and improve responses to child exploitation and was adopted by companies across the railway industry.[247]

123. **We welcome the 10-Year Drug Strategy's commitment to rolling up county lines but increasing law enforcement efforts is only one part of the solution. We therefore welcome the strategy's commitment to reducing demand for drugs and to re-building the drug treatment and recovery sector. We believe that these actions will play an important role in tackling county lines. However, we believe the Government could go further to prevent children and young people from becoming exploited by county lines.**

124. **To tackle county lines, we believe it is vital that the children and young people exploited (or at risk of exploitation) by criminal gangs are kept out of the criminal justice system.**

125. ***We recommend the Government build on the harm reduction measures within the strategy by implementing the recommendations on harm reduction outlined in this report, particularly our recommendations on expanding diversion schemes.***

126. ***We recommend that the Government work with local partners to link up drug treatment services for children and young people with exploitation services to ensure that they receive holistic support.***

127. ***We recommend that the Government consider adopting a statutory definition on Child Criminal Exploitation.***

128. ***We welcome the British Transport Police's efforts to improve responses to child exploitation through the secondment of two Prevention Officers from the Children's Society. We recommend that the Government work with other police forces with a dedicated County Lines Taskforce to pilot the inclusion of Prevention Officers within those teams, and the sharing of good practice.***

245 Q325; Q340.

246 Assistant Chief Constable, Charlie Doyle, British Transport Police (DRU0108), para.5.

247 The campaign is also coordinated by The Children's Society and the National County Lines Coordination Centre. Assistant Chief Constable, Charlie Doyle, British Transport Police (DRU0108).

5 Project ADDER

Overview

129. Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery) was launched in November 2020. It is a joint Home Office and Department of Health and Social Care pilot. It aims to reduce drug-related deaths, drug-related offending, and drug use, and to disrupt the supply and trafficking of drugs. It seeks to achieve these aims through coordinating law enforcement, expanding diversionary schemes and enhancing treatment and recovery—including housing and employment.[248] The pilot takes a local partnership approach with key partners including the police, local authorities and treatment providers. A Project ADDER Partnership Network provides locations with a forum to share knowledge and best practice.[249]

130. Five Project ADDER locations were established in January 2021.[250] A further eight local areas were added to the pilot in July 2021.[251] These areas were identified due to the levels of drug-related harms and deaths in those areas. The pilot is subject to monitoring and evaluation. The Combating Drugs Minister told us that Kantar Public have been commissioned to undertake an independent evaluation, which is due to report in later this year.[252]

131. The pilot was set to run until March 2023 and received an initial investment of £59 million. However, the strategy committed to extending the pilot until March 2025 and to providing further investment. In 2022/23, an additional £15.5 million was invested under the first tranche of funding under the Strategy.[253]

Experiences of Project ADDER pilot areas

132. We took evidence from stakeholders based in a number of Project ADDER locations. The Chief Constable of Merseyside, Serena Kennedy, told us about the experience of Project ADDER in her force area. She said it has had a positive impact on the broader community and encouraged a shift among officers towards supporting those identified with a chronic drug dependency into treatment and support. She said this has resulted in reduced demand for the police and other public services as people enter into recovery and become less reliant on such services.[254] Chief Constable Kennedy also said one-year funding cycles made it "really difficult" and that the three-year funding had helped partners to plan and recruit staff. However, she said there was a concern around what would happen when the funding ended and how locations could sustain delivery.[255]

248 Home Office and Department of Health and Social Care, About Project ADDER, 1 December 2021.
249 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, 6 December 2021.
250 Blackpool, Hastings, Middlesbrough, Norwich and Swansea Bay. HM Government, About Project ADDER, 1 December 2021.
251 Bristol, Newcastle, Wakefield, Tower Hamlets (London), Hackney (London), and Liverpool city region (Liverpool City, Knowsley, Wirral). HM Government, About Project ADDER, 1 December 2021.
252 Combating Drugs Minister (HUM0118).
253 Office for Health Improvement and Disparities, Additional drug and alcohol treatment funding allocations: 2022 to 2023, 13 April 2022.
254 Q211.
255 Q199.

133. South Wales Assistant Chief Constable, David Thorne, reflected on Project ADDER's operation in Swansea Bay. He said it had enabled his force to put an additional mental health worker within some of the diversionary treatment and enabled partners to identify gaps in service provision and plug those gaps.[256] He also noted the important role of the local Area Planning Board, which among other things, supports the dissemination of warnings on drug harms.[257] Maggie Boreham also told us about Project ADDER in Hackney, London. She said that it has helped create stronger pathways between criminal justice and community treatment, "so that people are essentially being signposted into community treatment".[258]

134. The Combating Drugs Minister told us that monitoring of Project ADDER's progress showed "positive early signs". Between January 2021 and September 2022, across all locations, it had (among other things) supported the disruption of almost 1,600 organised crime groups, over 20,500 arrests, over 12,500 out-of-court disposals, almost 2,500 safeguarding interventions by police and over 30,000 drug treatment interventions by outreach workers.[259]

Responses to Project ADDER

135. Project ADDER has received widespread support. The NPCC told us it has been well received by police forces and has had positive impact, for example, in terms of deferred prosecution schemes.[260] Of the senior officers we heard from, all supported the extension of Project ADDER across England and Wales.[261] The APCC was also "unequivocally and absolutely" in support of it.[262] The LGA has also welcomed it and Councillor Joanne Harding said she thought it was a "brilliant initiative".[263]

136. The Welsh Deputy Minister for Health and Wellbeing supported Project ADDER and told us that it fitted well with the approach being taken by the Welsh Government and Welsh policing partners.[264] Dame Carol also told us she was encouraged by it and said learnings from the pilot ought to be applied as the Strategy is rolled out:

> ADDER is doing exactly what I wanted to do in my report, with all the different players at local level—I have been impressed, in visiting the police and crime commissioners, by their interest in being part of the solution, rather than just being part of the criminal justice system, and their real interest in diversional systems and working with local authorities and the NHS. Therefore, ADDER is really interesting to me as a sort of prototype of what might happen.[265]

256 Q214.
257 Q212.
258 Q139.
259 The number of arrests related to drug trafficking, possession of drugs, possession of weapons, acquisitive crime, criminal damage/arson, violence and homicide. We were advised that as the data was collated using management information self-reported from Project ADDER locations, it may be subject to change. Additionally, the data is reflective of wider activity in each location and not solely related to Project ADDER activity. Combating Drugs Minister (HUM0118).
260 National Police Chiefs' Council (DRU0079).
261 Q215.
262 Q231.
263 Local Government Association (DRU0084).
264 Welsh Deputy Minister for Mental Health and Wellbeing, Lynne Neagle MS (DRU0124).
265 Q187.

137. The Chief Constable of Dyfed-Powys Police and NPCC Drugs Lead, Dr Richard Lewis, told us that the original Project ADDER areas had "significant success" in developing partnership-working among the agencies involved.[266] He also told us that it was having an effect on county lines by helping to tackle the problem "at source" before drugs can be trafficked to other parts of the country.[267]

138. However, some stakeholders in the drug treatment and recovery sector told us that Project ADDER was predominately a criminal justice initiative focused on reducing crime.[268] Transform consulted stakeholders involved in Project ADDER locations, It found that stakeholders supported a greater focus on public health over law enforcement. It also found that clearer guidance was needed on multi-agency working, trauma-informed training for police, and information sharing.[269] During our event with stakeholders from the drug treatment and recovery sector, some participants argued that Project ADDER is predominately a criminal justice initiative focused on reducing crime.[270]

139. **We found that the holistic, partnership approach adopted by the Project ADDER pilot has been largely well received. We conclude that Project ADDER demonstrates how effective joint responsibility for drug policy between the Home Office and the Department of Health and Social Care can be.**

140. ***As the Project ADDER pilot is set to continue until 2025, we recommend the Home Office provide us with an interim assessment of the pilot by January 2024. The Home Office must also provide us with an updated assessment of the pilot no more than three months after its conclusion in 2025.***

141. ***We recommend that Project ADDER be extended across all of England and Wales if the assessments indicate that the Project is effect in achieving all of its aims: reducing drug-related deaths, drug-related offending, drug use, and disrupting the supply and trafficking of drugs. If the Government does not extend Project ADDER beyond the pilot phase, we recommend that it must make clear how it will preserve the progress made in the existing 13 pilot locations beyond 2025.***

266 Q310.
267 Q307.
268 Engagement event with drug treatment and recovery sector (DRU0122).
269 Transform (DRU0106).
270 Engagement event with drug treatment and recovery sector (DRU0122).

6 Health-led harm reduction

142. In previous chapters we recommended that lead responsibility for drug policy be shared between the Home Office and the Department of Health and Social Care and that the Combating Drugs portfolio be held by a minister who sits in both departments. We believe that this approach will help to reduce the harms caused by drugs, and best support people in their recovery from drug dependency, whilst maintaining efforts to tackle the illicit production and supply of controlled drugs. In this chapter and the following chapter, we consider approaches that seek to reduce the harms associated with drugs in line with these recommendations.

Safe consumption facilities

143. Safe consumption facilities (SCFs) are facilities where people who use drugs can consume drugs they have obtained elsewhere in a sterile environment under medical supervision. The aim is to prevent drug-related overdose and other drug-related harms. There are SCFs operating in 16 countries worldwide.[271] The first SCF in Europe was established in Bern, Switzerland in 1986.[272] Since then, over 80 SCFs have opened in Europe.[273]

144. In 2016, a review of the evidence by the ACMD found that SCFs can reduce injecting risk behaviours and overdose fatalities; improve access to primary care and more intensive forms of drug treatment; and have been estimated to save more money than they cost due to reductions in deaths and HIV infections and other blood borne viruses. It also found that the effect of SCFs can be highly localised as regards reducing deaths and medical emergencies in the local area. The ACMD recommended the Government and devolved administrations consider SCFs in areas with a high concentration of injecting drug use.[274] In 2022, the Faculty of Public Health recommended piloting SCFs to reduce the number of opioid-related deaths in the UK.[275] During our inquiry SCFs received considerable support.[276]

145. However, under the Misuse of Drugs Act 1971, there is no legal pathway for SCFs to be established in the UK and the power to change this rests with the UK Government. In addition, others have been more cautious in expressing support or oppose them entirely. During our visit to Belfast, it was argued that for SCFs to be effective, they would need to provide wrap-around care and involve more than just clinicians; to be successful, a range

271 Harm reduction international, The global state of harm reduction 2022, October 2022.

272 European Monitoring Centre for Drugs and Drug Addiction, Spotlight on… drug consumption rooms, February 2022.

273 European Monitoring Centre for Drugs and Drug Addiction, Infographic. Location and number of drug consumption facilities throughout Europe, June 2023.

274 ACMD, Reducing opioid-related deaths in the UK, December 2016.

275 Faculty of Public Health, A call to pilot overdose prevention centres (supervised injecting facilities) in the UK, January 2022.

276 Ben Corken, Change, Grow, Live (DRU0009); Professor Alex Stevens, University of Kent (DRU0014); Dr Felipe Neis Araujo, University of Manchester (DRU0019); Bristol Drugs Project (DRU0022); Royal Pharmaceutical Society (DRU0035); Peter Reynolds (DRU0050); Law Enforcement Action Partnership UK (DRU0052); Drug Science (DRU0056); The Hepatitis C Trust (DRU0065); Cranstoun (DRU0067); APPG for Drug Policy Reform (DRU0070); Conservative Drug Policy Reform Group (DRU0071); Volteface (DRU0073); Release (DRU0075); Criminal Justice Alliance (DRU0090); Policing in Wales (DRU0091); APPG for Drugs, Alcohol and Justice (DRU0093); National AIDS Trust (DRU0094); Health Poverty Action (DRU0095); The Faculty of Public Health and The Association of Directors of Public Health (DRU0096); Scottish Government (DRU0100).

of professionals who can provide that wrap-around care would be required.[277] David Sidwick, Police and Crime Commissioner for Dorset, argued SCFs would need to have a benefit not just for the individuals but also for the community in which the facility was based and wider society.[278] David Raynes, former Assistant Chief Investigation Officer for HM Customs and Excise, argued they would not deal with polydrug use.[279] This may be because most SCFs target people who inject drugs, though facilities increasingly seek to include people who smoke or inhale drugs.[280]

Safe consumption facility pilot in Glasgow

146. Scotland has the highest drug misuse death rate of any UK nation.[281] Since 2017, the area of Greater Glasgow and Clyde had the highest drug misuse death rate in Scotland at 33.7 per 100,000 population.[282] During our visit to Glasgow in November 2022, the overwhelming majority of stakeholders we spoke to supported piloting an SCF in the city.[283] Professor Dame Carol Black told us that she would also be in favour of a "well-designed" pilot in an area of high-density drug-taking, such as Glasgow. She said that doing so would help to establish a UK evidence-base and determine whether SCFs would be effective in terms of preserving life and value for money.[284]

147. In 2019, the Scottish Affairs Committee recommended that the UK Government support a pilot in Scotland and that, if it was unwilling to do so, devolve the power to establish the pilot to the Scottish Government.[285] In response, the UK Government acknowledged that it has the power to establish a SCF by way of regulations but expressed concern that doing so could give rise to risks under the common law and civil liability. It said that providing for it under primary legislation would "take a great deal of time to develop and implement".[286]

148. The Scottish Government told us that it has made repeated requests to the Government to establish a pilot in Glasgow but that these requests have been rejected.[287] The Combating Drugs Minister repeated the above concerns to us stating that "facilitating drug consumption outside of a treatment programme is legally problematic, and [the Government] would prefer to concentrate [its] efforts on treating drug addiction". However, the Minister said any further proposals put forward by the Scottish Government would be considered "in a constructive and collegiate way".[288]

277 Visit to Glasgow and Belfast (DRU0119).
278 David Sidwick, Police and Crime Commissioner for Dorset (DRU0110).
279 David Raynes, former Assistant Chief Investigation Officer for HM Customs and Excise (DRU0043).
280 European Monitoring Centre for Drugs and Drug Addiction, Drug consumption rooms: An overview of provision and evidence, June 2018.
281 See Appendix 1.
282 National Records of Scotland, Drug-related deaths in Scotland in 2021, 28 July 2022.
283 Visit to Glasgow and Belfast (DRU0119).
284 Q170–172.
285 Scottish Affairs Committee, Problem drug use in Scotland, First report of Session 2019, HC 44.
286 Scottish Affairs Committee, Problem drug use in Scotland: Government response to the Committee's first report of the Session 2019, First special report of Session 2019–21, HC 698, p.8.
287 Scottish Government (DRU0100).
288 Q386.

149. **An evidence base for a safe consumption facility in the UK is needed.** ***We recommend that the Government support the piloting of safe consumption facilities in areas across the UK where there is deemed to be a need by local government and stakeholders.***

150. ***In particular, we recommend the Government support a pilot in Glasgow by creating a legislative pathway under the Misuse of Drugs Act 1971 that enables such a facility to operate legally. The pilot in Glasgow must be jointly funded by the Government and the Scottish Government. The Government must work with the Scottish Government and local partners to establish and operate the pilot. The pilot must be evaluated in order to establish a reliable evidence base on the utility of a safe consumption facility in the UK. We repeat the recommendation made by the Scottish Affairs Committee in 2019 that, if the UK Government is unwilling to support this, the power to establish a pilot be devolved to the Scottish Government.***

Drug checking

151. Drug checking services provide an analysis of the content and strength of a substance. The checking of drugs that have been seized is referred to as 'back-of-house' drug checking. The checking of drugs that have been voluntarily submitted is referred to as 'front-of-house' drug checking. Drug checking services can be at fixed or mobile locations, such as on-site at music festivals. In every case, samples are not returned. The primary aim of drug checking is to reduce drug-related harms. This is done through the provision of healthcare advice from medical professionals to the individuals who have submitted samples and/or via the dissemination of health warnings to the wider public—for example, to festival-goers. Countries, such as, the United States, Switzerland, Spain, Portugal, New Zealand, the Netherlands, Italy, Germany, Canada, Austria and Australia have established drug checking services.

Drug checking in the UK

152. A Home Office licence is required to undertake drug checking-related activities—such as the possession a controlled drug for the purposes of analysing the drug—otherwise offences under the Misuse of Drugs Act 1971 may arise. Examples of drug checking in the UK include the Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS) and The Loop.

153. WEDINOS is funded by the Welsh Government and provides a free, anonymous testing service of psychoactive substances and combinations of drugs. In addition to submitting drug samples, people may anonymously submit information on symptoms experienced from consuming drugs. WEDINOS disseminates harm reduction advice on the basis of the information collected (although it does not provide tailored harm reduction advice for individuals).[289]

154. In 2022, The Loop was granted a Home Office licence to provide a monthly pop-up drug checking service within the Bristol Drug Project. The service is funded by Bristol City Council. The Loop is working to establish other drug checking services in other UK

289 WEDINOS, Annual Report 2021–22.

locations.[290] Separately to this, The Loop has been drug checking at UK venues and music festivals using back-of-house testing since 2016. In that time, it has delivered healthcare consultations to more than 10,000 people.[291]

Drug checking at music festivals

155. In June, it was reported that drug checking at a number of music festivals, such as Parklife in Manchester and Secret Garden Party in Cambridgeshire, would not proceed. It was later reported that drug checking at other festivals including Glastonbury, Leeds and Reading would, however, go ahead.[292]

156. Founder of Parklife, Sasha Lord, argued that without the provision of drug checking, the risk of drug-related harms or overdose at festivals could increase.[293] Back-of-house testing has been operating at festivals for a number of years through memorandums of understanding between local stakeholders, including the police and local authorities. On 23 June, Sam Tarry MP sent a letter to the Home Secretary urging drug checking through the consent of local stakeholders to be reinstated. The letter was signed by 30 other MPs and musicians.[294]

157. In a judicial review claim letter issued on 30 June on behalf of Sasha Lord, and the Night Time Industries Association (NTIA) it was claimed that on 8 June (48 hours prior to the start of Parklife) the Home Office had informed The Loop that a Home Office licence specific to a named, permanent premises was required, and that on-site testing would fall outside of such a licence. The claim has argued that the time it takes to obtain a licence and the requirement to transport drugs to a permanent facility would undermine the effectiveness of drug checking at festivals.[295]

158. On 29 June, the Leader of the House of Commons, Penny Mordaunt, said:

> [The Government's] position on this issue has not changed: drug testing providers must have a licence to test for controlled drugs, including at festivals. We have always had that condition in place and we have made that clear, and law enforcement has always had a responsibility to uphold that legal requirement. We have not received any applications for drug testing at major festivals this summer, and we continue to keep an open dialogue with any potential applicants.[296]

159. With the launch of judicial review proceedings, the situation is fluid and fast-moving. We will continue to monitor the situation as it develops.

Responses to drug checking

160. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has said that the evidence on the impact of drug checking services on risk behaviours (i.e.,

290 The Loop, Drug Checking Services Briefing Document.
291 The Loop, Drug Checking Services Briefing Document.
292 BBC News, Glastonbury, Leeds and Reading will have drug safety testing, 22 June 2023.
293 BBC News, UK festivals: What's going on with drug testing in 2023?, 22 June 2023.
294 Twitter, Sam Barry MP, 23 June 2023.
295 Night Time Industries Association, NTIA and Sasha Lord instruct legal team to challenge the Government on drug testing at festivals, 3 July 2023.
296 HC Deb, 29 June 2023, col.431 [Commons Chamber].

behaviour that may expose a person to harm) is limited.[297] In addition, the Combating Drugs Minister, Chris Philp MP, has said that "illicit drugs are harmful and there is no safe way to take them" and that drug checking services could therefore give a "false impression that illicit drugs may be safe" or could "condone drug use, which would be counterproductive to [the Government's] aim of reducing illicit drug use".[298] However, drug checking services, like the Dutch Drugs Information and Monitoring System and The Loop, communicate the risks of drugs with people submitting samples and do not encourage drug use.[299] In addition, research conducted by The Loop on its drug checking services found that drug checking reduced drug use and poly-drug use where the results on the content of the drug were not what the person expected.[300] For example, if the drug was mixed with other substances.

161. Support for drug checking services has increased in recent years among parliamentarians. In 2019, the Health and Social Care Committee recommended services be established at festivals and in night-time economies.[301] In 2021, the Digital, Culture, Media and Sport Committee recommended that a dedicated drug checking licensing scheme be established.[302] Both the Welsh Deputy Minister for Health and Wellbeing, Lynne Neagle MS, and the then Scottish Minister for Drug Policy, Angela Constance MSP, have expressed support for drug checking as a way to reduce drug-related harms.[303] Angela Constance told us that drug checking services "are imperative", particularly in tackling a growing benzodiazepine problem in Scotland.[304] Research and preparation is ongoing to establish drug checking services in Glasgow, Aberdeen and Dundee.[305] We have also received several submissions supporting the expansion of drug checking services.[306] The Criminal Justice Alliance suggested that a dedicated licensing scheme for drug checking services be established because the current licensing scheme can be expensive and bureaucratic.[307]

162. ***We recommend that the Home Office and Department of Health and Social Care jointly establish a national drug checking service in England to enable people to submit drug samples by post anonymously. We recommend the Home Office consult stakeholders on how best to implement the service. In particular, we recommend that it learn lessons from the Welsh Government and Welsh partners on the experience of WEDINOS. We believe that, ultimately, a UK-wide drug checking service would provide the most effective approach, and we therefore encourage the UK Government and devolved Governments to consider jointly establishing such a service.***

297 EMCDDA, Spotlight on… Drug Checking, 31 March 2022.
298 Home Office (HUM0118), p.2.
299 Trimbos Instituut, Drugs Information Monitoring System: Fact sheet on drug checking in the Netherlands, 2019; The Loop, Our history.
300 Polydrug use means the consumption of more than one drug at the same time or sequentially. The Loop, Drug Checking Services Briefing Document; EMCDDA, Polydrug use: health and social responses, 22 October 2021.
301 Health and Social Care Committee, First Report of Session 2019, Drugs Policy, HC 143, para.37.
302 Digital, Culture, Media and Sport Committee, First Report of Session 2021–22, The future of UK music festivals, HC 49.
303 Welsh Deputy Minister for Mental Health and Wellbeing, Lynne Neagle MS (DRU0124); Scottish Government (DRU0100).
304 Q348.
305 Drugs Deaths Taskforce, Researching and developing key components of a new Scottish drug checking programme, 31 August 2022.
306 Peter Reynolds (DRU0050); APPG for Drug Policy Reform (DRU0070); Volteface (DRU0073); Criminal Justice Alliance (DRU0090); Faculty of Public Health and Association of Directors of Public Health (DRU0096).
307 Criminal Justice Alliance (DRU0090).

163. ***We recommend the expansion of on-site drug checking services at temporary events such as music festivals and within the night-time economy. We recommend that the Home Office establish a dedicated licensing scheme for drug checking at such events before the start of the summer 2024 festival season. The scheme must devolve the power to grant licences to local authorities.***

Opioid substitution treatment

164. Opioid substitution treatment (OST) (also called opioid agonist treatment or medication-assisted treatment) seeks to treat opioid dependency, particularly heroin dependency, through the prescription of a replacement opioid, such as methadone or buprenorphine. OST can be beneficial in retaining people in treatment, reducing the risk of overdose and suicide, reducing the risk of transmitting blood-borne viruses, in addition to improving a person's quality of life.[308] OST could also help reduce the risk of mortality by approximately 50%.[309]

165. The use of OST in the UK has expanded considerably since the mid-1990s,[310] but some have argued that the availability of the treatment needs to be further increased.[311] The National Aids Trust has also expressed concern that funding for drug treatment can be made conditional on rates of treatment exit, which can result in OST being provided for a defined time. The Trust argued that this may progress patients through treatment too quickly and result in a patient's wider needs not being taken into account.[312] Both the Faculty of Public Health and Association of Directors of Public Health have said that the welcome increase in funding for drug treatment services under the 10-Year Drugs Strategy is necessary to increase the availability of OST and the retention of patients in treatment in England.[313]

166. OST tends to be supported with psychosocial treatment, such as talking therapies. Indeed, this is outlined as a core element of OST in Government guidance to keyworkers.[314] However, Changing Lives told us that, among the aging cohort in long-term treatment, they had seen instances of patients continuing to use illicit drugs in addition to their prescription. Changing Lives said this was not necessarily because the prescription was inadequate but because drug-taking behaviour had not been appropriately challenged as the capacity to offer psychosocial interventions had reduced in recent years. Changing Lives said that capacity to offer effective psychosocial interventions needed to improve and be used alongside OST in order to address a person's drug-taking behaviour in addition to their drug dependency.[315] It is therefore welcome that the 10-Year Drug Strategy recognises the importance of mental health support in enabling a successful outcome from treatment and commits to improving mental health support.[316]

308 Giovanna Campello, Professor Mathew Hickman and Dr Jane Philpott (DRU0123); EMCDDA, Opioid Substitution Treatment (OST) to Reduce Mortality: Summary of the Evidence; ACMD, Reducing Opioid-Related Deaths in the UK, December 2016.

309 Giovanna Campello, Professor Mathew Hickman and Dr Jane Philpott (DRU0123).

310 ACMD, Reducing opioid-related deaths in the UK, 2016, 5.4.4.

311 The Hepatitis C Trust (DRU0065); National Aids Trust (DRU0094); Faculty of Public Health and Association of Directors of Public Health (DRU0096).

312 National Aids Trust (DRU0094).

313 Faculty of Public Health and Association of Directors of Public Health (DRU0096).

314 Public Health England, Part 1: Introducing opioid substitution treatment, 21 July 2021.

315 Changing Lives (DRU0082).

316 Home Office, From Hope to Harm: A 10-Year Drugs Plan to Cut Crime and Save Lives, 21 December 2021.

167. ***We recommend that the Government work with local authorities and health partners to ensure that people receive appropriate psychosocial support in addition to their opioid substitution treatment and ensure that they can continue to access opioid substitution treatment at a pace that meets their needs.***

Provision of longer prescriptions

168. Provision of daily prescriptions may not be the most effective method of maintaining patients in treatment, and responses during the Covid-19 lockdowns indicate that the provision of longer prescriptions may help to increase patient trust and engagement in treatment. The National Aids Trust, for example, told us that the provision of at-home methadone prescriptions that lasted for multiple days in England helped to increase patient trust and engagement in their own treatment.[317] In addition, the Welsh Government told us that the roll-out of the long-term injectable buprenorphine treatment, Buvidal, during the Covid-19 pandemic produced positive results with 80% of people retained in treatment.[318] The 10-Year Drugs Strategy has committed to exploring the rollout of buprenorphine.[319]

169. **We welcome the 10-Year Drug Strategy's recognition of the potential positive impact of long-acting buprenorphine. We think that the use of Buvidal in Wales has provided a very encouraging UK evidence base and proved that it is an effective form of opioid substitution treatment.** ***We recommend that the Government go further than its commitment under the 10-Year Drugs Strategy to explore the rollout of long-acting buprenorphine and commit to establishing it as a first-line treatment option in England for people with an opioid dependence.***

Scottish MAT standards

170. Following a recommendation by the Drug Deaths Taskforce, the Scottish Government adopted 10 standards of care for OST, which is also referred to as medication-assisted treatment ('the MAT standards'). The Scottish Government has said that the MAT standards "define what is needed for the consistent delivery of safe and accessible drug treatment and support in Scotland".[320] They apply to all services and organisations involved in drug treatment and recovery. There are 10 MAT standards, the purpose of which is to improve access to, and retention of patients in, treatment. For example, the standards state that people must be able to start receiving support on the day they ask for it and be able to make informed choices about the type of treatment they receive.[321]

171. ***We recommend that the Government replicate Scotland's medication-assisted treatment standards in England to ensure that a consistent, minimum standard of care is available to people accessing opioid substitution treatment. In doing so, the Government must first consult stakeholders in the medical and drug treatment and recovery sectors on adapting opioid substitution treatment standards in a manner appropriate to England.***

317 National Aids Trust (DRU0094).
318 Welsh Deputy Minister for Mental Health and Wellbeing, Lynne Neagle MS (DRU0124).
319 Home Office, From Hope to Harm: A 10-Year Drugs Plan to Cut Crime and Save Lives, 21 December 2021.
320 Scottish Government (DRU0100), para.37.
321 Scottish Government, Medication Assisted Treatment (MAT) standards: access, choice, support, 31 May 2021.

Diamorphine assisted treatment

172. Diamorphine assisted treatment (DAT) is a form of OST that involves provision of medical-grade heroin—usually diamorphine but also diacetylmorphine—to help reduce the harms caused by opioid dependency. The treatment is self-administered by the patient, usually once or twice a day and under medical supervision.

Prescription diamorphine

173. An early form of DAT was maintenance prescribing, which emerged in the 19th century. This treatment prescribed heroin on a long-term, take-home basis to provide people dependent on the drug with a stable and safe supply. The approach was known as 'the British System'. Though the use of this treatment largely receded in the mid-late 1960s, around 200 people continue to be treated by way of prescription diamorphine today.[322]

174. UK Government guidance to clinicians has made it clear that "the quality of care for these patients should be reviewed regularly and, where there is clear evidence of benefit, treatment [by way of prescribed diamorphine] should continue and be improved".[323] However, in January and March 2022, supply chain problems were reported in England limiting the availability of prescribed diamorphine.[324] The problems were reportedly due to the two main suppliers of diamorphine in England experiencing stocking issues.[325] Similar supply chain problems were also reported in Northern Ireland. Niamh Eastwood, the Executive Director of Release, told us that one of her clients—a care worker whose prescription diamorphine had run out—relapsed for the first time in 15 years.[326]

175. ***We are concerned by reported shortages of prescribed diamorphine, particularly because of the serious impact they may have on the health and lives of patients. As prescribed diamorphine is a viable form of treatment in England, the Government must work with suppliers to ensure that a sustainable supply is available to patients whom clinicians deem suitable for it.***

Supervised diamorphine assisted treatment

176. In 2010, the Randomised Injectable Opiate Treatment Trial (RIOTT)—which piloted three NHS DAT clinics in London, Brighton and Darlington—found that DAT led to "significantly lower use of street heroin than does supervised injectable methadone or optimised oral methadone".[327] RIOTT also concluded that DAT was more cost-effective than methadone treatment for people with opioid use disorder and that it should be rolled out as a form of treatment for people for whom OST has not been effective. It was noted that central Government funding would be necessary.[328] In 2016, the ACMD specifically

322 BBC News, Drug workers warn heroin treatment shortage will cost lives, 11 June 2022.
323 Public Health England, Injectable opioid treatment: commissioning and developing a service, 19 March 2021.
324 Pharmaceutical Service Negotiating Committee, Medicine Supply Notification: Diamorphine 100mg and 500mg powder for solution for injection ampoules, 17 March 2022; Medicine Supply Notification: Diamorphine 5mg and 10mg powder for solution for injection ampoules – Updated, 10 January 2022.
325 The Conversation, Diamorphine shortage could be more than just a problem for drug users, 23 June 2022.
326 Q27.
327 The clinics closed after central funding in England ended in 2015 and was not replaced at a local level.
328 Prof. John Strang et al., Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial, The Lancet, 2010.

recommended that "central government funding should be provided to support [diamorphine] assisted treatment for patients for whom other forms of OST have not been effective".[329]

177. Extending the use of DAT has received support during our inquiry, particularly in light of the increasing rate of deaths in the UK related to opioids.[330] Across each of the four nations, opioids are consistently the most commonly reported substances in drug misuse deaths.[331] DAT programmes were established in Middlesbrough and Glasgow in September and December 2019 respectively in response to the increasing problem with opioids and opioid-related deaths in those areas.

178. The facility in Glasgow–referred to as an Enhanced Drug Treatment Centre–is operated by Glasgow City Health and Social Care Partnership. The Centre is being evaluated by the Scottish Government Chief Scientist Office and Glasgow Caledonian University. The findings of this evaluation are yet to be published but the Scottish Government has said the findings will inform the work of the Centre going forward. The Scottish Government has said it is committed to additional DAT services in other locations and that the evaluation will help to inform this work.[332]

Visit to Middlesbrough

179. On 8 September 2022, we visited Middlesbrough to observe the DAT programme run by Foundations Medical Practice. During our visit, we spoke to some of the patients on the programme. We sincerely thank them for meeting with us and for sharing their experiences with us, which we understand may have been difficult for them to do.

180. The clinical lead of the DAT programme, Daniel Ahmed, told us that it cost approximately £300,000 per year to operate the programme twice a day, 365 days a year. The cost included the price of medication and staffing costs. He also told us about the difficulties in sourcing the medication; public health guidance recommends the use of single-use ampules (instead of multi-dose vials), which are more expensive and have a more fragile supply chain.[333] Given these issues, he argued that the guidance ought to be reviewed to allow the use of multi-dose vials.[334]

181. We were impressed by the DAT programme at Foundations, particularly with its provision of wrap-around psychosocial services for the patients. However, the programme struggled to maintain sustainable funding. In 2021, the Cleveland Police and Crime Commissioner, Steve Turner, withdrew funding for the programme on the basis that he

329 ACMD, Reducing opioid-related deaths in the UK, 2016, 5.4.18.

330 Professor Alex Steven, University of Kent (DRU0014); The Hepatitis C Trust (DRU0065); Cranstoun (DRU0067); Anonymised (DRU0069); The Conservative Drug Policy Reform Group (DRU0071); Volteface (DRU0073); Criminal Justice Alliance (DRU0090); Policing in Wales (DRU0091); APPG for Drugs, Alcohol and Justice (DRU0093); The Faculty of Public Health and The Association of Directors of Public Health (DRU0096); North Yorkshire Police and Crime Commissioner (DRU0099); Scottish Government (DRU0100).

331 See Appendix 1.

332 Scottish Government, National mission on drugs: Annual report 2021 to 2022, 21 November 2022.

333 A single-use ampule is a container (usually glass) that contains a single, measured amount of medicine for a single patient. A multi-dose vial contains more than one dose of a medication and may be used for more than one patient; however, they can increase the risk of contamination for this reason. Public Health England, Injectable opioid treatment: operating procedures, 19 March 2021.

334 Visit to Middlesbrough (DRU0120).

questioned the impact that it had on reducing crime in the area.[335] A second tranche of funding was subsequently secured through Project ADDER and through contributions from South Tees Public Health, and legacy funding from Durham Tees Valley Community Rehabilitation Company. This tranche secured funding until March 2022, which was welcomed by PCC Turner.[336] Project ADDER provided an additional package of funding for the March 2022–23 funding cycle. However, the funding was only enough to support the programme until the end of September 2022. Shortly after our visit, the programme closed due to a lack of funding. Patients were informed and transitioned on to other forms of treatment.

182. We are deeply disappointed with this outcome and conscious of the distressing effect this outcome had on the patients. Foundations staff have since informally told us that none of the patients have gone on to have a positive experience since the programme's closure. We were told that DAT was the lynchpin to enabling the patients to stabilise and that the offer of alternative forms of OST by the local authority has not been enough to maintain this stability. We were told that some patients have disengaged from treatment, some have returned to using drugs on a daily basis and some have returned to using street heroin. We were also told that the local authority's offer of psychosocial services has received low engagement. We are dismayed to learn that the substantial positive change the programme made to the lives of patients, their families and future prospects has been undermined.

183. We wrote to both Public Health, Middlesbrough—which oversees the local Project ADDER—and the Combating Drugs Minister, Chris Philp MP, on the programme's closure.[337] We recommended that centralised funding for the programme be provided. We again raised the matter with the Minister on 22 February 2023. The Minister and the Home Office have rejected these calls and said that such funding decisions are a matter for local authorities.[338] Mr Philp told us that he would instead consider the effectiveness of DAT.[339] Yet, as evidenced by RIOTT and the ACMD, there is an established evidence base on the effectiveness of DAT. The Home Office told us that "evidence based, high-quality treatment is the most effective way of tackling illicit and other harmful drug use".[340]

184. **We support the use of DAT supported by wrap-around psychosocial support. The impressive Middlesbrough DAT programme that we witnessed held benefits for both the public health and criminal justice sectors. We are most disappointed that joint local funding from both the health and criminal justice sectors could not be secured for the programme. That said, we recognise the cost of the programme and the difficult decisions that need to be made by local stakeholders when allocating funds to services. Given the rate of opioid-related deaths in England, it is not further consideration that is required from central government, it is swift action.**

335 The Northern Echo, Police and Crime Commissioner to end funding for heroin addiction treatment scheme, 16 May 2021.

336 PCC for Cleveland, Immediate future of Heroin-Assisted Treatment (HAT) programme secured.

337 Letter to Project ADDER on closure of Middlesbrough diamorphine assisted treatment programme, dated 27 October 2022; Letter to the Minister for Policing and Crime on closure of Middlesbrough diamorphine assisted treatment programme, dated 27 October 2022.

338 Letter from Minister for Crime, Policing and Fire on the Middlesbrough DAT programme, dated 11 November 2022; Q385.

339 Q399.

340 Home Office (DRU0080).

185. ***We repeat the ACMD's 2016 recommendation that the Government provide centralised funding to support the provision of DAT for people with a chronic heroin dependency for whom other forms of OST have not been successful. The centralised funding should first be provided to Foundations Medical Practice in order to re-establish its DAT programme in Middlesbrough as a matter of urgency. The Government should then work with local authorities to identify other locations in England where a DAT programme supported by holistic and wrap-around care is needed.***

186. ***We recommend that public health guidance on the provision of diamorphine be changed to allow for the use of multi-dose vials instead of single-use ampoules to mitigate the additional cost and supply chain pressures associated with single-use ampoules.***

Needle and syringe programmes

187. People who inject drugs are at a higher risk of experiencing "substantially worse health outcomes" than the general population.[341] This can include overdose, bacterial infections and blood borne viral infections, such as HIV, Hepatitis B and C. Needle and syringe programmes seek to reduce the transmission of these illnesses by providing sterile injecting equipment and limiting the sharing of (potentially contaminated) injecting equipment. Programmes are allowed to distribute needles and syringes to people who inject drugs.[342] They can also distribute other equipment such as swabs, filters, sterile water, utensils for the preparation of a controlled drug (such as spoons), and following a recommendation by the ACMD, foil.[343]

188. Needles and syringe programmes can also provide additional harm reduction interventions, including blood borne virus testing, vaccination and treatment services and advice on safer injecting practices. For example, Turning Point Scotland told us that, in providing this service, it can advise people of the dangers of injecting in high-risk areas, such as the groin. Injecting this area can carry a greater risk of Deep Vein Thrombosis and ulceration, as well as paralysis or severe bleeding if the injection were to hit a nerve or critical vein. To help mitigate these life-threatening risks, Turning Point uses techniques like Accuvein to help people find less life-threatening injection sites.[344]

189. We have been told that the UK was a pioneer of needle and syringe programmes in 1980s and 1990s.[345] However, concerns have been raised about the provision of these programmes in recent years.[346] The National Aids Trust has said there is problematic coverage, that standards vary greatly across the country, and that there is a concern that National Institute for Health and Care Excellence (NICE) guidelines are not being followed effectively.[347] The UK Health Security Agency (UKHSA) has said that a third of people who inject drugs reported inadequate provision of needles and syringes.[348] In

341 UK Health Security Agency, Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, data to end of 2021, 22 March 2023, foreword.
342 Section 9A.
343 The Misuse of Drugs Regulations 2001, regulation 6A; HC Deb, 4 July 2013, col 67WS [Commons written ministerial statement] The statement provides that the provision of foil "is subject to the strict condition that it is part of structured efforts to get people into treatment and off drugs".
344 Visit to Glasgow and Belfast (DRU0119).
345 Dr Felipe Neis Araujo, University of Manchester (DRU0019).
346 The Hepatitis C Trust (DRU0065); National Aids Trust (DRU0094).
347 National Aids Trust (DRU0094).
348 UK Health Security Agency, Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, data to end of 2021, 22 March 2023.

particular, we have heard that the provision of low dead space syringes is inadequate. This type of syringe can be helpful in reducing the risk of blood-borne virus transmission by reducing the amount of blood that remains in the syringe after it has been used. However, The Hepatitis C Trust has told us that only 58% of needle and syringe programmes provide this type of equipment.[349] The UKHSA and its predecessor, Public Health England, have recommended greater provision of low dead space syringes.[350]

190. The UKHSA has also said that there is evidence to suggest an increase in risk behaviour, such as sharing injecting equipment, among people who inject drugs during the Covid-19 pandemic.[351] Indeed, we have been told that the Covid-19 pandemic has had a concerning impact on needle and syringe programmes as the lockdowns restricted access to these services.[352] In addition, The Hepatitis C Trust has said that the issue of people using unsafe water sources to prepare injections became more problematic during the Covid-19 pandemic due to the closure of public toilets.[353] The UKHSA has recognised that the Covid-19 pandemic had a significant impact on people who inject drugs and the services they use. The UKHSA has said that this has likely widened existing health inequalities for those people, though the full impact of this will take time to emerge and evaluate.[354]

191. We have been told that needle and syringe programmes should be scaled up to reduce the transmission of blood-borne viruses.[355] In relation to England, though the 10-Year Drugs Strategy's commitment to needle and syringe programmes has been welcomed, some organisations have suggested that it provides only a "vague" commitment to expanding these programmes, and that it needs to go further by supporting the programmes with other harm reduction measures like more blood borne virus testing, OST, DAT and safe consumption rooms.[356] Indeed, the UKHSA has said that a range of "easily accessible harm reduction services" need to be provided for all people who inject drugs, including needle and syringe programmes and OST.[357]

192. **We are concerned by the effect the Covid-19 pandemic has had on the provision of needle and syringe programmes. The UK must continue its efforts in preventing the spread of blood-borne viruses by ensuring needle and syringe programmes reach as wide a population as possible.**

193. ***The Combating Drugs Minister must work with the Department of Health and Social Care, the devolved administrations, and health partners to ensure that the provision of equipment—particularly low dead space syringes and safe water—is increased to reduce the transmission of blood-borne viruses and other illnesses. The Combating***

349 The Hepatitis C Trust (DRU0065).
350 UK Health Security Agency, Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, data to end of 2021, 22 March 2023; Public Health England, Hepatitis C in England 2020, Working to eliminate hepatitis C as a major public health threat, May 2020.
351 UK Health Security Agency, Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, data to end of 2021, 22 March 2023.
352 The Hepatitis C Trust (DRU0065); National Aids Trust (DRU0094).
353 The Hepatitis C Trust (DRU0065).
354 UK Health Security Agency, Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, data to end of 2021, 22 March 2023.
355 Engagement event with drug treatment and recovery sector (DRU0122).
356 The Hepatitis C Trust (DRU0065); National Aids Trust (DRU0094).
357 UK Health Security Agency, Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, data to end of 2021, 22 March 2023, Injecting risk behaviours.

Drugs Minister must work to ensure that needle and syringe programme providers have the capability and capacity to provide additional services to people presenting to the service, such as blood-borne virus testing.

Naloxone

194. Naloxone can be used to counter the effects of overdose, particularly breathing difficulties, caused by opioids. It can be administered via a nasal spray or by injection. If used immediately, naloxone can quickly reverse an overdose. It can also be used by anyone to save a life in an emergency. However, it is a prescription-only medicine meaning that only commissioned drug treatment services can supply it without a prescription or Patient Group Direction.[358]

195. Since 2015 drug services have been able to supply naloxone without a prescription.[359] Provision was later expanded in 2019 to enable drug services to supply nasal naloxone.[360] In 2022, the ACMD said that naloxone provision should be expanded to include community pharmacies, peers, the police, and the supply of take-home naloxone (THN) to prison leavers.[361]

196. We have heard about the limitations regarding access to naloxone under the current system, and how this ought to be eased. For example, Changing Lives told us that the current provision of naloxone is too bureaucratic, and provision can vary "massively" between areas. It said that increased funding for local services would increase capacity and suggested that disparities in the provision of naloxone could be reduced by provision being coordinated at national level.[362]

197. The UK Government and devolved administrations have recognised that the availability of naloxone could be further expanded. In 2021, they jointly consulted on expanding access through THN.[363] The majority of respondents to the consultation supported enabling people and services to supply naloxone and THN without prescription, with many believing that this would help to reduce overdose and drug-related deaths.[364] The consultation was noted in the 10-Year Drugs Strategy, which has committed to expanding the provision of naloxone. This commitment has been welcomed by many.[365] However, at the time of writing, outcomes from the consultation were yet to be announced and, with the exception of staff in prisons and approved premises, the 10-Year Drugs Strategy does not provide further detail on how the provision of naloxone will be expanded.

358 A Patient Group Direction allows some registered health professionals to supply and/or administer specified medicines to a group of patients without a prescription.

359 This actioned recommendations made by the ACMD in 2012. ACMD, Consideration of naloxone, May 2012; The Human Medicines (Amendment) (No.3) Regulations 2012.

360 The Human Medicines (Amendment) Regulations 2019.

361 ACMD, Review of the UK naloxone implementation: Availability and use of naloxone to prevent opioid-related deaths, June 2022.

362 Changing Lives (DRU0082), para.5.1–5.2.

363 Department of Health and Social Care, Expanding access to naloxone, 15 March 2022.

364 Department of Health and Social Care, Expanding access to naloxone, 15 March 2022.

365 The Company Chemists' Association (DRU0025); The Hepatitis C Trust (DRU0065); Association of Police and Crime Commissioners (DRU0078).

Take-home naloxone

198. THN involves training people—including people at risk of overdose, their family and friends, and service workers—to administer naloxone. THN is an established harm reduction response in the UK with funded national programmes operating in Wales, Scotland and Northern Ireland since 2009, 2011 and 2012 respectively.[366] England is the only UK country not to have a nationally funded naloxone programme; provision in England is funded by local authority commissioning.[367]

199. In response to the Covid-19 pandemic, Wales and Scotland expanded THN provision by enabling kits to be delivered to people unable to attend services. In Scotland, this development followed a statement of prosecution policy by the Lord Advocate on 27 April 2020 that it was not in the public interest to prosecute non-drug treatment services for supplying THN, thereby expanding access to THN by enabling such services to supply it.[368] The Scottish Government has requested that the UK Government make this change permanent as part of efforts to expand THN provision following the UK-wide 2021 consultation to widen access to naloxone.[369]

Community pharmacies

200. As noted above, pharmacies in Scotland are able to distribute naloxone kits as non-prescribed medication following a decision by the Lord Advocate. However, in England, Wales and Northern Ireland we have heard that access to naloxone in community pharmacies is varied and limited. However, in relation to a Patient Group Direction, provision is not a pre-requisite and may depend on local arrangements. The Company Chemists' Association and The Royal Pharmaceutical Society argue that community pharmacies are well-placed to engage with people who use drugs because they can offer a flexible and informal setting in which to provide services.[370] Both organisations argue that with appropriate safeguards, training and funding, the power to distribute naloxone should be expanded to community pharmacies.[371] The Royal Pharmaceutical Society also argues that naloxone should be supplied in first aid boxes in clinical settings with staff in those settings trained to use it.[372]

Peer-to-peer programmes

201. Peers—people with lived experience of using drugs—play a "vital" role in engaging people who use drugs in treatment and recovery services, and in supporting their long-term recovery.[373] Under peer-to-peer programmes, peers proactively distribute naloxone

366 Welsh Government (DRU0081); Public Health Scotland, National Naloxone Programme Scotland, 19 October 2022; Northern Ireland Public Health Agency, Take Home Naloxone Reports, 12 April 2022.
367 ACMD, Review of the UK naloxone implementation: Availability and use of naloxone to prevent opioid-related deaths, June 2022.
368 Crown Office and Procurator Fiscal Service, Lord Advocate's guidelines in relation to the supply of naloxone during the COVID-19/Coronavirus pandemic, 11 January 2022.
369 Power to amend the rules on the regulation of naloxone are reserved to the UK Government. Scottish Government (DRU0100).
370 The Company Chemists' Association (DRU0025); The Royal Pharmaceutical Society (DRU0035).
371 The Company Chemists' Association (DRU0025).
372 The Royal Pharmaceutical Society (DRU0035).
373 The Hepatitis C Trust (DRU0065).

on the streets to people who use opiates and train them how to use to it. The ACMD has recognised the utility of peer-to-peer programmes but has said that further research is needed to consider the efficacy of peer-to-peer naloxone within a range of contexts.[374]

202. The use of peer-to-peer programmes is increasing across the UK, particularly in response to the Covid-19 pandemic. In Wales, all Area Planning Boards are rolling out peer-to-peer schemes following a successful pilot.[375] Peers in Wales have also trained people in the community to use naloxone. In Cardiff and the Vale, this has included staff at a number of high street premises including fast food retailers. We were also told about schemes that seek to provide naloxone to prison leavers identified as being at risk of overdose.[376] The Scottish Government has also invested over £500,000 in a Scotland-wide peer-to-peer programme run through the Scottish Drugs Forum. This programme also includes a prison-based peer network to reduce the risk of overdose among prison leavers, which we discuss above.[377] In England, areas such as Wigan have also introduced peer-to-peer programmes.[378]

The police

203. The West Yorkshire Deputy Mayor for Policing and Crime argued that that the increasing number of drug misuse deaths meant that police officers are more likely to come into contact with people who require support to prevent fatal overdose and therefore supported widespread rollout of naloxone.[379] The APCC told us that there is widespread support among Police and Crime Commissioners for police officers to provide naloxone voluntarily.[380] The NPCC said that there was support among police forces for the provision of naloxone by officers. However, the NPCC noted that concerns remain among some police forces about the financial costs and potential health and safety risks to staff in providing naloxone without, for example, appropriate safeguards being put in place.[381]

204. In recent years, the number of UK forces training officers to carry and administer naloxone has increased. Scotland is the first country in the world where all police officers up to the rank of Inspector will carry a naloxone kit and are trained in overdose prevention.[382] The national roll out—which is now complete—is mandatory and in April it was confirmed that officers will receive legal and financial protection from the Scottish Police Federation.[383] The then Scottish Minister for Drug Policy, Angela Constance MSP, told us that over 100 lives had been saved by officers administering naloxone.[384] Policing in Wales told us that, following a successful pilot launched in 2020 by North Wales Police, officers are being trained to carry and administer naloxone in all four Welsh police

374 ACMD, Review of the UK naloxone implementation: Availability and use of naloxone to prevent opioid-related deaths, June 2022.
375 HM Government, From harm to hope: A 10-year drugs plan to cut crime and save lives, December 2021.
376 Welsh Deputy Minister for Mental Health and Wellbeing, Lynne Neagle MS (DRU0124).
377 Scottish Government (DRU0100).
378 With You, New programme to reduce drug-related deaths in Wigan, August 2022.
379 West Yorkshire Deputy Mayor for Policing and Crime (DRU0018).
380 Association of Police and Crime Commissioners (DRU0078).
381 The National Police Chiefs' Council (DRU0079).
382 Scottish Government (DRU0100).
383 Scottish Police Federation, Compulsory carriage of naloxone, 14 April 2023.
384 Q374. Scottish officials have since told us that naloxone has been administered over 200 times but that it may not translate into lives saved because more than one administration may have occurred with the same individual.

forces.[385] The Police Service of Northern Ireland has also held a three-month pilot of the provision and administration of naloxone by officers, which resulted in three successful interventions.[386] West Midlands Police was the first force in the UK to train and equip officers with naloxone across three neighbourhood police teams. The West Midlands PCC told us that the force is working towards full coverage across the entire force area.[387] However, not all police forces in England have adopted the provision of naloxone.

205. **The evidence on the lifesaving effects of naloxone in counteracting opioid-related overdose is clear. We welcome the national naloxone programmes in the devolved nations but are concerned that no such programme exists in England. We also welcome the joint working between the Government and the devolved administrations to expand access to naloxone. However, progress is slow. The need to expand and embed naloxone within services and communities is crucial to saving as many lives from opioid-related overdose as possible.**

206. ***We recommend that the Government establish a national naloxone programme in England to bring it in line with the devolved nations. We also recommend that the Government speed up its work on expanding the provision of naloxone following the UK-wide consultation in 2021. Expanding provision must include any service and person who may come into contact with people who are likely to suffer an opioid-related overdose. In particular, we think that community pharmacists and peer-to-peer programmes are well-positioned in their local areas to supply, distribute and administer this life saving treatment. It must also include enhanced distribution of naloxone to prison leavers.***

207. **The efforts of UK police forces to roll out this life saving treatment is welcome. However, provision of naloxone across English forces is not universal, which risks creating a postcode lottery on the availability of this potentially life-saving treatment in England. Further, while we recognise the concerns of some officers to carrying naloxone, we conclude that the saving and preservation of life is too important, particularly when a person's health is in a life-threatening condition due to overdose.**

208. ***We recommend that the Home Office requires all 43 police forces in England and Wales to roll out the voluntary provision of naloxone by operational officers. Volunteer officers must be provided with adequate training in the carrying and administration of naloxone before they can carry it on duty. The Home Office must provide additional funding to all 43 forces to supply naloxone and to support the training of officers on the administration of naloxone. The Home Office must also work with policing and health partners to devise guidance on the carrying and administration of naloxone for operational police officers. All 43 police forces must record when its officers have administered naloxone, and the surrounding circumstances, in order to better understand the use of the treatment in emergency situations.***

Recovery cafés

209. In her review, Dame Carol noted that recovery services should "provide networks of peer-based recovery support and establish communities of recovery and mutual aid

385 Policing in Wales (DRU0091); Office of the Police and Crime Commissioner North Wales, Police boss launches trial of life-saving spray for drug overdoses, 21 July 2020.

386 Police Service of Northern Ireland (DRU0089). Visit to Glasgow and Belfast (DRU0119).

387 Office of the West Midlands Police and Crime Commissioner (DRU0066).

groups".[388] Recovery cafés fall within this network as places that seek to promote and support recovery from drug and alcohol dependency in an informal space. People at any stage of the recovery journey can attend. The cafés are often run by, or with the help of, people with lived experience of drug and alcohol dependency.

210. During our inquiry we visited two recovery cafés–one in Middlesbrough called Recovery Connections and Springburn Recovery Café in Glasgow. At Recovery Connections we met with staff and learnt how the organisation supports people in recovery through the development of skills, like culinary skills at its eatery The Fork in the Road. At the Springburn Recovery Café, we had the opportunity to sit with attendees during a recovery meeting before speaking with volunteers and staff at the café.

211. During both visits, it became obvious to us that these organisations played an important role in supporting a person's long-term recovery. These organisations provide people with a community and support network that can relate to their experience and support people to develop new skills. In addition, the Springburn Recovery Café also provides support for families by providing a safe space in which they could spend time together.

388 Professor Dame Carol Black, Review of drugs part two: Prevention, treatment and recovery, August 2021, part 3.4.

7 Criminal justice-led harm reduction

Diversion schemes

212. Diversion schemes are a method in which the police can deal with a case of low-level offending without the involvement of the courts (these methods are referred to as out-of-court disposals).[389] Such schemes seek to divert people away from the criminal justice system. They can occur at street level via pre-arrest diversion and post-arrest. There are diversion schemes operating in over 10 UK police forces.[390] In addition, diversion is one element to Project ADDER.

213. The College of Policing has noted that, in relation to low-risk young people, there is evidence to show that diversion can be effective in reducing young peoples' future contact with the criminal justice system compared to traditional approaches, including in circumstances linked with drug possession.[391] The Health and Social Care Committee, the Scottish Affairs Committee, the ACMD and Dame Carol Black have expressed support for diversion schemes.[392] The Lammy Review and the Commission on Racial and Ethnic Disparity have also expressed support for the use of diversion schemes to tackle ethnic disparity in the criminal justice system.[393] Diversion schemes have also received considerable support during the course of our inquiry, including from the NPCC, Police and Crime Commissioners and senior police officers.[394]

214. We were repeatedly referred to diversion schemes operating in Thames Valley, Durham and the West Midlands.[395] Reflecting on the diversion scheme operating in Thames Valley, Chief Constable John Campbell told us that: " All our professional instincts suggest it is a very positive thing".[396] A randomised control trial found that Durham's Checkpoint programme had a 10.3% reduction in reoffending compared to traditional criminal justice

389 The Police, Crime, Sentencing and Courts Act 2022, Part 6, has legislated to simplify the number of out-of-court disposals that police forces in England and Wales can use to deal with low-level offences. It will apply a two-tier framework across England and Wales that includes a higher tier of 'diversionary cautions' – which will require a person to comply with conditions or face prosecution – and a lower tier of 'community cautions' – which will require the person to pay a fine or comply with rehabilitative or reparative conditions or face a further fine. The commencement date of Part 6 is yet to be determined. Home Office, Reforms to the adult out of court disposals framework in the Police, Crime, Sentencing and Courts Bill: Equalities impact assessment, 9 May 2022; Commencement schedule, 13 April 2023.

390 Criminal Justice Alliance (DRU0090).

391 College of Policing, Drug crimes evidence briefing: Police-led diversion, 19 October 2022.

392 Health and Social Care Committee, First Report of Session 2019, Drugs Policy, HC 143; Scottish Affairs Committee, First Report of Session 2019, Problem Drug Use in Scotland, HC 44; ACMD, Sentencing Guidelines Council - ACMD response, 1 July 2011; Dame Carol Black, Independent review of drugs part two: Prevention, treatment, and recovery, 2 August 2021.

393 The Lammy Review, An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System, September 2017, recommendation 10; Commission on Racial and Ethnic Disparity, The report, March 2021, recommendation 12.

394 Professor Alex Stevens, University of Kent (DRU0014); West Midlands Police and Crime Commissioner (DRU0066); Cranstoun (DRU0067); Centre for Justice Innovation (DRU0068); Volteface (DRU0073); Association of Police and Crime Commissioners (DRU0078); National Police Chief's Council (DRU0079); Changing Lives (DRU0082); The Criminal Justice Alliance (DRU0090); Q119; Q241.

395 West Midlands Police and Crime Commissioner (DRU0066); Cranstoun (DRU0067); Criminal Justice Alliance (DRU0090).

396 Q216.

outcomes.[397] The former Combating Drugs Minister, The Rt Hon Kit Malthouse MP, said in evidence to the Scottish Affairs Committee in 2019 that the scheme in Durham seemed to him like "a wholly laudable project".[398]

215. However, some have argued that the current approach to diversion schemes in England and Wales could be improved upon. South Wales Assistant Chief Constable, David Thorne, and Public Health Specialist at Hackney Council, Maggie Boreham noted that 'one size does not fit all' and that diversion needs to accommodate for different factors—such as age, gender, cultural and ethnic backgrounds—in order to be effective.[399] Other factors to consider include the environment in which the diversion would operate. For example, if the scheme were to operate in a rural area, that may require working in partnership with multiple clinical commissioning groups and other stakeholders compared to urban areas.[400] The Criminal Justice Alliance noted that for diversion to be effective, sustained investment in treatment services is needed to accommodate people being diverted.[401] We were also told that availability and substance of diversion schemes can vary across forces, and this can result in a postcode lottery.[402] Further, BTP Assistant Chief Constable, Charlie Doyle, told us that there were challenges in linking up the approximately one third of young people detained by BTP for county lines activity with appropriate support services because BTP operates across Scotland, Wales and England.[403] Finally, the Centre for Justice Innovation noted that there is a lack of national guidance and a lack of national aggregated data on different force approaches. Such information could, for example, help to build a national evidence base and establish clearly defined outcomes to measure diversion schemes against.[404]

216. There was support during our inquiry for a national diversion scheme.[405] Transform argued that street-level pre-arrest diversion should be expanded. It also suggested that a national scheme should explore diversion in other forms, for example, allowing schools, universities and youth clubs to deliver educational programmes and to make treatment referrals instead of punishing or excluding young people from education.[406] However, some noted the value of local-level decision-making in ensuring diversion schemes work for the community as well as the individual. PCC Andy Dunbobbin told us that "the more local you can make decisions, the better the outcomes are going to be".[407]

217. The Home Office has told us that "police forces exercise operational discretion in their diversionary approaches", which can adopt support and education according to local needs.[408] The 10-Year Drugs Strategy has committed to exploring ways to address a person's offending whilst they remain in their community and has committed to increasing drug, alcohol and mental health rehabilitation requirements, among other measures.[409]

397 Association of Police and Crime Commissioners (DRU0078).
398 Q429.
399 Q219–220; Q128.
400 Q235; Q243.
401 Criminal Justice Alliance (DRU0090).
402 Centre for Justice Innovation (DRU0068); Release (DRU0075).
403 Q303.
404 Centre for Justice Innovation (DRU0068).
405 Centre for Justice Innovation (DRU0068); Release (DRU0075); Transform (DRU0106).
406 Transform (DRU0106).
407 Q242.
408 Home Office (HUM0118), p.3.
409 Home Office, From hope to harm: A 10-year drugs plan to cut crime and save lives, 29 April 2022; Home Office (HUM0118).

218. **We support the use of diversion schemes for low-level offences. The use of such schemes by police forces in England and Wales is increasing and we welcome the efforts of those forces in rolling out these schemes. However, we are concerned that the use and substance of diversion schemes can vary across police forces. This can result in the criminal justice system responding differently to individuals for suspected drug-related offences. This postcode lottery is wholly unfair. It is time that a more coordinated, national approach is adopted.**

219. ***We recommend that the Home Office place a duty on all 43 police forces in England and Wales to establish diversion schemes in their force area for young people and adults who have committed low-level offences. The duty must outline requirements for the diversion schemes in order to ensure a minimum standard that all diversion schemes must satisfy. In drafting the duty, the Home Office must consult with police forces and relevant stakeholders on what the minimum standards should include. The Home Office must also publish guidance on the implementation and operation of diversion schemes.***

220. ***We recommend that police forces record the use of diversion schemes in their force areas to develop a national picture and an understanding of best practice. The Home Office must regularly update the guidance to incorporate this evidence base.***

Trauma-informed policing

221. Trauma-informed practices seek to recognise the trauma a person may have experienced and how that may have impacted their life or behaviour. The Association of Directors of Public Health has said that the police are well-positioned to identify trauma given their role as first responders and their role within local communities.[410] Indeed, a growing number of UK police forces are adopting trauma informed practices, particularly in relation to victims and people with adverse childhood experiences.

222. Police Scotland has sought to adopt trauma-informed practices as part of the Scottish Government's National Trauma Training Programme.[411] This includes, for example, the incorporation of trauma-informed training in the force's development programmes for detectives and probation officers.[412] In Northern Ireland, the PSNI have stated that trauma-informed training and responses to victims is a "core theme" of its training of officers.[413] In England and Wales, the Home Office announced in 2021 that £17 million in funding would be provided to establish trauma-informed training for frontline professionals.[414] This aims to support early intervention and prevent young people being drawn into serious violence. Six police forces received funding to adopt trauma-informed practices in police custody units.[415] Seven forces received funding to adopt trauma-informed practices in Violence Reduction Units.[416]

223. ACC David Thorne told us that the diversion schemes operating in South Wales Police work in a trauma-informed manner. He said this was the key advantage to the

410 Association of Directors of Public Health, Guidance for the policing sector: Creating ACE-informed places: Promoting a whole systems approach to tackling adverse childhood experiences in local communities, 2021.
411 NHS Education for Scotland, What is the National Trauma Training Programme (NTTP)?
412 NHS Education for Scotland, Police Scotland – Pledge.
413 Northern Ireland Policing Board, Questions to the Chief Constable: Trauma training, 6 April 2023.
414 Home Office, New investment to support young people at risk of serious violence, 27 July 2021.
415 Thames Valley, Lancashire, Northumbria, Nottinghamshire, Leicestershire, South Wales.
416 Avon and Somerset, Greater Manchester, Leicestershire, Hampshire, Lancashire, Sussex and the West Midlands.

diversion schemes because it enabled people to receive relevant support.[417] Transform told us that trauma-informed policing is "crucial" to the delivery of Project ADDER, but that clear guidance and training was needed.[418]

224. **We welcome the increasing adoption of trauma-informed approaches by UK police forces. As drug use—particularly problematic or chronic drug use, can often be a consequence of trauma—we conclude that trauma-informed policing should be extended to situations involving drug use. We believe that this aligns with the Government's commitment to adopting a whole system response to drugs outlined in the 10-Year Drugs Strategy.**

225. ***We recommend that trauma-informed training and practices be expanded to all 43 police forces in England and Wales. The Home Office must work with police forces and stakeholders to establish training and guidance on trauma-informed policing. The training and guidance should take into consideration the types of trauma associated with drugs and the ways to reduce stigma linked to drugs.***

417 Q217.
418 Transform (DRU0106), para.3.b.

8 Cannabis

Cannabis-based products for medicinal use

226. In November 2018, cannabis was rescheduled from Schedule 1 to Schedule 2 to the Misuse of Drugs Regulations 2001 (2001 Regulations). The change offered clinicians on the Specialist Register of the General Medical Council the ability to prescribe medical cannabis. These specialist clinicians can work in the NHS or privately.[419] This actioned a recommendation by the then Chief Medical Officer for England, Professor Dame Sally Davies, who said there was "conclusive evidence of the therapeutic benefit of cannabis based medicinal products for certain medical conditions, and reasonable evidence of therapeutic benefit in several other medical conditions".[420]

227. Products under Schedule 2 are referred to as cannabis-based products for medicinal use (CBPMs). For a product to be licensed as such, it must satisfy the definition of a CBPM in Schedule 2 and hold marketing authorisation from the Medicines and Healthcare Products Regulatory Authority (MHRA) or the European Medicines Agency (EMA).[421] There are currently no licensed CBPMs in the UK. There are, however, unlicensed CBPMs available, which satisfy the Schedule 2 definition but have not been granted marketing authorisation.[422] In addition, three products—Epidyolex, Nabilone and Sativex—have marketing authorisation but are scheduled separately under the 2001 Regulations. They are therefore considered licensed cannabis-based medicines, not CBPMs.[423] Respectively, these three products can be prescribed to treat severe and rare forms of epilepsy; vomiting or nausea caused by chemotherapy; and spasticity caused by multiple sclerosis.[424]

Prescriptions for cannabis-based products for medicinal use

228. NHS England says that very few people are likely to be prescribed medical cannabis and that this would only be done when other treatments have failed or were unsuitable.[425] On 13 January 2023, the Minister for Health and Secondary Care, Will Quince MP, outlined the number of private and NHS prescriptions for medical cannabis in England since the legislative change. He said that fewer than five patients had been prescribed unlicensed CBPMs on the NHS in England and that a breakdown on the number of items prescribed would not be disclosed to protect the privacy of those patients.[426]

419 The National Institute for Health Care Excellence (NICE) has issued guidance on which conditions it may be appropriate to prescribe medical cannabis: NICE, Cannabis-based medicinal products, 22 March 2021.

420 Professor Dame Sally Davies, Cannabis Scheduling Review: The therapeutic and medicinal benefits of Cannabis based products – a review of recent evidence, June 2018, para.1.4. Prior to this change, it was already possible to receive a cannabis-derived drug—Sativex—to treat spasticity in multiple sclerosis.

421 Marketing authorisation means a product has been assessed and approved by the Medicines and Healthcare Products Regulatory Authority or the European Medicines Agency for safety, quality or efficacy. Advisory Council on the Misuse of Drugs, Cannabis-based products for medicinal use (CBPMs) in humans, November 2020.

422 Products such as Bedrolite, Bedica and Aurrora fall under this category. Unlicensed CBPMs may be prescribed by clinicians on the Specialist Register but have not received marketing authorisation. Advisory Council on the Misuse of Drugs, Cannabis-based products for medicinal use (CBPMs) in humans, November 2020.

423 Advisory Council on the Misuse of Drugs, Cannabis-based products for medicinal use (CBPMs) in humans, November 2020. Nabilone, Sativex and Epidyolex are listed in Schedules 2, 4 Part I, and 5 to the MDR respectively.

424 House of Commons Library, Medical use of cannabis, December 2021.

425 NHS England, Medical cannabis (and cannabis oils), 27 May 2022.

426 PQ 117459 [on Cannabis: Medical treatments], 13 January 2023.

Table 2: Prescriptions in England for unlicensed CBPMs and licensed cannabis-based medicines

Type of prescribing	Time period	Number of items
NHS prescribing licensed cannabis-based medicines	November 2018 to October 2022	11,976
NHS prescribing unlicensed CBPMs	Data unavailable	Data unavailable
Private prescribing licensed cannabis-based medicines	November 2018 to October 2022	140
Private prescribing unlicensed CBPMs	November 2018 to July 2022	89,239

Source: PQ 117459 [on Cannabis: Medical treatments], 13 January 2023.

Treatment of chronic pain

229. In her 2018 review, Dame Sally Davies concluded there was evidence to suggest that medical cannabis may also be effective for managing chronic pain.[427] Similarly, Professor David Nutt told us about an ongoing observational trial of patients who are using medical cannabis for chronic pain, which is being run by his charity Drug Science. He said initial analysis of 500 patients (out of 3,000 trial patients) found that 44% had stopped using opiate painkillers.[428] However, an evaluation of other systematic reviews concluded that the benefits of medical cannabis for reducing pain was less clear due to "sub-optimal" analysis and reporting methods.[429] Current guidance from the National Institute for Health and Care Excellence does not recommend prescribing CBPMs to treat chronic pain on the basis that the potential benefits offered were small compared with the cost of the treatment for the NHS.[430]

Availability of cannabis-based products for medicinal use

230. Cancard—which advocates for medical cannabis—argued that the current pathways for accessing medical cannabis are restrictive, costly and suffer from supply chain issues.[431] We were told that many patients obtain prescriptions privately and that the price can vary from £250 to £1,800 per month.[432] As a result of these issues, people may turn to the illicit market to treat their medical conditions.[433] Drug research and campaign organisation, Volteface, argued that a lack of awareness on the legality of medical cannabis (in part due to advertising restrictions) may also play a role in these people turning to the illicit market.[434] Volteface argued this risks criminalising people with a genuine medical need.[435] Professor Alex Stevens from the University of Kent suggested that access to medical cannabis could

427 Professor Dame Sally Davies, Cannabis Scheduling Review: The therapeutic and medicinal benefits of Cannabis based products – a review of recent evidence, June 2018.
428 Q56. Drug Science, T21 Data.
429 Pratt M, et. al, Benefits and harms of medical cannabis: A scoping review of systematic reviews, December 2019.
430 NICE, Cannabis-based medicinal products, 22 March 2021.
431 Cancard (DRU0023).
432 Anonymised (DRU0063); Volteface (POP0114).
433 Co-Chair of the All-Party Parliamentary Group on Access to Medical Cannabis Under Prescription (DRU0024).
434 Volteface (POP0114).
435 Volteface (POP0114). See also, Co-Chair of the All-Party Parliamentary Group on Access to Medical Cannabis Under Prescription (DRU0024); Anonymous (DRU0063).

be increased by moving it to Schedule 4 Part II to the 2001 Regulations because it would reduce restrictions on prescribing medical cannabis.[436] However, in November 2020, the ACMD concluded that Schedule 2 remained appropriate for CBPMs.[437]

231. Separately in November 2020, the ACMD concluded that there was not sufficient evidence at that stage to fully assess any and all consequences of the legislative change.[438] The Government later commissioned the ACMD to conduct a further assessment of CBPMs, which is ongoing.[439] In 2020, the ACMD also recommended that further research should be conducted on the safety, quality and efficacy of medical cannabis.[440] The Government has said that NHS England and the National Institute for Health and Care Research are working to develop two randomised control trials on medical cannabis to treat epilepsy and that the Institute is open to research proposals in this areas as a priority.[441] However, the Government also said that:

> [L]ike other medicines, it is the responsibility of manufacturers to produce evidence on safety, quality and efficacy and to put forward their products for scrutiny by the Medicines and Healthcare products Regulatory Agency before a marketing authorisation (licence) is granted. Despite calls from [Department of Health and Social Care] Ministers, the industry has largely failed to invest in clinical trials to establish the safety, quality and efficacy of their products.[442]

232. Further, the Home Office has told us that "the law does not restrict which conditions CBPMs may be prescribed for and there is no legal impediment to specialist doctors prescribing CBPMs where clinically appropriate and in the best interests of patients".[443]

233. **We support cannabis-based products for medicinal use (CBPMs) where there is an evidence base that it can be an effective form of treatment for managing conditions or symptoms. We welcome the ACMD conducting a further assessment of CBPMs following on from its 2020 report. However, we are concerned that there is currently a lack of access on the NHS for patients with a genuine medical need. Access continues to be a problem despite the high-profile cases of Billy Caldwell and Alfie Dingley –two children with severe and rare forms of epilepsy who have received medical cannabis to treat their conditions. *Pending the outcome of the ACMD's review, we recommend that the Government widens the accessibility of unlicensed CBPMs on the NHS before the end of this Parliament.***

234. **There is evidence of the potential therapeutic value of CBPMs to treat chronic pain. *We recommend that the Government supports researchers to conduct randomised control trials into the effectiveness of CBPMs to treat chronic pain. If the evidence base***

436 Professor Alex Stevens, University of Kent (DRU0014).
437 ACMD, Letter to the Home Secretary reviewing the scheduling of CBPMs, 27 November 2020.
438 ACMD, Cannabis-based products for medicinal use (CBPMs) in humans, November 2020.
439 Home Office, Government response letter to ACMD on CBPMs in humans, 21 January 2022; Q113.
440 ACMD, Cannabis-based products for medicinal use (CBPMs) in humans, November 2020.
441 Specifically, whether adding THC to CBD-based medicines can improve their anti-epileptic properties. Both are naturally found in the cannabis plant but, unlike CBD, THC has a psychoactive effect. Home Office, Government response letter to ACMD on CBPMs in humans, 21 January 2022.
442 Home Office, Government response letter to ACMD on CBPMs in humans, 21 January 2022.
443 Home Office (DRU0080), para.7.1.

supports this, and it is deemed to be cost-effective, we recommend that the Government enables the use of CBPMs for this purpose and works with clinicians to ensure that it is a treatment option in appropriate cases.

Cannabis for non-medical use

235. In the early 2010s, a global policy shift on the legalisation and regulation of cannabis began. In 2012, Colorado and Washington became the first American states to legalise cannabis for non-medical use.[444] In 2013, Uruguay became the first country in the world to pass legislation to legalise and regulate the cultivation and sale of cannabis for non-medical use.[445] Other countries have since followed, including Canada and Malta.[446] This is despite the fact that the legalisation and regulation of controlled drugs for purposes other than medical or scientific use is inconsistent with the Drug Control Conventions.[447]

Visit to Uruguay

236. On 14 December 2013, the government of the then President, José Mujica, passed a bill to legalise the cultivation and the sale of cannabis (Law No. 19172). In February 2022, we visited Uruguay to understand its cannabis regulation model, which is summarised below.

Box 1: Uruguay cannabis regulation model

The Uruguayan model is largely state-controlled and seeks to enable adults to legally access cannabis whilst eliminating incentives to increase consumption. Regulation is overseen by the government agency the Instituto de Regulación y Control del Cannabis (IRCCA).

To obtain cannabis, one must be aged 18 or over, be a Uruguayan citizen or permanent resident, and be registered with IRCCA. A person is restricted to obtaining cannabis through one of the following three methods.

- Grow up to six flowering plants per household with a maximum total yield of 480 grams per year. Registration of consumers using this method began in April 2014.
- Become a member of a 'cannabis club' under which a group of between 15 to 45 people can collectively grow up to 99 plants per year. Registration of consumers using this method began in October 2014.
- Purchase up to 40 grams of cannabis per month from a licensed pharmacy. Consumers must use a fingerprint scanner to verify their identity when making a purchase. Pharmacies began to sell cannabis in July 2017. The maximum strength of THC available in cannabis products was increased from 9% to 15% in late 2022.

444 Time, Two U.S. states become first to legalise marijuana, 7 November 2012.
445 Reuters, Uruguay becomes first country to legalize marijuana trade, 11 December 2013.
446 Canada legalised cannabis for non-medical use in October 2018. Malta became the first EU nation to legalise cannabis in December 2021. Government of Canada, Cannabis legalization and regulation, July 2021; BBC News, Malta becomes first EU nation to legalise cannabis, 14 December 2021.
447 See chapter 2.

237. During our visit, we met a range of stakeholders including the then Minister for Public Health, Dr Daniel Salinas, parliamentarians, the National Drugs Board, IRCCA, lawyers and academics. We also sought to understand the methods by which individuals can obtain cannabis and therefore visited a cannabis club, a pharmacy which sells cannabis and a state-owned cannabis cultivation site that supplies cannabis products to the pharmacies.

238. It was widely accepted among the Uruguayan stakeholders we met that drugs and drug use are ubiquitous, and that prohibition was not effective in reducing drug use or drug harms. During our visit we found there was some support among the stakeholders we spoke to that the legalisation of cannabis for non-medical use was a beneficial policy for the country. We were told that cannabis regulation was part of Uruguay's overall harm reduction efforts and that the state had been careful to introduce a regulatory model that aimed to provide consumers with choice in a responsible way – both through the method of obtaining cannabis and through providing a variety of strengths of cannabis. Some stakeholders argued that this approach would encourage people away from obtaining cannabis on the black market. The Social Market Foundation told us that the Uruguayan model can be viewed as a "middle-ground between prohibition and commercialisation" and, when compared to models adopted elsewhere, is the "most effective approach to cannabis policy".[448]

239. However, other stakeholders, including Dr Salinas, expressed concerns about the public health implications of the policy given the potential harms of cannabis. For example, the WHO has reported that there is evidence of a link between cannabis and psychosis and schizophrenia, though the causal role of cannabis in this continues to be debated.[449] We also noted that the state had released a stronger cannabis product in pharmacies in 2022. This was in response to greater demand for stronger cannabis products and to replace what was available on the black market. We were concerned to observe during our visit to a pharmacy that consumers wanted to purchase only this stronger product, not the lower-strength products.

240. In addition, we identified a number of areas of concern. First, we found that there was no public health campaign to raise awareness of the harms cannabis may pose. Second, we found there was a lack of data being collected—particularly longitudinal data—on the impact of this policy change in Uruguay. Third, we noted a lack of education—particularly for young Uruguayans—on the potential harms of cannabis. For example, the WHO has noted there is a growing body of evidence that "regular, heavy cannabis use during adolescence is associated with more severe and persistent negative outcomes than use during adulthood".[450] However, a recent double-blind, randomised control study found no evidence that adolescent cannabis users were more resilient or more vulnerable than adult cannabis users to memory impairment or cannabis-induced psychosis-like symptoms.[451]

241. It appeared to us that the policy change had little impact on the poorest in Uruguayan society. For example, memberships for social clubs are expensive and this option may not therefore be open to those with limited financial means. We also heard that, since the implementation of this policy, overall drug use and drug-related crime had not decreased,

448 Social Market Foundation (DRU0086), para.9.
449 WHO, The health and social effects of nonmedical cannabis use, 2016.
450 WHO, The health and social effects of nonmedical cannabis use, 2016, p.41.
451 Lawn, W., et al, The acute effects of cannabis with and without cannabidiol in adults and adolescents: A randomised, double-blind, placebo-controlled, crossover experiment, Addiction, February 2023.

and that people being sent to prison for drug-related offences continued to increase. Finally, we heard of the increasing problem in Uruguay (and in other South American countries) with a type of cocaine called 'pasta base'.[452] Some stakeholders argued that the creation of a legal cannabis market would help mitigate the risk of people using other, more harmful, substances on the illicit market, like pasta base. We were not convinced by this argument, and some have said that this happened because of growing prevalence of stronger cannabis products after the legalisation of cannabis.

Regulation of cannabis in the UK

242. We have received a mixed response on whether cannabis ought to be legalised and regulated in the UK. Release argued that the increasing move towards regulation globally and the potential generation of tax revenue suggested that the regulation of cannabis may be inevitable.[453] However, the Police and Crime Commissioner for Dorset, David Sidwick, argued that cannabis can be harmful and therefore should remain a controlled drug.[454] The Home Office has recognised that other countries may adopt a different approach but has argued that "there is clear scientific and medical evidence that cannabis is a harmful drug which can damage people's mental and physical health, and harm individuals and communities".[455]

243. **We are concerned by the harms that cannabis for non-medical use may pose, particularly in relation to young people. We do not believe that cannabis should be legalised and regulated for non-medical use.**

452 Pasta base (also referred to as 'cocaine/coca base' or 'paco') is a by-product of processing raw coca leaf before it is made into cocaine hydrochloride (powder). It tends to be smoked along with tobacco. As with other forms of cocaine, it can be highly addictive and can pose serious health risks. UNODC, New report looks at use of cocaine paste in Peru, May 2013.

453 Release (DRU0075).

454 David Sidwick, Police and Crime Commissioner for Dorset (DRU0110).

455 Home Office (DRU0080), para.6.6.

9 Northern Ireland

244. We found the situation in Northern Ireland to be different from that in the other UK nations due to its geography, history and politics. Together, these factors add layers of complexity to Northern Ireland's response to drugs. On 16 November 2022, we visited Belfast and met the Police Service of Northern Ireland (PSNI), the Lord Mayor of Belfast, Councillor Christina Black, and third sector stakeholders including the Northern Ireland Alcohol and Drug Alliance (NIADA) and the Welcome Organisation.[456]

245. Northern Ireland is the only UK nation to share a land border with another country (Ireland). Not only does this have an impact on the way in which drugs are trafficked in and out of the UK, it also requires a cross-border law enforcement response between the PSNI and An Garda Síochána.[457] The supply and trafficking of drugs is further complicated by the involvement of paramilitary groups, who continue to have a presence among certain communities in Northern Ireland, particularly among young people in those communities.[458] The PSNI and NIADA supported greater early intervention and prevention support for children and young people.[459] NIADA also supported a more trauma-informed approach, particularly given the traumatic history of Northern Ireland.[460] We note that the Government and the Northern Ireland Executive have funded the Tackling Paramilitary Activity, Criminality and Organised Crime Programme to prevent and reduce the harms associated with paramilitary activity. One of the primary aims of the Programme is to prevent children and young people from being drawn into paramilitary and criminal activity.[461]

246. In addition, Northern Ireland has gone through a number of periods without a functioning Northern Ireland Executive, thereby creating periods of instability for public services and the people of Northern Ireland.[462] The current political stalemate began in February 2022 when the First Minister, Paul Givan, resigned.[463] Ministers continued to oversee departments in a caretaking capacity until October 2022.[464] Without a Northern Ireland Executive, officials can make decisions only in so far as they support a department to exercise functions that are in the public interest. Major policies, or changes to major policies, are matters for an elected minister; officials are expected to maintain the policy direction previously set by ministers.[465] This could have an impact on the progression of long-term responses to drugs (among other policy areas). NIADA told us that the drug

456 Glasgow/Belfast summary.
457 Police Service of Northern Ireland (DRU0089).
458 Police Service of Northern Ireland (DRU0088).
459 Glasgow/Belfast summary; Police Service of Northern Ireland (DRU0088).
460 Glasgow/Belfast summary.
461 Northern Ireland Executive, Executive programme for tackling paramilitary activity and organised crime.
462 A summary of the functioning of the Northern Ireland Executive up to May 2019 is at Figure 2: Institute for Government, Governing without ministers Northern Ireland since the fall of the power-sharing executive, September 2019.
463 The devolution settlement requires the First and deputy First Minister to hold office jointly and act jointly. Without both office holders, an Executive cannot operate. HM Government, Devolution settlement: Northern Ireland, 23 September 2019
464 Institute for Government, Northern Ireland: Functioning of government without ministers, 14 November 2022.
465 Northern Ireland Office, Guidance on decision-making for Northern Ireland Departments May 2023, 25 May 2023.

treatment and recovery sector no longer had a minister to engage with, which contrasted with when the Executive was functioning and the sector felt its concerns were responded to.[466]

247. Efforts to respond to drugs nevertheless continue in local areas and on the ground, particularly in relation to vulnerable homeless populations. The Welcome Organisation—a charity that supports people affected by homelessness—told us about its plans to open accommodation dedicated to supporting homeless women. The facility, Catherine House, opened in March and can support up to 10 women with the aim of supporting the women into independent living. This includes skills training but also support for mental health and drug and alcohol dependency.[467] In addition, the Lord Mayor told us about Belfast City Council's 'whole-system approach' to helping chronically homeless people with drug and alcohol dependency called Complex Lives. It is a multi-agency partnership involving the Council, the PSNI, the probation board, health partners, and third sector organisations. It adopts a person-centred approach that assesses the particular needs of an individual in order to provide them with appropriate wrap-around care.[468] This approach echoes that advocated by Professor Dame Carol Black in her review of drugs in England.[469] However, during our visit to Belfast, we heard concerns about a lack of sustainable, long-term funding and how this undermines the ability of services to recruit and retain staff and, in turn, provide a quality service.[470] Dame Carol also identified this as a problem in England, which the Government has accepted and sought to address in the 10-Year Drugs Strategy.[471]

248. **We are deeply concerned by the role paramilitary groups play in organised drug crime in Northern Ireland, and the impact that this has on local communities, children and young people. We are also deeply concerned by the effect the current political stalemate is having in Northern Ireland and the extent to which it restricts Northern Ireland's response to drugs, among many other issues. However, we welcome the continued efforts of public services and stakeholders to respond to drugs, particularly efforts that adopt a multi-agency response.**

249. ***In the absence of an operational Northern Ireland Executive and Assembly, the Government must further support officials and communities in Northern Ireland to respond to drugs. This must include support to develop and sustain early intervention and prevention initiatives under the Tackling Paramilitarism, Criminality and Organised Crime Programme, which seeks to draw young people away from paramilitary groups. It must also include the extension of the harm reduction policies outlined in this report.***

466 Glasgow/Belfast summaryt.

467 The facility is funded through the Northern Ireland Housing Executive's Supporting People Programme. Glasgow/Belfast summary; Welcome Organisation, The Welcome Organisation to open new women's service, 3 March 2023.

468 Glasgow/Belfast summary.

469 Professor Dame Carol Black, Review of drugs part two: Prevention, treatment and recovery, 2 August 2021.

470 Glasgow/Belfast summary.

471 Professor Dame Carol Black, Review of drugs part two: Prevention, treatment and recovery, 2 August 2021.

Conclusions and recommendations

The UK's drugs legislative framework

1. There is increasing support for public health responses as a tool to respond to drugs, and the adoption of such responses are within the spirit of the Drug Control Conventions. (Paragraph 16)

2. *We recommend that the Government balances its criminal justice response to drugs with an increased public health response that seeks to prevent and treat drug use and tackle the root causes of drug use through, for example, a broad range of harm reduction approaches.* (Paragraph 16)

3. We conclude the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001 require reform. (Paragraph 20)

4. *We recommend that the UK Government reform the 1971 Act and 2001 Regulations in a way that promotes a greater role for public health in our response to drugs, whilst maintaining our law enforcement to tackling the illicit production and supply of controlled drugs.* (Paragraph 20)

5. We welcome the ACMD's work reviewing the status of drugs controlled under Schedule 1 to the 2001 Regulations. However, we conclude a wider review is required. (Paragraph 29)

6. *We recommend that the Home Office commission the ACMD to review whether the most commonly used controlled drugs in the UK are correctly classified under the 1971 Act and correctly scheduled under the 2001 Regulations based on the scientific evidence available. The Home Office must reform the classification system and the scheduling system based on the findings of that review. We recommend the ACMD conduct updated assessments every 10 years, or in circumstances where a review is required, to take into account the emerging scientific evidence on controlled drugs.* (Paragraph 29)

7. *We welcome the UK Government's commitment to reducing barriers to researching psychedelic drugs under Schedule 1 to the 2001 Regulations. Pending the outcomes of the ACMD's ongoing review of Schedule 1 controlled drugs, we recommend the UK Government urgently moves psychedelic drugs to Schedule 2 in order to facilitate research on the medical or therapeutic value of these drugs.* (Paragraph 30)

8. We recognise that the Psychoactive Substances Act 2016 was enacted to deal with the surge in new psychoactive substances (NPS) and the related health harms. We note that it was successful in removing the open sale of NPS but are concerned with the use of NPS among vulnerable populations, such as homeless people and people in prison, and with the increasing potency of NPS. (Paragraph 42)

9. We are concerned about the increasing prevalence of benzodiazepine use, and its implication in drug misuse deaths, across the UK. We await the outcome of the Home Office's consultation on the creation of a new offence to better enable law enforcement to prove the illicit use of pill presses. (Paragraph 43)

10. *The Combating Drugs Minister must write to us with an update on the outcome of the consultation before 18 December 2023.* (Paragraph 43)

11. We are alarmed by the health and social harms of synthetic opioids, such as fentanyl. We are concerned that a reduction in the global supply of heroin will have the effect of people with an opioid dependency turning to even more potent and harmful synthetic opioids, which have contributed to the ongoing opioid crisis in North America. (Paragraph 44)

12. *To mitigate this risk, we recommend the Government, in partnership with the devolved administrations, increase its monitoring of synthetic drugs being trafficked in, and around, the UK, and prioritise supporting people with a chronic heroin dependency into treatment and recovery.* (Paragraph 45)

13. *We recommend that the Government must prepare a strategy to mitigate the risk of an increase in the supply and availability of synthetic opioids in the UK before the end of this Parliament.* (Paragraph 46)

14. The ACMD seeks to provide scientific, evidence-based recommendations to support the development of evidence-based drug policy. We note that the Home Office appears more likely to adopt advice to increase the classification of a controlled drug than it is to adopt advice to reduce the classification of a controlled drug. For example, we note that in the cases of cannabis, MDMA, khat and nitrous oxide, the ACMD recommended a lower classification, or no classification based on a review of the evidence. We acknowledge that scientific evidence should remain a key driver but not the main driver in the development drug policy in all cases, including when the scientific evidence supports reducing the level of control placed upon a drug. (Paragraph 54)

15. We are disappointed that the Home Office has repeatedly refused to publish the ACMD's 2016 report, including to this Committee on a confidential basis. No other ACMD report remains unpublished and withholding this one contravenes established practice and undermines the ACMD's transparency. (Paragraph 55)

16. *We, once again, request that the Home Office publish the ACMD's 2016 report. At the very least, we request that the Home Office provide us with a confidential copy of the document within one month of receiving this report. Failing that, the Government must explain in its response to this Report why this ACMD paper, and no other, deserves to be withheld from public view.* (Paragraph 55)

The 10-Year Drugs Strategy

17. *In line with the spirit of the partnership approach in the 10-Year Drugs Strategy, we recommend that the Government make the Department of Health and Social Care and the Home Office jointly responsible for drug policy. We recommend that the Combating Drugs portfolio be held by a minister that sits across both departments. There is already precedent of Home Office ministers sitting across other departments such as the Ministry of Justice. The Home Office and law enforcement authorities would continue to respond to the illicit production and supply of drugs.* (Paragraph 65)

18. We welcome the Government's efforts to recognise and respond to the issues in Professor Dame Carol Black's Independent Review of Drugs and we welcome the ambition of the 10-Year Drugs Strategy. In particular, we welcome the cross-departmental and partnership approach and the increase in funding for the drug treatment and recovery sector. We believe the strategy is an important step in the right direction. (Paragraph 66)

19. We are concerned about the long-term sustainability and security of funding for the drug treatment and recovery sector. (Paragraph 74)

    a) We welcome the Government's latest funding announcement, which provides funding in England over a two year period. However, we question whether this is a sufficient length of time for service providers to utilise the funding to embed change.*We recommend that the UK Government provide funding throughout the 10 year lifespan of the strategy in three year cycles.*

    b) *In relation to the public health grant in England, we recommend that the Government go further than placing a condition on local authorities to have regard to drug and alcohol treatment by requiring local authorities to ringfence funding allocated under the public health grant for these services.*

    c) *We recommend that the Government give service providers a minimum of three months' notice of forthcoming funding allocations under the strategy and public health grant to enable them time to plan appropriately.*

20. The 10-Year Drugs Strategy recognises some harm reduction approaches but could go further. Abstinence-based recovery may not be an effective form of treatment for everyone. A broader range of harm reduction treatments are therefore required to help as many people into recovery as possible. (Paragraph 86)

21. *We recommend that the Government update the strategy to increase the range of harm reduction approaches available to support a person's treatment and recovery from drugs in line with the approaches outlined in this report.* (Paragraph 86)

22. The strategy states a commitment to breaking down stigma but provides little detail on how this commitment would be actioned. Stigma is a key issue for people with lived experience of using drugs and for their loved ones. Tackling stigma in all its forms must be a priority in the Government's entire response to drugs. (Paragraph 98)

23. *We recommend that the Combating Drugs Minister leads on devising a cross-departmental action plan to tackle stigma. In devising the action plan, the Government must engage with people with lived experience of drugs and stakeholders in the drug treatment and recovery sector to understand fully how stigma can affect people and how best to tackle it. The action plan must be published before the end of February 2024. We further recommend that the Government work with the devolved administrations to roll-out a coordinated, UK-wide campaign to tackle stigma.* (Paragraph 99)

24. We were concerned to hear about the barriers people, such as women and black, Asian and minority ethnic people, can face when accessing treatment. No-one should be unable, or feel unable, to receive treatment and support. (Paragraph 100)

25. *We recommend that Combating Drugs Partnerships prioritise identifying the likely barriers to treatment and recovery for people within their local area and take steps to address these barriers as part of fulfilling their commitments under the 10-Year Drugs Strategy.* (Paragraph 101)

26. We welcome the strategy's recommendation that the membership of local Combating Drugs Partnerships should include people affected by drug-related harm because it gives people with lived experience a platform to help reduce barriers to treatment and recovery at a local level. However, we question whether this is reflected at a national level. (Paragraph 102)

27. *We recommend that the Government explain how the voices of people with experience of drug-related harms are being recognised and included in national efforts to implement the strategy.* (Paragraph 103)

28. We welcome the strategy's commitment to supporting families. It focuses on the important role of the family in preventing drug use, particularly in relation to young people. However, it does not recognise the role that families can play in the treatment and recovery of family members who have already developed a dependence on drugs. Our discussions with families also made it clear that the level of support available for families, particularly mental health support, could be improved. (Paragraph 104)

29. *We recommend that local authorities use the funding allocated under the 10-Year Drugs Strategy to embed specialist practical and mental health support within drug treatment and support services for the families and the loved ones of people who use, or used, drugs.* (Paragraph 105)

30. We welcome the Government's ambition to reduce demand for drugs including recreational drugs. However, we have heard concerns that the three-tiered framework of escalating sanctions under the Swift, Certain, Tough: New Consequences for Drug Possession White Paper may have a negative impact in, for example, perpetuating stigma and in relation to young people. (Paragraph 112)

31. *Though we await the outcome of the consultation on this White Paper, we ask that the Home Office further explain:* (Paragraph 113)

    a) *How people with a drug dependency—to whom this policy will not apply—will be identified and directed into treatment.*

    b) *The extent to which the policy is likely to affect young people aged 16–24 years old—among whom recreational drug use tends to be higher—and what analysis it has done on how effective the policy is likely to be among this age group compared to police-led diversion schemes.*

    c) *To what extent the cost of implementing the policy would fall to the devolved administrations.*

County lines

32. We welcome the 10-Year Drug Strategy's commitment to rolling up county lines but increasing law enforcement efforts is only one part of the solution. We therefore welcome the strategy's commitment to reducing demand for drugs and to re-building the drug treatment and recovery sector. We believe that these actions will play an important role in tackling county lines. However, we believe the Government could go further to prevent children and young people from becoming exploited by county lines. (Paragraph 123)

33. To tackle county lines, we believe it is vital that the children and young people exploited (or at risk of exploitation) by criminal gangs are kept out of the criminal justice system. (Paragraph 124)

34. *We recommend the Government build on the harm reduction measures within the strategy by implementing the recommendations on harm reduction outlined in this report, particularly our recommendations on expanding diversion schemes.* (Paragraph 125)

35. *We recommend that the Government work with local partners to link up drug treatment services for children and young people with exploitation services to ensure that they receive holistic support.* (Paragraph 126)

36. *We recommend that the Government consider adopting a statutory definition on Child Criminal Exploitation.* (Paragraph 127)

37. *We welcome the British Transport Police's efforts to improve responses to child exploitation through the secondment of two Prevention Officers from the Children's Society. We recommend that the Government work with other police forces with a dedicated County Lines Taskforce to pilot the inclusion of Prevention Officers within those teams, and the sharing of good practice.* (Paragraph 128)

Project ADDER

38. We found that the holistic, partnership approach adopted by the Project ADDER pilot has been largely well received. We conclude that Project ADDER demonstrates how effective joint responsibility for drug policy between the Home Office and the Department of Health and Social Care can be. (Paragraph 139)

39. *As the Project ADDER pilot is set to continue until 2025, we recommend the Home Office provide us with an interim assessment of the pilot by January 2024. The Home Office must also provide us with an updated assessment of the pilot no more than three months after its conclusion in 2025.* (Paragraph 140)

40. *We recommend that Project ADDER be extended across all of England and Wales if the assessments indicate that the Project is effect in achieving all of its aims: reducing drug-related deaths, drug-related offending, drug use, and disrupting the supply and trafficking of drugs. If the Government does not extend Project ADDER beyond the pilot phase, we recommend that it must make clear how it will preserve the progress made in the existing 13 pilot locations beyond 2025.* (Paragraph 141)

Health-led harm reduction

41. An evidence base for a safe consumption facility in the UK is needed. (Paragraph 149)

42. *We recommend that the Government support the piloting of safe consumption facilities in areas across the UK where there is deemed to be a need by local government and stakeholders.* (Paragraph 149)

43. *In particular, we recommend the Government support a pilot in Glasgow by creating a legislative pathway under the Misuse of Drugs Act 1971 that enables such a facility to operate legally. The pilot in Glasgow must be jointly funded by the Government and the Scottish Government. The Government must work with the Scottish Government and local partners to establish and operate the pilot. The pilot must be evaluated in order to establish a reliable evidence base on the utility of a safe consumption facility in the UK. We repeat the recommendation made by the Scottish Affairs Committee in 2019 that, if the UK Government is unwilling to support this, the power to establish a pilot be devolved to the Scottish Government.* (Paragraph 150)

44. *We recommend that the Home Office and Department of Health and Social Care jointly establish a national drug checking service in England to enable people to submit drug samples by post anonymously. We recommend the Home Office consult stakeholders on how best to implement the service. In particular, we recommend that it learn lessons from the Welsh Government and Welsh partners on the experience of WEDINOS. We believe that, ultimately, a UK-wide drug checking service would provide the most effective approach, and we therefore encourage the UK Government and devolved Governments to consider jointly establishing such a service.* (Paragraph 162)

45. *We recommend the expansion of on-site drug checking services at temporary events such as music festivals and within the night-time economy. We recommend that the Home Office establish a dedicated licensing scheme for drug checking at such events before the start of the summer 2024 festival season. The scheme must devolve the power to grant licences to local authorities.* (Paragraph 163)

46. *We recommend that the Government work with local authorities and health partners to ensure that people receive appropriate psychosocial support in addition to their opioid substitution treatment and ensure that they can continue to access opioid substitution treatment at a pace that meets their needs.* (Paragraph 167)

47. We welcome the 10-Year Drug Strategy's recognition of the potential positive impact of long-acting buprenorphine. We think that the use of Buvidal in Wales has provided a very encouraging UK evidence base and proved that it is an effective form of opioid substitution treatment. (Paragraph 169)

48. *We recommend that the Government go further than its commitment under the 10-Year Drugs Strategy to explore the rollout of long-acting buprenorphine and commit to establishing it as a first-line treatment option in England for people with an opioid dependence.* (Paragraph 169)

49. *We recommend that the Government replicate Scotland's medication-assisted treatment standards in England to ensure that a consistent, minimum standard of care is available to people accessing opioid substitution treatment. In doing so, the*

Government must first consult stakeholders in the medical and drug treatment and recovery sectors on adapting opioid substitution treatment standards in a manner appropriate to England. (Paragraph 171)

50. *We are concerned by reported shortages of prescribed diamorphine, particularly because of the serious impact they may have on the health and lives of patients. As prescribed diamorphine is a viable form of treatment in England, the Government must work with suppliers to ensure that a sustainable supply is available to patients whom clinicians deem suitable for it.* (Paragraph 175)

51. We support the use of DAT supported by wrap-around psychosocial support. The impressive Middlesbrough DAT programme that we witnessed held benefits for both the public health and criminal justice sectors. We are most disappointed that joint local funding from both the health and criminal justice sectors could not be secured for the programme. That said, we recognise the cost of the programme and the difficult decisions that need to be made by local stakeholders when allocating funds to services. Given the rate of opioid-related deaths in England, it is not further consideration that is required from central government, it is swift action. (Paragraph 184)

52. *We repeat the ACMD's 2016 recommendation that the Government provide centralised funding to support the provision of DAT for people with a chronic heroin dependency for whom other forms of OST have not been successful. The centralised funding should first be provided to Foundations Medical Practice in order to re-establish its DAT programme in Middlesbrough as a matter of urgency. The Government should then work with local authorities to identify other locations in England where a DAT programme supported by holistic and wrap-around care is needed.* (Paragraph 185)

53. *We recommend that public health guidance on the provision of diamorphine be changed to allow for the use of multi-dose vials instead of single-use ampoules to mitigate the additional cost and supply chain pressures associated with single-use ampoules.* (Paragraph 186)

54. We are concerned by the effect the Covid-19 pandemic has had on the provision of needle and syringe programmes. The UK must continue its efforts in preventing the spread of blood-borne viruses by ensuring needle and syringe programmes reach as wide a population as possible. (Paragraph 192)

55. *The Combating Drugs Minister must work with the Department of Health and Social Care, the devolved administrations, and health partners to ensure that the provision of equipment—particularly low dead space syringes and safe water—is increased to reduce the transmission of blood-borne viruses and other illnesses. The Combating Drugs Minister must work to ensure that needle and syringe programme providers have the capability and capacity to provide additional services to people presenting to the service, such as blood-borne virus testing.* (Paragraph 193)

56. The evidence on the lifesaving effects of naloxone in counteracting opioid-related overdose is clear. We welcome the national naloxone programmes in the devolved nations but are concerned that no such programme exists in England. We also welcome the joint working between the Government and the devolved

administrations to expand access to naloxone. However, progress is slow. The need to expand and embed naloxone within services and communities is crucial to saving as many lives from opioid-related overdose as possible. (Paragraph 205)

57. *We recommend that the Government establish a national naloxone programme in England to bring it in line with the devolved nations. We also recommend that the Government speed up its work on expanding the provision of naloxone following the UK-wide consultation in 2021. Expanding provision must include any service and person who may come into contact with people who are likely to suffer an opioid-related overdose. In particular, we think that community pharmacists and peer-to-peer programmes are well-positioned in their local areas to supply, distribute and administer this life saving treatment. It must also include enhanced distribution of naloxone to prison leavers.* (Paragraph 206)

58. The efforts of UK police forces to roll out this life saving treatment is welcome. However, provision of naloxone across English forces is not universal, which risks creating a postcode lottery on the availability of this potentially life-saving treatment in England. Further, while we recognise the concerns of some officers to carrying naloxone, we conclude that the saving and preservation of life is too important, particularly when a person's health is in a life-threatening condition due to overdose. (Paragraph 207)

59. *We recommend that the Home Office requires all 43 police forces in England and Wales to roll out the voluntary provision of naloxone by operational officers. Volunteer officers must be provided with adequate training in the carrying and administration of naloxone before they can carry it on duty. The Home Office must provide additional funding to all 43 forces to supply naloxone and to support the training of officers on the administration of naloxone. The Home Office must also work with policing and health partners to devise guidance on the carrying and administration of naloxone for operational police officers. All 43 police forces must record when its officers have administered naloxone, and the surrounding circumstances, in order to better understand the use of the treatment in emergency situations.* (Paragraph 208)

Criminal justice-led harm reduction

60. We support the use of diversion schemes for low-level offences. The use of such schemes by police forces in England and Wales is increasing and we welcome the efforts of those forces in rolling out these schemes. However, we are concerned that the use and substance of diversion schemes can vary across police forces. This can result in the criminal justice system responding differently to individuals for suspected drug-related offences. This postcode lottery is wholly unfair. It is time that a more coordinated, national approach is adopted. (Paragraph 218)

61. *We recommend that the Home Office place a duty on all 43 police forces in England and Wales to establish diversion schemes in their force area for young people and adults who have committed low-level offences. The duty must outline requirements for the diversion schemes in order to ensure a minimum standard that all diversion schemes must satisfy. In drafting the duty, the Home Office must consult with police*

forces and relevant stakeholders on what the minimum standards should include. The Home Office must also publish guidance on the implementation and operation of diversion schemes. (Paragraph 219)

62. *We recommend that police forces record the use of diversion schemes in their force areas to develop a national picture and an understanding of best practice. The Home Office must regularly update the guidance to incorporate this evidence base.* (Paragraph 220)

63. We welcome the increasing adoption of trauma-informed approaches by UK police forces. As drug use—particularly problematic or chronic drug use, can often be a consequence of trauma—we conclude that trauma-informed policing should be extended to situations involving drug use. We believe that this aligns with the Government's commitment to adopting a whole system response to drugs outlined in the 10-Year Drugs Strategy. (Paragraph 224)

64. *We recommend that trauma-informed training and practices be expanded to all 43 police forces in England and Wales. The Home Office must work with police forces and stakeholders to establish training and guidance on trauma-informed policing. The training and guidance should take into consideration the types of trauma associated with drugs and the ways to reduce stigma linked to drugs.* (Paragraph 225)

Cannabis

65. We support cannabis-based products for medicinal use (CBPMs) where there is an evidence base that it can be an effective form of treatment for managing conditions or symptoms. We welcome the ACMD conducting a further assessment of CBPMs following on from its 2020 report. However, we are concerned that there is currently a lack of access on the NHS for patients with a genuine medical need. Access continues to be a problem despite the high-profile cases of Billy Caldwell and Alfie Dingley—two children with severe and rare forms of epilepsy who have received medical cannabis to treat their conditions. (Paragraph 233)

66. *Pending the outcome of the ACMD's review, we recommend that the Government widens the accessibility of unlicensed CBPMs on the NHS before the end of this Parliament.* (Paragraph 233)

67. There is evidence of the potential therapeutic value of CBPMs to treat chronic pain. (Paragraph 234)

68. *We recommend that the Government supports researchers to conduct randomised control trials into the effectiveness of CBPMs to treat chronic pain. If the evidence base supports this, and it is deemed to be cost-effective, we recommend that the Government enables the use of CBPMs for this purpose and works with clinicians to ensure that it is a treatment option in appropriate cases.* (Paragraph 234)

69. We are concerned by the harms that cannabis for non-medical use may pose, particularly in relation to young people. We do not believe that cannabis should be legalised and regulated for non-medical use. (Paragraph 243)

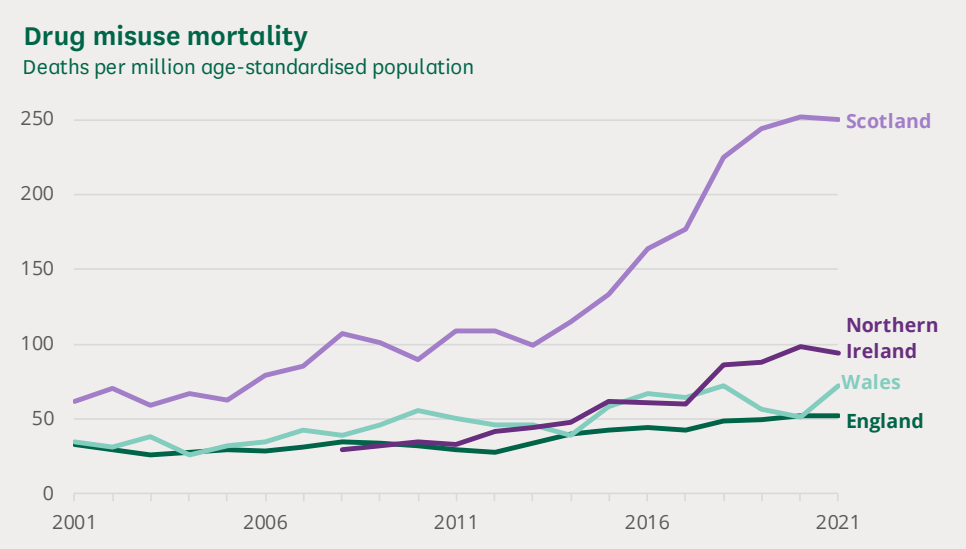
Northern Ireland

70. We are deeply concerned by the role paramilitary groups play in organised drug crime in Northern Ireland, and the impact that this has on local communities, children and young people. We are also deeply concerned by the effect the current political stalemate is having in Northern Ireland and the extent to which it restricts Northern Ireland's response to drugs, among many other issues. However, we welcome the continued efforts of public services and stakeholders to respond to drugs, particularly efforts that adopt a multi-agency response. (Paragraph 248)

71. *In the absence of an operational Northern Ireland Executive and Assembly, the Government must further support officials and communities in Northern Ireland to respond to drugs. This must include support to develop and sustain early intervention and prevention initiatives under the Tackling Paramilitarism, Criminality and Organised Crime Programme, which seeks to draw young people away from paramilitary groups. It must also include the extension of the harm reduction policies outlined in this report.* (Paragraph 249)

Appendix: Drug misuse deaths in the UK

1. As noted in chapter 1, the number of people who have died as a result of drug misuse has continued to rise across the four UK nations.[472]



Note: Comparable age-standardised rates for Northern Ireland are only available from 2008 onwards.

England and Wales

2. In 2021, there were 53.2 drug misuse deaths per million population in England and Wales. The highest number of deaths were among men and those born in the 1970s. For nine consecutive years, the North-East of England had the highest rate of drug misuse deaths (104.1 deaths per million population). The Office for National Statistics (ONS) noted that there was a marked north-south divide in drug misuse deaths in England.[473]

3. The ONS has suggested that the upward trend in drug misuse deaths is mainly driven by deaths involving opiates, which were involved in almost half of all drug poisonings. However, the increase in drug misuse deaths may also be linked to other drugs. Deaths involving methadone and NPS rose "significantly" in 2021 and deaths involving cocaine rose for the tenth consecutive year.[474] Deaths involving benzodiazepines, pregabalin and gabapentin rose by 13%, 18.9% and 12.7% respectively compared to 2020.[475]

472 The term 'drug misuse deaths' is defined by the Office for National Statistics as a death that involves a drug poisoning and meets "either one (or both) of the following conditions: the underlying cause is drug abuse or drug dependence, or any of the substances controlled under the Misuse of Drugs Act 1971 are involved". Office for National Statistics, Deaths related to drug poisoning in England and Wales: 2021 registrations, 3 August 2022, Glossary.

473 Office for National Statistics, Deaths related to drug poisoning in England and Wales: 2021 registrations, 3 August 2022, section 1.

474 Deaths involving methadone rose by 28.5% from 516 in 2020 to 663 in 2021. Deaths involving NPS rose by 88.3% from 137 in 2020 to 258 in 2021. Deaths from cocaine rose from 777 in 2020 to 840 in 2021. Office for National Statistics, Deaths related to drug poisoning in England and Wales: 2021 registrations, 3 August 2022, section 5.

475 Office for National Statistics, Deaths related to drug poisoning in England and Wales: 2021 registrations, 3 August 2022, section 5.

4. The ONS suggests that the increase in drug misuse deaths may be explained by the ageing cohort of people who use drugs who may be at an increased risk of fatal overdose; an increase in polydrug use (which can increase one's risk of overdose); and an increase in disengagement or non-compliance with OST.[476]

Scotland

5. The increase in drug misuse deaths in Scotland has been more pronounced and consistently higher than in the other UK nations. The National Records of Scotland reported that Scotland had a higher rate of drug deaths in 2020 than any other European country.[477] In 2020, deaths peaked at 252 deaths per million (1,339). The rate fell slightly to 250 deaths per million in 2021 (1,330 deaths), but this was still five times higher than for England and three times higher than in Wales and Northern Ireland.[478]

6. Polydrug use was associated with 93% of drug misuse deaths in 2021. Opiates and opioids were the most commonly implicated drugs (84%), a trend that has continued since 2008. Other drugs that have been increasingly implicated in drug misuse deaths include benzodiazepines (in 69%), gabapentin and/or pregabalin (in 36%), and cocaine (in 30%).[479]

Northern Ireland

7. The rate of drug misuse deaths in Northern Ireland peaked in 2020 (182). It fell slightly in 2021 (175). People aged 25 to 44 years old accounted for 54.3% of drug misuse deaths and the death rate for males was over three times the rate for females (14.5 and 4.4. respectively). Deaths continued to be higher in areas of deprivation.[480]

8. As with the rest of the UK, opioids were the most commonly mentioned drug in drug-related deaths (59.2%).[481] Deaths involving benzodiazepines increased to the highest recorded rate (111). Pregabalin has consistently risen since its first appearance in the statistics in 2013; it peaked at 77 in 2019 and fell slightly to 71 in 2021. There was a sharp rise in deaths involving NPS from 11 in 2019 to 73 in 2021. This was primarily driven by flubromazolam, flualzaprolam and etizloam. Cocaine was recorded in 33 deaths—down

476 Office for National Statistics, Deaths related to drug poisoning in England and Wales: 2021 registrations, 3 August 2022, section 7.

477 This comparison was calculated differently to align with the calculation used for other European countries; on this basis, Scotland had a drug-death rate of 327 per million population aged 15–64 in 2020. National Records of Scotland, Drug-related deaths in Scotland in 2021, 28 July 2022, p.20.

478 The three other UK nations had a rate of 52, 72 and 94 drug misuse deaths per million population respectively. National Records of Scotland, Drug-related deaths in Scotland in 2021, 28 July 2022; Office for National Statistics, Deaths related to drug poisoning in England and Wales: 2021 registrations, 3 August 2022; Northern Ireland Statistics and Research Agency, Drug-related and drug-misuse deaths in Northern Ireland, 2021, 24 November 2022.

479 National Records of Scotland, Drug-related deaths in Scotland in 2021, 28 July 2022.

480 Northern Ireland Statistics and Research Agency, Drug-related and drug-misuse deaths in Northern Ireland, 2021, 24 November 2022.

481 The term 'drug-related deaths' is wider than 'drug misuse deaths' and includes deaths involving controlled and non-controlled drugs, prescription medicines and over-the-counter medications. As well as deaths from drug abuse and dependence, these figures include accidental misuse, adverse reactions and suicides involving drug poisonings.

from 36 in 2020. The number of deaths involving antidepressants reached 51, the highest rate recorded.[482] Over two-thirds (68.4%) of drug-related deaths in 2021 involved more than one drug, up from 52.9% in 2011.[483]

482 Northern Ireland Statistics and Research Agency, Drug-related and drug-misuse deaths in Northern Ireland, 2021, 24 November 2022.

483 Northern Ireland Statistics and Research Agency, Drug-related and drug-misuse deaths in Northern Ireland, 2021, 24 November 2022.

Formal minutes

Wednesday 12 July 2023

Members present:

Dame Diana Johnson, in the Chair

Lee Anderson

Paula Barker

Simon Fell

Tim Loughton

Drugs

Draft Report (Drugs) proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 234 read and agreed to.

Paragraphs 235 to 243 read and postponed.

Paragraphs 244 to 249 read and agreed to.

Annex agreed to.

Summary agreed to.

Consideration adjourned.

Adjournment

Adjourned till Wednesday 19 July at 9.15am.

Wednesday 19 July 2023

Members present:

Dame Diana Johnson, in the Chair

Lee Anderson

James Daly

Simon Fell

Carolyn Harris

Marco Longhi

Tim Loughton

Drugs

Draft Report (*Drugs*), consideration resumed.

Paragraphs 235 to 243 read and agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjournment

Adjourned till Wednesday 6 September 2023 at 9.00am.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Wednesday 27 April 2022

Niamh Eastwood, Executive Director, Release; **Dr Kojo Koram**, Lecturer, School of Law, Birkbeck College, University of London; **Dr Karenza Moore**, Lecturer in Sociology of Crime, Newcastle University; **Martin Powell**, Head of Partnerships, Transform Drug Policy Foundation; **Chloe Hartnell**, Partner, Hodge Jones and Allen LLP; **Rudi Fortson QC**, Barrister, 25 Bedford Row Chambers — Q1–34

Wednesday 18 May 2022

Professor Ornella Corazza, Professor of Addiction Science, Hertfordshire University; **Professor Jo Neill**, Professor of Psychopharmacology, Manchester Pharmacy School, Manchester University; **Professor David Nutt**, Professor of Neuropsychopharmacology, Imperial College, London; **Professor Stuart Reece**, Associate Professor of Medicine, University of Western Australia — Q35–63

Dr Owen Bowden-Jones, Chair, Advisory Council on the Misuse of Drugs; **Dr Emily Finch**, Co-chair of the Recovery Committee, Advisory Council on the Misuse of Drugs; **Professor Roger Knaggs**, Chair of the Technical Committee, Advisory Council on the Misuse of Drugs — Q64–117

Wednesday 25 May 2022

Councillor Joanne Harding, Local Government Association; **Maggie Boreham**, City and Hackney Public Health Team, Hackney Council; **Professor Jim McManus**, President of the Association of Directors of Public Health and Director of Public Health, Hertfordshire County Council — Q118–158

Professor Dame Carol Black, independent advisor to the Government on drugs — Q159–193

Wednesday 15 June 2022

John Campbell QPM, Chief Constable, Thames Valley Police; **Serena Kennedy**, Chief Constable, Merseyside Police; **David Thorne**, Assistant Chief Constable, South Wales Police — Q194–229

Andy Dunbobbin, North Wales Police and Crime Commissioner; **Zoe Metcalfe**, Police, Fire and Crime Commissioner for North Yorkshire and the City of York; **David Sidwick**, Police and Crime Commissioner for Dorset — Q230–264

Wednesday 29 June 2022

Charlie Doyle, Assistant Chief Constable, British Transport Police; **Dr Richard Lewis**, Drugs lead for the National Police Chiefs' Council and Chief Constable of Dyfed-Powys Police; **Steve Rodhouse**, Director General of Operations, National Crime Agency — Q265–313

Dr Jack Spicer, Lecturer in Criminology, University of the West of England; **Junior Smart OBE**, Business development manager and head of SOS Gangs Project, St Giles Trust; **Nicky Hill**, Head of Services, Abianda — Q314–344

Wednesday 22 February 2023

Angela Constance, MSP, Minister for Drugs Policy, Scottish Government Q345–376

Rt Hon Chris Philp MP, Combatting Drugs Minister and Minister for Crime, Policing and Fire, Home Office; **Marcus Starling**, Deputy Director of the Drug Misuse Unit, Crime Reduction Directorate, Home Office; **Caroline Hart**, Deputy Director for Drugs Supply and County Lines, Home Office Q377–423

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

DRU numbers are generated by the evidence processing system and so may not be complete.

1 Alliance for rights-oriented drug policies (AROD) (DRU0010)

2 Anonymised (DRU0098)

3 Anonymised (DRU0112)

4 Anonymised (DRU0111)

5 Anonymised (DRU0037)

6 Anonymised (DRU0104)

7 Anonymised (DRU0101)

8 Anonymised (DRU0069)

9 Anonymised (DRU0063)

10 Anonymised (DRU0053)

11 Anonymised (DRU0038)

12 Anonymised (DRU0036)

13 Anonymised (DRU0031)

14 Anonymised (DRU0017)

15 Anonymised (DRU0016)

16 Anonymised (DRU0103)

17 Antoniazzi, Tonia (Co-Chair of The All-Party Parliamentary Group on Access to Medical Cannabis Under Prescription) (DRU0024)

18 APPG for Drug Policy Reform (DRU0070)

19 APPG for Drugs, Alcohol and Justice (DRU0093)

20 Anyone's Child: Families for Safer Drug Control (DRU0044)

21 Araujo, Dr Felipe Neis (Research Associate , The Department of Criminology, The University of Manchester) (DRU0019)

22 Association of Police and Crime Commissioners (DRU0078)

23 Baker, Rt Hon Norman (Consultant / author, Freelance) (DRU0005)

24 Barrow Cadbury Trust Transition to Adulthood Alliance (DRU0059)

25 Berlusconi, Dr Giulia (Lecturer in Criminology, University of Surrey) (DRU0076)

26 Boots UK (DRU0048)

27 Brains Bioceutical (DRU0109)

28 Brick, Dr Carlton (Lecturer in Sociology, University of the West of Scotland) (DRU0040)

29 Bristol Drugs Project (DRU0022)

30 CLIVE, Preventing Drug-Related Death (Lecturer (R), University of Essex) (DRU0061)

31 Campello, Giovanna Hickman, Professor Matthew and Philpott, Dr Jane (DRU0123)

32 Camurus Ltd. (DRU0055)

33 Cancard (DRU0023)

34 Centre for Justice Innovation (DRU0068)

35 Changing Lives (DRU0082)

36 Collective Voice (DRU0060)

37 Corken, Mr Ben (Rough Sleeping Navigator, Change, Grow, Live) (DRU0009)

38 Cranstoun (DRU0067)

39 Criminal Justice Alliance (DRU0090)

40 D.Tec International Ltd. (DRU0013)

41 Doyle, Charlie (Assistant Chief Constable, British Transport Police) (DRU0108)

42 Drug Science (DRU0056)

43 Engagement event with drug treatment and recovery sector (DRU0122)

44 Faculty of Public Health and the Association of Directors of Public Health (DRU0096)

45 Grace, Ms Sharon (Senior Lecturer/Deputy Head of Department, Department of Social Policy and Social Work, University of York); Lloyd, Professor Charlie (Professor, Department of Social Policy and Social Work, University of York); and Page, Dr Geoff (Associate Lecturer, Department of Social Policy and Social Work, University of York) (DRU0074)

46 Grainger, Mr Ross (DRU0008)

47 Green Party of England and Wales (DRU0087)

48 Health Poverty Action (DRU0095)

49 Hitchens, Peter (DRU0041)

50 Home Office (DRU0118)

51 Home Office (DRU0080)

52 Jazz Pharmaceuticals (DRU0054)

53 Jones, Mr (DRU0007)

54 Kennett, Mr Dylan (Solicitor, DLA Piper); Owen, Mr Tim (Barrister and Queen's Counsel, Matrix Chambers); and Ford, Ms Laura (Solicitor, DLA Piper) (DRU0064)

55 Law Enforcement Action Parternship UK (LEAP UK) (DRU0052)

56 Lived experience roundtables (DRU0121)

57 Local Government Association (DRU0084)

58 Long, Naomi (Justice Minister, Northern Ireland Department for Justice) (DRU0113)

59 Marks, Amber (Lecturer in Law, Queen Mary, University of London) (DRU0020)

60 Baroness Meacher; and Neil Woods (DRU0105)

61 Moss, Jack (ABI Rehabilitation Support Coach at TRU) (DRU0034)

62 Murphy, Philip (DRU0092)

63 National AIDS Trust (DRU0094)

64 National Police Chiefs' Council (DRU0079)

65 Neill, Professor Jo (Professor of Pharmacology, The University of Manchester); Tai, Dr Sara (Senior Lecturer in Clinical Psychology, The University of Manchester); and Gigg, Dr John (Senior Lecturer in Neuroscience and Experimental Psychology, The University of Manchester) (DRU0062)

66 North Yorkshire Police and Crime Commissioner (DRU0099)

67 Office of the West Midlands Police and Crime Commissioner (DRU0066)

68 Police Service of Northern Ireland (DRU0088)

69 Police Service of Northern Ireland (DRU0089)

70 Policing in Wales (DRU0091)

71 Preston, Mx John (DRU0047)

72 Raynes, David (DRU0043)

73 Reece, Dr Stuart (Professor, University of Western Australia) (DRU0026)

74 Release (DRU0107)

75 Release (DRU0075)

76 Reynolds, Mr Peter (Expert in the Science, Medicine, Law and Politics of Cannabis, Self) (DRU0050)

77 Royal Pharmaceutical Society (DRU0035)

78 Scottish Drugs Death Taskforce (DRU0102)

79 Scottish Government (DRU0117)

80 Scottish Government (DRU0100)

81 Sidwick, David (Dorset Police and Crime Commissioner) (DRU0110)

82 Simmons, Mr John (Visiting Lecturer, Hertfordshire Business School – University of Hertfordshire) (DRU0015)

83 Social Market Foundation (DRU0086)

84 Spicer, Dr Jack (Lecturer in Criminology, University of the West of England) (DRU0027)

85 Stevens, Professor Alex (DRU0014)

86 The Christian Institute (DRU0085)

87 The Company Chemists' Association (DRU0025)

88 The Conservative Drug Policy Reform Group (DRU0071)

89 The Hepatitis C Trust (DRU0065)

90 Transform Drug Policy Foundation (DRU0106)

91 Transform Drug Policy Foundation (DRU0097)

92 Turning Point Scotland (DRU0057)

93 UK Health Security Agency (DRU0049)

94 Villadsen, Dr Aase (Research Associate, University College London); and Fitzsimons, Emla Professor (Professor of Economics, University College London) (DRU0021)

95 Visit to Glasgow and Belfast (DRU0119)

96 Visit to Middlesbrough (DRU0120)

97 Volteface (DRU0114)

98 Volteface (DRU0073)

99 Welsh Government (DRU0081)

100 Welsh Deputy Minister for Mental Health and Wellbeing (DRU0124)

101 West Yorkshire Combined Authority (DRU0018)

102 WithYou (DRU0115)

103 Wright (DRU0011)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

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Number	Title	Reference
1st	Channel crossings, migration and asylum	HC 199
2nd	Asylum and migration: Albania	HC 197
4th	Terrorism (Protection of Premises) draft Bill	HC 1359
1st Special Report	The Macpherson Report: twenty-two years on: Government Response to the Committee's Third Report of Session 2021–22	HC 274
2nd Special Report	Spiking: Government Response to the Committee's Ninth Report of Session 2021–22	HC 508
3rd Special Report	The investigation and prosecution of rape: Government Response to the Committee's Eighth Report of Session 2021–22	HC 507
4th Special Report	Channel crossings, migration and asylum: Government Response to the Committee's First Report	HC 706

Session 2021–22

Number	Title	Reference
1st	Violence and abuse towards retail workers	HC 141
2nd	The UK's offer of visa and settlement routes for residents of Hong Kong	HC 191
3rd	The Macpherson Report: Twenty-two years on	HC 139
4th	Appointment of the Chair of the Gangmasters and Labour Abuse Authority	HC 814
5th	The Windrush Compensation Scheme	HC 204
6th	Police Conduct and Complaints	HC 140
7th	Appointment of Her Majesty's Chief Inspector of Constabulary and Her Majesty's Chief Inspector of Fire & Rescue Authorities in England	HC 1071
8th	Investigation and prosecution of rape	HC 193
9th	Spiking	HC 967
1st Special Report	Violence and abuse towards retail workers: Government Response to the Committee's First Report	HC 669

Number	Title	Reference
2nd Special Report	The UK's offer of visa and settlement routes for residents of Hong Kong: Government Response to the Committee's Second Report	HC 682
3rd Special Report	The Windrush Compensation Scheme: Government Response to the Committee's Fifth Report	HC 1098
4th Special Report	Police conduct and complaints: Government Response to the Committee's Sixth Report	HC 1264

Session 2019–21

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1st	Home Office preparedness for Covid-19 (Coronavirus): Policing	HC 232
2nd	Home Office preparedness for Covid-19 (Coronavirus): domestic abuse and risks of harm within the home	HC 321
3rd	Home Office preparedness for Covid-19 (coronavirus): immigration and visas	HC 362
4th	Home Office preparedness for COVID-19 (Coronavirus): institutional accommodation	HC 562
5th	Home Office preparedness for COVID-19 (coronavirus): management of the borders	HC 563
6th	Appointment of the Independent Chief Inspector of Borders and Immigration	HC 1024
1st Special Report	Serious Youth Violence: Government Response to the Committee's Sixteenth Report of Session 2017–2019	HC 57
2nd Special Report	Home Office preparedness for Covid-19 (coronavirus): domestic abuse and risks of harm: Government Response to the Committee's Second Report	HC 661
3rd Special Report	Home Office preparedness for Covid-19: coronavirus: policing: Government Response to the Committee's First Report	HC 660
4th Special Report	Home Office preparedness for COVID-19 (coronavirus): immigration and visas: Government Response to the Committee's Third Report	HC 909
5th Special Report	Home Office preparedness for COVID-19 (coronavirus): institutional accommodation: Government Response to the Committee's Fourth Report	HC 973
6th Special Report	Home Office preparedness for COVID-19 (coronavirus): management of the borders: Government Response to the Committee's Fifth Report	HC 974