House of Commons

Home Affairs Committee

Drugs: Breaking the Cycle

Ninth Report of Session 2012–13

Volume II

Oral and written evidence

Additional written evidence is contained in Volume III, available on the Committee website at www.parliament.uk/homeaffairscom

Ordered by the House of Commons to be printed 3 December 2012

HC 184-II
Published on 10 December 2012
by authority of the House of Commons
London: The Stationery Office Limited
£20.50

Home Affairs Committee

The Home Affairs Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Home Office and its associated public bodies.

Current membership

Rt Hon Keith Vaz MP (*Labour, Leicester East*) (Chair)
Nicola Blackwood MP (*Conservative, Oxford West and Abingdon*)
James Clappison MP (*Conservative, Hertsmere*)
Michael Ellis MP (*Conservative*, *Northampton North*)
Lorraine Fullbrook MP (*Conservative, South Ribble*)
Dr Julian Huppert MP (*Liberal Democrat, Cambridge*)
Steve McCabe MP (*Labour, Birmingham Selly Oak*)
Bridget Phillipson MP (*Labour, Houghton and Sunderland South*)
Mark Reckless MP (*Conservative, Rochester and Strood*)
Karl Turner MP (*Labour, Kingston upon Hull East*)
Mr David Winnick MP (*Labour, Walsall North*)

The following Member was also a member of the Committee during the Parliament.

Rt Hon Alun Michael MP (*Labour & Co-operative, Cardiff South and Penarth*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publication

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/homeaffairscom.

Committee staff

The current staff of the Committee are Tom Healey (Clerk), Richard Benwell (Second Clerk), Ruth Davis (Committee Specialist), Eleanor Scarnell (Committee Specialist), Andy Boyd (Senior Committee Assistant), Michelle Garratty (Committee Assistant), Iwona Hankin (Committee Support Officer) and Alex Paterson (Select Committee Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Home Affairs Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 3276; the Committee's email address is homeaffcom@parliament.uk.

Witnesses

Tuesday 24 January 2012 **Page**

Sir Richard Branson, Global Commission on Drugs Policy, and **Dame Ruth Dreifuss**, Global Commission on Drugs Policy Ev 1

Dame Ruth Runciman, Chair, and **Roger Howard**, Chief Executive, UK Drug Policy Commission Ev 8

Tuesday 21 February 2012

Paul Tuohy, Mentor, and **Maryon Stewart**, the Angelus Foundation Ev 14

Wendy Dawson, Chief Executive, The Ley Community, **Dominic Ruffy**, RehabGrads and **Adam Langer** Ev 19

Professor John Strang, Director of the National Addictions Centre Ev 24

Thursday 22 March 2012

Professor Averil Mansfield, Chair of the Board of Science, British Medical Association, **Dr Owen Bowden-Jones**, Chair, Faculty of Addictions, Royal College of Psychiatrists, and **Dr Clare Gerada**, Chair, Royal College Of General Practitioners Ev 28

Paul Hayes, Chief Executive, National Treatment Agency Ev 34

Tuesday 24 April 2012

Russell Brand, former drug-user, and **Chip Somers**, Chief Executive, Focus 12 Ev 39

Mary Brett, former Vice-President of Eurad, Member of Prisons and Addictions Forum at the Centre for Policy Studies, Trustee of CanSS, **Kathy Gyngell**, Chair, Prisons and Addictions Forum and Research Fellow at the Centre for Policy Studies and **Peter Hitchens**, journalist and author Ev 44

Tuesday 19 June 2012

Professor David Nutt, Independent Scientific Committee on Drugs and former Chairman of the Advisory Council on the Misuse of Drugs and **Dr Les King**, former ISCD and former ACMD member Ev 52

Professor Les Iversen, **Professor Ray Hill**, and **Annette Dale-Perera**, Advisory Council on the Misuse of Drugs Ev 60

Tuesday 3 July 2012

Richard Bradshaw, Director of Offender Health, National Offender Management Service and **Digby Griffith**, Director of National Operational Services, National Offender Management Service Ev 65

Rt Hon Kenneth Clarke QC MP, Lord Chancellor and Secretary of State for Justice Ev 68

Tuesday 11 July 2012

Danny Kushlick, Transform Drug Policy Foundation and **Niamh Eastwood**, Release Ev 76

Chief Constable Tim Hollis CBE, QPM, Association of Chief Police Officers, and **Tom Lloyd**, former Chief Constable of Cambridgeshire Ev 82

Trevor Pearce, Director General, Serious Organised Crime Agency Ev 89

Tuesday 30 October 2012

Lord Turner, Chairman, Financial Services Authority and **Tracey McDermott**, Financial Services Authority Ev 93

List of printed written evidence

1	Dr Leslie King	Ev 99, Ev 103
2	Mary Brett	Ev 104, Ev 107
3	UK Drug Policy Commission	Ev 109
4	Mentor	Ev 117
5	National Treatment Agency for Substance Misuse	Ev 121, Ev 124
6	Serious Organised Crime Agency	Ev 125, Ev 128, Ev 129
7	Tom Lloyd	Ev 129
8	Release	Ev 133
9	Independent Scientific Committee on Drugs	Ev 138
10	Angelus Foundation	Ev 139
11	Royal College of Psychiatrists	Ev 143
12	Kathy Gyngell	Ev 147, Ev 151
13	Transform Drug Policy Foundation	Ev 152, Ev 157
14	Adam Langer	Ev 161
15	RehabGrads	Ev 165
16	Peter Hitchens	Ev 168
17	Home Office	Ev 170, Ev 176
18	Association of Chief Police Officers	Ev 177
19	Advisory Council on the Misuse of Drugs	Ev 181, Ev 188
20	Russell Brand	Ev 189
21	Ministry of Justice	Ev 191
22	Royal College of General Practitioners	Ev 194
23	Professor John Strang	Ev 195
24	Transcript of conference held in Portcullis House on 10 September 2012	Ev 196

Oral evidence

Taken before the Home Affairs Committee

on Tuesday 24 January 2012

Members present:

Keith Vaz (Chair)

Nicola Blackwood	Alun Michael
Lorraine Fullbrook	Mark Reckless
Dr Julian Huppert	Mr David Winnick
Steve McCabe	

Examination of Witnesses

Witnesses: **Sir Richard Branson**, Global Commission on Drug Policy, and **Dame Ruth Dreifuss**, Global Commission on Drug Policy, gave evidence.

Chair: I invite our two witnesses to come to the dais. May I ask members of the Committee to declare any interests over and above what is in the Register of Members' Interests?

Dr Huppert: I am vice-chair of the all-party parliamentary group on drug policy reform.

Nicola Blackwood: I am patron of the Ley Community, which is a drugs and alcohol rehabilitation centre in Oxfordshire.

Q1 Chair: Thank you.

Sir Richard, Federal Councillor Dreifuss, thank you very much for coming to give evidence today. This is the Committee's first evidence session in our major inquiry into drugs. The last time the Committee considered this question was 10 years ago; in fact, I think only Mr Winnick is a survivor of the last report. We made a number of recommendations, not all of which were accepted by the Government then, or indeed have been accepted now. We will be looking again at those recommendations and also at the development of drug policy over the past 10 years. As we all know, the number of people who use drugs has increased enormously and therefore the work of the Commission is of great interest to us.

Sir Richard, in your article in *The Daily Telegraph* yesterday, you said that that the war on drugs had been lost and basically that policymakers all over the world had spent a trillion dollars on fighting this war to no effect. Why did you say that?

Sir Richard Branson: We wondered whether we could make literally just a 30-second statement, just to open up, if that is possible.

Chair: Yes, certainly.

Sir Richard Branson: First, I would like to thank you and the members of the Home Affairs Select Committee for inviting Ruth and myself to give evidence on the findings of the Global Commission on Drug Policy. We understand that this is the first hearing for 10 years, and we welcome the opportunity to give evidence and to answer questions.

The Global Commission investigated in depth the workings over 50 years of the existing drug control system and we found that it had totally failed to stop the growth of the drug trade. The commission proposed a few simple principles to change how Governments deal with drugs. First, drug policy should be based on scientific evidence and empirical data. Secondly, drug policy should focus on the rights of citizens and on protecting public health to stop unnecessary suffering. Thirdly, Governments should take a flexible approach to drug policy co-ordination, and Governments around the world have started to recognise the waste and the human toll of our existing approach. There are models to look at such as Switzerland, Germany, the Netherlands and Portugal, where decriminalisation 10 years ago has led to a large reduction in heroin use and other drug use, and massive drops in property crimes, HIV infections and violence.

I hope that this hearing can start a new debate around drugs policy and we look forward to discussing this with you today. We need obviously to reduce the crime, health and social problems associated with drug markets in whatever way is the most effective. Also, if I may just ask Ruth to say a couple of words herself.

Q2 Chair: Federal Councillor, could you be very brief because we are going to ask you a lot of questions. You were for 10 years the Chairman of your own Committee in Switzerland, so you know that Members are keen to ask questions.

Dame Ruth Dreifuss: Exactly, so I just want to say on which points I can give some evidence from my experience and as a member of the Global Commission. As you say, I was for 10 years Minister of Health and, as such, responsible for drug policy in Switzerland. During the time of my responsibility, we introduced a change in the law and introduced new kinds of harm reduction measures and treatments so, in this field, I think I can give you some evidence you want to hear.

Q3 Chair: That is why you are here—both you and Sir Richard—to answer questions on the commission, and Members will have questions to put to you.

Going back to my initial question, why was it lost? The commission consists of five ex-Presidents, a former Secretary-General of the United Nations and a former US Treasury Secretary. All these people—your fellow commissioners—including Federal Councillor

Dreifuss were in charge of this policy, but you are saying it failed. Why did it fail?

Sir Richard Branson: I think that most of these Presidents who are now on the Commission feel that they made the wrong decisions when they were in power and in a position to do something about it, and that is why they decided to become members of the Commission. I think Ruth is one of the few exceptions to that because she did do a lot in Switzerland that made a big difference there. Most of the commissioners feel they made the wrong choices in trying effectively to do to drugs what was done to alcohol for 20 years in America: trying to deal with it as a criminal problem rather than a health problem. What the Commission did was to look at countries like Portugal, Switzerland and other countries, and to realise that there were better ways.

Q4 Chair: We are coming on to Portugal. Thank you for raising Portugal, but it is different from the United Kingdom though. The three biggest countries in Europe for the consumption of drugs are the United Kingdom, France and Italy; Portugal and Switzerland are very small countries. When you went over and congratulated the Portuguese on decriminalisation, did you not see an increase in drug use? Did you see an increase or decrease in drug use?

Sir Richard Branson: A decrease. First of all, yes, Portugal is a smaller country than Britain, but if you break Britain up into smaller units and tackle it city by city, I think there is no reason why you should not get the same results as in Portugal. Ten years ago, Portugal had a massive drug problem—heroin was rampant. They decided to move drugs from the Home Office to the Health Department, and they said to the Health Department, "You are now in charge. Nobody will be sent to prison in Portugal," and not one person has been sent to prison for taking drugs in the Past 10 years. They have then, if you look at heroin, set up places where people can go to get clean needles throughout Portugal, and they have helped people who have heroin problems get off heroin. The number of people taking heroin has dropped by 50%.

Q5 Chair: Federal Councillor, you are a politician. The message that goes out if you decriminalise, even in a country like Switzerland, is pretty stark. Does it not send the wrong message to the public in that if you decriminalise, it actually says that you can use these drugs?

Dame Ruth Dreifuss: No, the contrary. If you say it is a public health problem, you have to cure people who are ill—who are dependent on the drug. I think that is a stronger message than if you criminalise them. I am sure also that young people—and they are the ones we need to avoid entering in drug consumption—do not want to be considered as ill people. They want to have a kick; they want to experiment something perhaps at the margin of what is allowed. When you medicalise it, it is exactly the thing that can avoid them entering into that. We had no increase in consumption in Switzerland during the 15 years of experimenting and introducing the new policy. I think the main problem is that we are confronted with criminal organisations changing the substance and bringing in new things—new "kicks", if I may use that word—and that is the problem.

Q6 Chair: We will come on to that. Finally from me, I do not know whether you have seen in the papers this morning that new sentencing guidelines have been proposed under which there is going to be more leniency to those who are regarded as mules who carry drugs, even unwittingly, and, in effect, tougher sentences on those who deal in drugs. Would you support those who are caught in the middle of this whole issue—a retail trade that is worth £332 billion in the United States—should be treated more leniently than those who are organised criminals involved in this?

Sir Richard Branson: The commission has asked countries to experiment with different scenarios from in the past, and it has said that it feels that mules should be treated more leniently than the people behind the mules, who often resort to violence and major criminal activities, and that they should come down hard on those people. For the courts to decide that fines are more appropriate than prison sentences, I suspect that other members of the commission would welcome that.

Dame Ruth Dreifuss: Yes, I think you have to have punishments that are proportional and efficient. You have to have a different tariff, I would say, for different types of crime. Mules and street dealers are not the aim we have to put all our means on, but the criminal organisations are the aim we have to pursue.

Q7 Alun Michael: You referred to that aspect of the policy, as did the Sentencing Council. The Sentencing Council seems to have said nothing about what works in terms of reducing supply. Do you have any comment on that?

Dame Ruth Dreifuss: I did not exactly catch your question. Can you repeat it?

Alun Michael: The question that I believe is very important in dealing with what level a sentence should be is: what works in terms of reducing whatever the nuisance is that you are seeking to address? Do you have anything to say about the effectiveness of sentencing?

Dame Ruth Dreifuss: I think we have to look at which kind of sentence and the harms of such sentences. For instance, for a young—

Q8 Alun Michael: That is a different issue, with respect. I was just asking specifically about what works in terms of reducing supply. If you do not have any evidence on that, that is fine.

Dame Ruth Dreifuss: The question of supply is, from my own experience, terribly simple. You take somebody from the street—a street dealer—and then the day after you have another man standing at the same place.

Q9 Alun Michael: Sir Richard, in what was a very succinct summary of your position at the beginning—and I congratulate you on that; they are usually much longer—you ran through a number of countries where you said that decriminalisation had been tried and had been effective. Within those you referred to Holland,

which is very often cited as an example. I looked at the situation of Holland some years ago; in fact, they did not decriminalise drug use. What they did was introduce a policy on policing and enforcement of tolerance, as long as things were not getting out of hand, and they then moved away from that approach as the result of the impact of drug tourism on their cities. Why do you cite that as an example of success?
Sir Richard Branson: The decriminalisation was a reference to Portugal. Portugal is the one country that has decriminalised all drugs, so not one person has gone to prison in the last 10 years. That has saved the country a lot of money in prison costs.

Q10 Alun Michael: So you were not drawing a similar parallel in relation to Holland?
Sir Richard Branson: No, that was simply Portugal.
Dame Ruth Dreifuss: May I add something?
Chair: If you could do it briefly, because we will cover these issues.
Dame Ruth Dreifuss: Just on Holland, this tolerance was reduced so as not to have a conflict with neighbour countries but, for their own population, the Netherlands continues to have the same policy because they think it is reducing dealing and the harm of having the open deal in the streets. I know this also from Switzerland; we had to look with our neighbour countries at how to have a known policy without jeopardising their rules, and this is very important, I think.

Q11 Lorraine Fullbrook: Sir Richard, I would like to go back to some of the comments you made about Portugal. You said that heroin use had reduced by 50%. Therefore, there are still 50% of people who were previously using heroin are still using heroin, and they are given clean needles, which presumably are supplied by the Health Department in Portugal. Who supplies the heroin to those 50% of users?
Sir Richard Branson: Presumably it is illegally supplied to them.

Q12 Lorraine Fullbrook: So that does not take out the Mr Bigs from the drug—
Sir Richard Branson: A reduction of 50% is a great step in the right direction. It is not just a reduction in heroin; there has been a reduction in other drugs as well. The number of deaths related to heroin has dropped by over 50% as well, and the number of HIV infections has dropped by over 50%.

Q13 Lorraine Fullbrook: But that is presumably because clean needles have been used.
Sir Richard Branson: Exactly, it is a combination. In England, drugs are not regulated at all and there is no checking on drugs. Three people died in hospital recently from taking ecstasy tablets, but they were not ecstasy tablets. They were laced with PMA, so the kids did not know what they were taking. At the moment it is a completely unregulated market with nobody checking up on what our kids are taking.

Q14 Lorraine Fullbrook: But there is still, surely, a criminal element within Portugal where people are buying heroin?
Sir Richard Branson: Yes. What the commission has said is that it wants countries to experiment with new systems. Portugal's particular system is to say, "Nobody who takes drugs will be put in prison, but we are not regulating and taxing drugs," so they have not gone that far. Therefore, you still do have an underground world selling drugs, but much less so, because if people can get methadone treatment from clinics set up by the Government, they do not have the need to go into the underworld to get their drugs. Most people now go to the clinics and then when they are ready to wean themselves off drugs, instead of them being frightened about being put in prison, there is somebody there to advise them on how to get help and get off drugs.
Dame Ruth Dreifuss: May I just add that Switzerland—
Chair: Yes, we will come on to Switzerland a little bit later.
Dame Ruth Dreifuss: I mean there is legal heroin also.

Q15 Nicola Blackwood: Sir Richard, in your article yesterday, one of your paragraphs said, "Drugs are dangerous and ruin lives. They need to be regulated". In the UK, obviously we have full criminalisation, but we still allow the police force discretion as to whether to charge or to offer diversion programmes into treatment. Can I ask what specific improvements of the UK regulation you would recommend?
Sir Richard Branson: At the moment in the UK 100,000 young people are arrested every year for taking drugs, and the figures are growing. Some 75,000 of those young people are given criminal records, which means it might be difficult for them to travel or get passports to certain countries. What the commission would urge is that by moving drugs into the Health Department and away from the Home Office, if people have problems, just like in Portugal, they should go in front of a panel of health experts to try to help them. If my brother or sister has a drug problem or my children have a drug problem, I do not want the law to get involved, and I do not think that most people I know would want the law to get involved. We would want them to get help.

Q16 Nicola Blackwood: Have you studied the Home Office's drug strategy?
Sir Richard Branson: I have not myself personally; I am sure that the commission as a whole would have done.

Q17 Nicola Blackwood: The drug strategy does include early intervention for young people and families, intensive support for young people, and a number of policies that include the Department for Education, the Department of Health—all the different Departments—that are intended to provide diversion programmes and avoid exactly the routes that you are proposing. What I am asking is: are there specific regulatory policy changes that you think would change the route processes you are criticising?
Sir Richard Branson: That may be the case in writing, but there are still 100,000 young people.

Q18 Nicola Blackwood: This is a new strategy. It has just been published.
Sir Richard Branson: Okay. Then if, next year, those 100,000 people are not prosecuted for taking drugs but are helped—and particularly if those people who have serious drug problems are helped—I think that the commission would welcome Britain doing that. The commission is not saying, "This is how each individual country should behave." We are just suggesting that the current way does not work; let's come up with new ways.

Q19 Dr Huppert: Thank you very much to both of you for coming to speak. Following on from Lorraine Fullbrook's questions, when the Misuse of Drugs Act 1971 was passed, the vision was that it would eliminate all illegal drug use within this country. I think we clearly have not achieved that; a 50% reduction would be quite a good step. Are you familiar with the recent report from the European Monitoring Centre for Drugs and Drug Addiction that came out earlier? It says that despite the UK's spend on drug strategy—I think it is 0.48% of GDP—it is in the top few for use of cannabis, top for amphetamines, top for ecstasy, and second for cocaine, although that was the highest for use by young people in the last year, so we will probably catch up there. Given that we are spending more than any other European country and having the worst outcomes, does that suggest that we ought to have a rather different strategy?
Sir Richard Branson: Yes.
Chair: We like brief answers.

Q20 Dr Huppert: May I follow up on that? As I understand it, and you may know more than I do, the UK and Ireland are the only two countries in Europe where the lead agency to deal with drug strategy is the Home Office or its equivalent. I think in Malta it is the Prime Minister's office; everywhere else it is a health lead. How important is what the lead agency is—whether we start off thinking of it as a public health problem or a criminal justice problem?
Sir Richard Branson: Extremely important. I think if it comes under health, it will be treated as a health issue, and every single bit of concern will be about the individual and making sure that they get better, especially those people who have had too much alcohol or drugs. They should be helped. The commission urges Governments to treat drugs as a health issue, not a criminal issue.
Dame Ruth Dreifuss: In Switzerland, my experience is that we began to change our policy because it was a sanitary urgency with the continuation of the pandemic of AIDS, and also because the police force was despairing about having an endless job, beginning always with the same people and the same ineffective activities. I think they were very happy to have the leadership of the Health Ministry, but it was also our duty to have a good collaboration between all people working at the front on drug problems. I think the most important thing is that they learned to co-operate, to understand also the different practice and to help each other. Just to take one example: at the beginning, the police took syringes as evidence for the crime. You could have a place where you received clean syringes and policemen were taking them just after this distribution. We have to learn to work together, and I think this was an important process in Switzerland, but under the lead of the health authority.

Q21 Dr Huppert: Was there still a good relationship and involvement with the police agencies to deal with organised crime and those groups that siphon off a huge amount of the money?
Dame Ruth Dreifuss: I think the police have to concentrate on the organised crime. They also have to concentrate on money laundering and the global issue of drug trafficking. The fight in the streets—with the people involved in the street deal—is just a hopeless fight.

Q22 Chair: We will come on to criminality later on. Sir Richard, you did mention the fact that it was a health issue, but you are on record as saying that you have smoked cannabis. Is that right?
Sir Richard Branson: I would say that 50% of my generation have smoked cannabis and that 75% of my children's generation have smoked cannabis. There are between 3 million and 5 million cannabis smokers in the UK.

Q23 Chair: It has not been detrimental to your health or the health of anyone you know?
Sir Richard Branson: If I was smoking cigarettes, I would be extremely worried.

Q24 Mr Winnick: Perhaps it is a generational matter, Sir Richard. I must confess, if it is a matter for confession, that I have never taken a drug in my life, apart from prescriptions.
Sir Richard Branson: I think that is generally wise.
Chair: May I say to members of the Committee that there is no need for further confessions? One is enough.

Q25 Mr Winnick: When you advocate decriminalisation—there will be other questions about that—can we get it absolutely clear that you are in fact recommending is the sort of policy practised in Switzerland, Portugal and Holland. Am I right?
Sir Richard Branson: The commission is suggesting that policies like Portugal's or Switzerland's are ones with which Governments should consider experimenting. If Governments in some countries wish to go further with, say, cannabis, by deregulating and taxing cannabis, that is something we think they should experiment with as well, because at least you can then make sure that the cannabis is of good quality. I mean, skunk is something that is too strong, whereas almost normal marijuana is found by *The Lancet* and other magazines and studies to be less harmful than alcohol. All the commission is saying is let us experiment with different approaches than have happened up to now.

Q26 Mr Winnick: Sir Richard, there is no question, therefore, of advocating that drugs of the sort we are talking about should be sold, say, in supermarkets like cigarettes or alcohol with the phrase "Buy some

heroin and you will get cannabis free"? There is no question of that being your policy.
Sir Richard Branson: The drug commission has not advocated policies as such. It is asking Governments and organisations like your own to look at what is right for particular countries, and obviously we would not advocate heroin or cocaine to be sold in supermarkets.

Q27 Mr Winnick: Would I be right to take the view that among the strongest upholders of the status quo in Britain would be the drug criminals and the drug barons? Sometimes, as we know, such criminals are acting on the international scene. Wouldn't they have a very strong interest that the status quo—successive Governments have pursued such a policy—should be maintained?
Sir Richard Branson: Absolutely.
Dame Ruth Dreifuss: It is clear. There is now the possibility to make big money with the trafficking of drugs. The regulation of this market by the state would take away this possibility for making big money. We have figures on how a gram of cocaine is gaining value between the producer and the end consumer in the States. It is clear, yes. I would say that the biggest interest for maintaining the status quo in the field of repression and law enforcement is the criminal organisations.
Sir Richard Branson: It is estimated that $300 billion a year goes into the underworld from drugs.

Q28 Nicola Blackwood: Federal Councillor, we have heard a little bit from you already about the shift in Switzerland by moving the focus of drugs policy from essentially what we would have as the Home Office to the Department of Health, and therefore considering it as a disease issue—an addiction issue, rather. Can you tell us, first, how you managed that politically? In the UK, there is a real difficulty with focusing that level of resource on drugs policy as a public health issue rather than a criminal issue.
Dame Ruth Dreifuss: First, we have still law enforcement and it is still the one of the four pillars that takes most money—more than treatment, prevention and harm reduction. The process was very interesting. It began with multi-partisan research of solutions, and I think that your Committee will also do a big step in this direction. Several parties were looking for a change in the policy in the situation of emergency. We had a large demand from cities, neighbourhoods, and families of drug addicts coming to central Government, so we had just to look at how to accompany new ways to monitor them scientifically and to publish the scientific evidence. We have the chance—and the difficulty—to vote very often on public issues in Switzerland. We had something like 15 votes at local, cantonal or federal level on the drug policy, and each of the campaigns and votes was preceded by a political campaign and discussion. I would say that Switzerland became the people of Europe who were well informed on the drug issue, and they accepted the change of our policy and accompanied it.
Sir Richard Branson: If I could say one thing: treatment is a lot cheaper than prison and much more effective. Between 60% and 80% of all break-ins are drug related, so if you can treat people and get them off drugs, they will not have the need to get their fix and they will not need to break in. There is an enormous benefit to individuals in society if you can treat people.

Q29 Nicola Blackwood: Could you discuss the specific forms of harm reduction and treatment that you pursued in Switzerland, and in particular whether this was maintenance or abstinence-based?
Dame Ruth Dreifuss: We always had abstinence-oriented treatments and they are still at the same level—the same number of persons are entering in that. We have a huge experience in methadone and substitution treatment generally from over 30 years. This is the largest number of treatments we offer and we have the people ready to enter it. We have the same number, more or less, as the treatment aimed at abstinence in heroin-based treatment. These people were taken off the street.

Q30 Chair: You did say earlier that this was provided legally, so the Swiss authorities provide heroin legally to people with these problems?
Dame Ruth Dreifuss: Absolutely. We have heroin recognised as a medicine by our medical authority, but I think it is the same here in the UK. The difference with UK and Switzerland is that we did not allow general practitioners to enter into this treatment. We have specialised clinics—it is only specialised clinics—so that there is absolute control of the substance in clinics linked with social integration programmes.
So this is the treatment. In harm reduction, I think we were quite a pioneer, with not only needle exchange—many countries are now doing that—but with safe consumption rooms, harm reduction information and party substances testing. Needle exchange and substitution treatments are also available for prisoners.

Q31 Nicola Blackwood: Could you tell me what percentage moved from the maintenance programmes into the abstinence programmes and then out into normal life and contributing back—being off drug dependence?
Dame Ruth Dreifuss: You mean from the budget?
Sir Richard Branson: No, how many people moved back into society from going through the programme.

Q32 Nicola Blackwood: What was the success rate of the programmes? You can write to us.
Dame Ruth Dreifuss: It is difficult to give the numbers. Perhaps I can give you, if you want, the information afterwards.
Nicola Blackwood: You can write to us. It would be very interesting to see.
Chair: If you could drop us a note, it will save us coming to Switzerland.
Dame Ruth Dreifuss: We will send you the complete information.

Q33 Mark Reckless: Sir Richard, you referred to treatment to get people off drugs. To clarify, are you emphasising the abstinence-based treatment or

referring to much the treatment we have now in the way of methadone maintenance?
Sir Richard Branson: Whatever treatment works. Research is needed to see what the latest, most effective treatments are, so we are not advocating any specific treatment.

Q34 Mark Reckless: But most effective in what sense? What are the criteria you would use to assess that?
Sir Richard Branson: I am not an expert on treatment, but I would recommend that the commission looks at the various treatments that are going on around the world and recommends the absolute best treatment.
Chair: We will be doing that. Not going around the world, but certainly looking.

Q35 Lorraine Fullbrook: Sir Richard, I have two questions, one of which goes back to some comments you made about moving drugs policy from the Home Office to the Department of Health. Don't you think it would be best across both Departments? The Health Department would help the individuals you are talking about, but the Home Office would still have to be involved to catch the criminal barons who are moving the stuff, and along with drug barons comes money laundering, firearms, people smuggling and people trafficking.
Sir Richard Branson: The Home Office can concentrate on organised crime and the Health Department can concentre on the individuals who have drug problems. Of the 100,000 people who are arrested every year for minor offences, as I said, 70,000 are given criminal sentences. Some 20% of police time is spent dealing with those minor offences and that 20% of police time could be spent on going after the criminal gangs. They spend over £200 million just on paperwork and dealing with those minor offences. Again, that £200 million could be spent on going after the criminal gangs. I do think it is a win-win all round.

Q36 Lorraine Fullbrook: Across both Departments?
Sir Richard Branson: Yes.

Q37 Lorraine Fullbrook: As you heard earlier, the Government's drug strategy, which has just been launched, is an intervention and diversion route, basically to reintegrate people into society. As a major employer, what do you think business can bring to this? What help do you think major businesses can bring?
Sir Richard Branson: I can use only Virgin as an immediate example. We are proactively trying to take find jobs for people who have left prison in the Virgin Group because we think that if people can get back on their feet again—

Q38 Lorraine Fullbrook: Were they specifically jailed for drug offences?
Sir Richard Branson: I am sure there will be a mixture of some people with drug problems and some people without. However, I think employers generally need to try to do their best to help people get back on their feet again.

Q39 Chair: If you find somebody in your organisation who was taking drugs, presumably you would dismiss them, would you?
Sir Richard Branson: Not necessarily. Hopefully we would try to help them if they were taking drugs and find out what the problem was. They certainly would not automatically be dismissed. They have a problem.
Mr Winnick: We would hope not.

Q40 Chair: Presumably it would depend on what they were doing and the circumstances.
Sir Richard Branson: There are people within every company who have drink problems. There are people who are addicted to smoking. There are people who maybe take too much marijuana, or even more serious drugs, and they need to be helped. I think that should be the approach for society as a whole.
Mr Winnick: Highly commendable.

Q41 Alun Michael: The Global Commission's report looks at West Africa and suggests that it is a place where aid and development could stifle the emergence of a new market. Can you say a little bit about this? What are the practicalities of that?
Dame Ruth Dreifuss: The problem is that Western Africa is now becoming a hub in the international roads between Latin America and Europe. Being that, it also has to see an explosion in consumption. So what we have to do—

Q42 Alun Michael: I understand that, but you refer specifically to aid and development offering the opportunity to stifle the emergence of that market. How do you see that working?
Dame Ruth Dreifuss: We are now, under the leadership of Kofi Annan, looking to bring together different leaders in the region to have a better approach to this problem—mainly the linked health problems—and also to enforce the police in these countries, to support the fight against the corruption and to a better governance. I think this is what we intend in development aid. It is in the field of Governments' fight against corruption and health issues, and police enforcement.

Q43 Alun Michael: Sorry, I don't quite understand what you see in practice as being the connection between international aid and—I think I am using the words in the report—stifling the emergence of a new market. As you said, there is a market developing. We are seeing a growth in that. We are seeing the development of a hub. What practical steps through international aid are you proposing to stifle that market?
Dame Ruth Dreifuss: As I said, we have to see what the needs are. I see the main needs—I think Kofi Annan sees the main needs—as technical co-operation in the fields of public health, police forces and good governance. That is the priority. To think that just having better economic development avoids people entering into a drug deal is, in a certain sense, an illusion.

Q44 Alun Michael: Sorry, let me just try once more. You referred again to governance and to policy, but you made a specific suggestion in the report that international aid can effectively stifle the emergence of a new market and provide incentives for reducing drug supply. I am not hearing how you see that working.
Sir Richard Branson: If we may, we will send you a note on that.
Chair: That would be very helpful, thank you.

Q45 Mark Reckless: During the 1990s, at least, drug policy in Switzerland was very different from that of neighbouring countries. What impact did that have on your relations with your neighbours and how did the Swiss Government deal with that?
Dame Ruth Dreifuss: The only problem we had to face was that at a certain time, although it is no longer the case, farmers were producing cannabis and selling it in the spirit of the tolerance of the state for such production. Our neighbours were afraid that, as the Netherlands is, Switzerland might be the place where their citizens would go to buy cannabis products, so we had to discuss with them how to have control at the border and how to avoid this attractiveness of Switzerland for the neighbour. We had very good discussions with our neighbours. They understood very well and we found solutions.
On the other hand, our neighbours and other European countries were very interested in what we were doing, and because we had an open-book policy about what we were doing, they were visiting Switzerland—we had fewer tourists for drug purchase than tourists looking at our policy. I do not know how many Ministers and civil servants I received to explain what we were doing, and they were very interested. As you know, Germany, Netherlands and Belgium have followed what we were doing in heroin prescription and adapted it for their countries.
Perhaps your question is also about our relationship with the international UN body in control of crime and drugs. This was a more difficult relationship, because we were obliged—and also very eager—to present our conclusions each year on what we were doing. Often the remarks were critical and we had to discuss the compliance of Switzerland with the convention. Nobody could say that Switzerland was not complying and implementing the commitments stated in the convention—with one difference. We are sure that we are in the frame of the convention with the safe consumption rooms and Vienna is still denying this. This is the only measure we took where we are still in discussion about how far it fits inside the frame of the convention.

Q46 Chair: Cutting off drugs at source is obviously absolutely crucial, as is the operation of international criminal gangs. The list of people on your commission, as I mentioned earlier, includes the former Presidents of Colombia, Mexico, Brazil and a number of other countries where the drugs come from. The Committee will be visiting Colombia later in the year because 50% of the drugs that come into our country originate from there. What does the Commission propose about what should happen at source? These former Presidents presumably admit that the war has failed, as in the Commission report, so what was their recommendation on what should be done to these people right at source? If the drugs do not come from Colombia, they do not enter the United Kingdom.
Sir Richard Branson: Take heroin as an example. You have clinics where people go to get their fix of methadone or heroin, which is supplied by Government. Let us say that methadone is bought by Governments from Afghanistan or wherever. You then have effectively pulled the rug out from underneath the drug barons who would otherwise have been supplying it to these people on the streets. You have avoided those people on the streets breaking and entering to get their money and, hopefully, when they are ready, you will be able to send these people to clinics to get them off heroin.

Q47 Chair: You are advocating the legal purchase of drugs from countries like Colombia, are you?
Sir Richard Branson: No. I do not know where Switzerland specifically got its heroin from, but in order to have a programme to help to wean people off drugs, you are initially going to have to supply them with their methadone fix or whatever until they are ready to get off drugs. If the state administers it, that immediately pulls the rug out from under the cartels—they therefore do not have a market any more.

Q48 Chair: Federal Councillor, it is an international approach, is it not? One country cannot do it on its own, as your report indicates.
Dame Ruth Dreifuss: Yes.

Q49 Chair: From your level as a former President and someone who dealt with these issues for over 10 years in Switzerland, do you think that the mood is changing among international leaders, and not just former leaders who have signed up to the fact that they may have made mistakes? Do you see a cultural shift among the present leadership of these countries?
Dame Ruth Dreifuss: Yes. When you listen to the President Santos of Colombia and if you listen to the President of Mexico, they all agree that the debate should take place. They do not agree with a change at this moment, but they know that they cannot just continue as they did without questioning what they did. Former Columbian President Gaviria, who is one of the members of our Commission, said, "I was the chief of the war on drugs in my country and we did very well but we didn't solve the problem". The fight was hard. We could fight but we have a harsher war now in the country. Mexico is just now in a situation of quasi-civil war. They know that this is not the solution. They do not know exactly how to change, but they want this debate and this change is existing.
In the political discussion in the UN, we are looking for more consistency because any of these specialised organisations has another constituency. In Vienna, you find the people for law enforcement, in Geneva the people for public health, and in New York the people for development—the policy is not consistent. I think that the General-Secretary of the UN is aware of that

and tries to bring together these different approaches of the drug problem.

Q50 Chair: Finally, Sir Richard, as far as the UK's drug policy is concerned, this is the quote of a young member of the Home Affairs Select Committee in 2002 who said, after the publication of our report, "Drugs policy in this country has been failing for decades. Drug abuse has increased massively. The number of drug-related deaths has risen substantially and drug-related crime accounts for up to half of all acquisitive crime". He is now the Prime Minister, so you must be heartened that Government policy is going to be moving in that direction.
Sir Richard Branson: I think what it illustrates is that if you talk to any individual in positions of power or responsibility, they know that the current system is not right and they know that a health-based system is right; they are just worried whether, politically, they can be brave enough to push it through. David Cameron was not then Prime Minister. He now is Prime Minister, and obviously we hope that we can give him the facts to make him brave in changing current policy for the benefit of society as a whole.
Since you gave me one quote, the head of Interpol 18 years ago said, "Western governments will lose the war against dealers unless efforts are switched to prevention and therapy. All penalties for drug users should be dropped. Making drug abuse a crime is useless and even dangerous. Every year we seize more and more drugs and arrest more and more dealers but at the same time the quantity available in our country still increases. Police are losing the drug battle worldwide". That was Raymond Kendall, who was Secretary General of Interpol in 1994 and also, I think, a very well-respected policeman in the UK.
Chair: I have no quotes to match that, I am afraid. The battle of the quotes is over.
Sir Richard Branson: Your quote was absolutely fine.

Q51 Chair: We should declare an interest. We will be travelling Virgin when we go to Colombia, and that is not because of your interests in the commission.
Sir Richard Branson: I would like to say that we do use fuel on our planes and we don't just fly high.
Chair: We wanted to know whether this was going to be proposed for Virgin Galactic when people went to Mars at your suggestion.
Sir Richard Branson: We will see whether we are allowed to first.
Chair: Sir Richard, Federal Councillor, thank you very much. We kept you longer than anticipated but we are most grateful. If you could send us those notes, that would be very helpful.
Sir Richard Branson: Also, good luck on your research.
Chair: Thank you very much.

Examination of Witnesses

Witnesses: **Dame Ruth Runciman**, Chair, UK Drug Policy Commission, and **Roger Howard**, Chief Executive, UK Drug Policy Commission, gave evidence.

Q52 Chair: Dame Ruth, Mr Howard, thank you very much for coming. I apologise for keeping you waiting longer than was anticipated, but you had the enviable position of listening to the evidence of the Global Commission. I have to start by asking you, Dame Ruth, has the war on drugs been lost?
Dame Ruth Runciman: My answer to that is an unsatisfactory one; I don't think in those terms at all. I think part of the problem that we face, and indeed one of the reasons why we set up the UKDPC, is that the polarities between the war on drugs and legalisation seem to pit sides against each other in terms of "lose", when there are many nuances that we need to be considering very carefully.

Q53 Chair: Is the war on the drugs successful? Are we combating an increase in drug use?
Roger Howard: As Dame Ruth said, in the UK we do not think that we have had a war on drugs. We have had some pretty sensible and pragmatic drug policies over the last few years.

Q54 Chair: But surely we want to stop people using hard drugs for health reasons and for reasons of crime and criminality.
Roger Howard: Indeed, we do, and so we do not use that terminology "war on drugs", as Dame Ruth said. We find it particularly unhelpful.

Q55 Chair: So what is a better terminology?
Roger Howard: Whether it is public health or through policing and enforcement, we have a big task on our hands to try to reduce the harms that come from drug use and drug supply. I think that we all share that mission to try to bring down the level of harm in our society.

Q56 Chair: Is it coming down?
Dame Ruth Runciman: In some respects it is. We have in this country a remarkable history. In terms of the harm reduction of HIV, we have one of the great successes in this country as we have among the lowest rates of HIV among injecting drug users in the whole world. Fifteen years ago, that would have seemed a very astonishing achievement.
Chair: You will need to speak up just a little, Dame Ruth, because of the acoustics—
Dame Ruth Runciman: I am sorry.
Chair: No, it is not your fault; the acoustics in this room are not perfect.
Dame Ruth Runciman: I am so sorry.
Chair: That is very helpful. Thank you.

Q57 Dr Huppert: Dame Ruth, you produced a report of an independent inquiry into the Misuse of Drugs Act in 2000 and there has not been a formal Government review of that. What were the summaries of your report?

Dame Ruth Runciman: You are referring to the Police Foundation Report?
Dr Huppert: Yes.
Dame Ruth Runciman: It was entirely to look at the Misuse of Drugs Act.

Q58 Dr Huppert: What were your conclusions?
Dame Ruth Runciman: We had a lot of conclusions, which became a source of much muddle to people, because I have spent the past 10 years assuring people I am not a legaliser. We recommended some change in the classification of drugs. We recommended some changes in the way offences were defined. We did the first big poll on people's attitudes to the law and found that it was not the great deterrent we thought it was and that the health harms of drugs were of much greater interest to people. We were convened by the Police Foundation to look at the Misuse of Drugs Act for the first time in the 30 years, at that point, since it had been enacted. That was our task.

Q59 Dr Huppert: Just to be clear, would you stand by the report now? Is it still valid?
Dame Ruth Runciman: It is. I looked at it only recently and thought what a good report it is, which is very rare.

Q60 Dr Huppert: The commission recommends a programme for research, development and evaluation of strategies, and I would hope that we would all agree that evidence-based drugs policy is clearly something we should aspire to and on which we should insist. One issue, though, is how that interacts with public opinion. Dame Ruth, you just mentioned that. Do either of you have any sense of recent polling evidence, for example, about where the majority of the British public are on the various options that there might be?
Roger Howard: It has been numerous. The Home Office has done research, as have various people. Like any poll, I think that if you ask a particular question, you will get a particular answer, so we are fairly cautious about the vox pop public opinion poll. What I think is interesting is that when there have been some small and modest attempts to have deliberative-type engagement with the general public, people begin to look and see the responses to drug problems in quite a different light. For example, we did a large national survey that mirrored the one that the Department of Health commissions on mental health trying to look at people's attitudes towards people with mental health problems. We did a similar one. We commissioned the same market research company and this was a very big survey. Like a lot of polls, it tells you two different things. On the one hand there is a lot of sympathy for people getting drug treatment and help to overcome their problems; on the other hand, individuals do not want such people living next door to them, which is not surprising, is it?

Q61 Dr Huppert: You will know all of the polls better than I do. If you had a strategy that focused on treatment for users and strong criminal action against drugs barons and the organised crime side, do you have any sense—has there been any polling—as to whether that would be popular?
Roger Howard: As I just said, I think that the evidence we have and that other organisations have looked at on attitudes towards treatment is very strong. It is very supportive, and I would imagine that for anyone sensible there would be strong support for dealing with serious organised crime. I do not think anyone would want to see the pressure let up on that.

Q62 Lorraine Fullbrook: In your legal highs report, you say that the ability of traditional drugs policy to keep pace with the current levels of change is in question. Presumably you are talking about the legal highs that are changing week by week and coming in from China. Can you highlight some of the issues that we are facing with the legal highs—I presume that the changes from China on a weekly basis are one of them?
Dame Ruth Runciman: The challenges we are facing are as you have just described. We have grave reservations about the temporary ban response at the moment because we think that a synthetic drug put on a temporary ban is then not likely then to be unbanned, and we are likely to get a growing number of drugs about which we know too little under the Misuse of Drugs Act and that are unenforceable. What we would like to see is some—"experiment" perhaps is the wrong word—form of looking at consumer protection as a way of dealing with this very new and very pressing problem, in particular with trading standards, because that would bring a lot of advantages, including an ability to insist that the onus is on sellers to demonstrate the safety of the product and what the product consists of. We could have regulations that can't apply to the Misuse of Drugs Act on where it can be sold, what the age limits are and so on. We would like to see some carefully evaluated work under consumer protection legislation to deal with this very difficult and complicated new problem.

Q63 Lorraine Fullbrook: Can I just clarify that you don't agree with the Government's temporary ban on the legal highs that we have?
Roger Howard: No, that's not what Dame Ruth was inferring.
Dame Ruth Runciman: We have reservations.
Roger Howard: We have reservations about what it is intended to do and what it can achieve, and I think this is because over the past two or three years we have seen a rapid explosion in these new substances. Last year, 41 new substances were identified to the European Monitoring Centre. My understanding is that you can expect more this year when they make their announcement; it will be probably nearer one a week. What we are saying is that to base good scientific assessment of the harms of these drugs, we doubt whether a year is going to be sufficient to be able to do a thorough assessment. Our suspicion will be—it remains to be tested, of course—that once a drug is in there, I think it is very unlikely you will ever see one coming out again. It may go in a lower classification.

Q64 Lorraine Fullbrook: Do you think that there is a legislative framework in place to deal with these, or do you think we need to design a new one?
Dame Ruth Runciman: In fact, one of our recommendations is that this is a good opportunity to look at our regulatory framework in total and reassess it[1]. That is one good reason to do it, among many others.

Q65 Lorraine Fullbrook: Is it not being naive to ask sellers of these legal highs to conform to consumer trading standards?
Roger Howard: No. We do this with alcohol and tobacco, and we do it with food regulations. May I just steer you towards looking at the New Zealand Law Commission[2]? It did a huge report looking at their misuse of drugs legislation. One of their conclusions is virtually the same as what we are saying: the New Zealand Government should look towards their consumer protection legislation. Other countries use medicine legislation to begin to control these novel psychoactive substances. I think we should be clear. We are not saying that, at some point, if these prove to be harmful, they should not then be controlled within the misuse of drugs legislation. We are not saying that everything can be controlled in time to—

Q66 Lorraine Fullbrook: But there are so many coming out every week. How would you possibly do that to put them through health and safety rules and regulations to discover if they are harmful?
Roger Howard: We share the view of the New Zealand Law Commission. The onus should begin to shift on to the seller to prove that that product is safe. If that is not done, trading standards or the Medicines and Healthcare Regulatory Authority—whichever mechanism is used—have the powers to be able to confiscate those products, and it may be that civil action, or indeed criminal action, could be taken against those people.
Chair: Mrs Fullbrook is highlighting this very important issue that sometimes one has to wait for the death of an individual in order for people to act, yet that process takes a very long time. For example, with "meow meow", it took a long time for that to be acted on after a young girl had died at a party. What she is saying is—

Q67 Lorraine Fullbrook: I don't think you are being reasonable in suggesting that this is a trading standards issue, and I don't think it is reasonable to expect that the number of synthetic or proactive drugs that come on to the market on a weekly basis could go through safety checks.
Roger Howard: No. We were not saying that they go through safety checking. The onus and the responsibility has to shift to the seller to be able to prove—we are not suggesting that you follow the medicines—

Q68 Lorraine Fullbrook: But do you really think that is feasible for the people who sell this?
Roger Howard: Other countries are looking at this and have proposed this, like the New Zealand Law Commission. The European Monitoring Centre for Drugs and Drug Addiction is saying that there are a variety of powers that one can look at and they are steering people towards looking at those particular powers, so it would strengthen—

Q69 Lorraine Fullbrook: What is the main method of sale? How do people sell in New Zealand? Is it in a shop, at a street corner or through the internet?
Roger Howard: It is all mixed. These are coming through the internet and through post, and reselling goes on—as traditional drug markets have always done—through family, friends, siblings and people like that. That is the traditional route through which people get this.
Chair: Thank you. We will return to that later.

Q70 Alun Michael: You published findings recently that drug-related police expenditure and activity—and it is the activity that is the key thing—is expected to decrease as a result of the cuts. What do you see as the likely impact on police work generally and on local neighbourhood policing in particular?
Roger Howard: If I could just put this in context, this was part of a wider research project that we are undertaking to look at the impact of localism and austerity generally, and the first tranche of work was working with ACPO to look at the impact on policing. So this is the early product. Given your timetable, we are more than willing to come back to you and share with you later, with a supplementary note, the other findings that come from that research. With that in context—

Q71 Alun Michael: Those findings aren't available as yet?
Roger Howard: Yes; the ones on policing are.
Alun Michael: Could you let us have that?
Roger Howard: Yes[3]. What we found from the research—and I should caveat that this was undertaken just before last summer—was their perceptions of what would happen. I think that one would need to go back carefully, if we were methodologically rigorous, to check this out. My understanding is that is pretty much what we found—something like 50% of English forces were expecting that their expenditure on policing was going to decrease. Where this was going to hit was all what I might loosely call the intelligence-gathering arena, so it was forensic testing, test purchases and those particular sorts of activities. The police were making the point very strongly to us that these are the sort of easy things to cut in the first instance. The problem is if you want to build up an intelligence-led approach to policing—the evidence seems to be that that is an

[1] See UKDPC/Demos, *Taking Drugs Seriously*, May 2011, www.ukdpc.org.uk/resources/Taking_Drugs_Seriously.pdf

[2] New Zealand Law Commission, *Controlling and Regulating Drugs: A review of the Misuse of Drugs Act 1975*, April 2011, www.lawcom.govt.nz/sites/default/files/publications/2011/05/part_1_report_-_controlling_and_regulating_drugs.pdf

[3] See: UKDPC, *Drug enforcement in an age of austerity*, October 2011, www.ukdpc.org.uk/resources/Drug_related_enforcement.pdf

effective way—you potentially may be shooting yourself in the foot.

Q72 Alun Michael: Your brief answer is that it is going to damage intelligence-led policing on drug-related issues?
Roger Howard: Probably, yes.

Q73 Alun Michael: Can I just ask—and perhaps I ought to, in asking this question, declare an interest in that I have indicated that I shall seek the nomination to stand for election as a South Wales Police Commissioner—what would your advice be as to the way the Police and Crime Commissioners ought to approach the way that organisation of policing activity and expenditure on police activity in relation to drugs ought to be developed?
Roger Howard: I think it is too early for us to say, is a short answer on some of it, because I think the Police and Crime Commissioner development is evolving. We are asking people locally what impact it might be having and everyone is saying to us it is premature, but what we have concluded is—

Q74 Alun Michael: You are not even offering advice?
Roger Howard: If we may say on two areas. One is that we suspect that, in the coming elections, there may be some very cheap shots and cheap wins to be got from people bearing down on drug supply and drug dealing. I think that is one thing. I think the other is that what we are beginning to pick up a great worry that Police and Crime Commissioners don't— The links between the new Health and Wellbeing Boards are to be forged, and I think our advice would be a very strong collaboration between Police and Crime Commissioners and Health and Wellbeing Boards.
Dame Ruth Runciman: Also, if I might add, with local community organisations where the policing of drug markets is so incredibly important in those particular partnerships.

Q75 Alun Michael: You are referring specifically to the English pattern of organisation?
Roger Howard: Yes, but our suspicion is that, even in Wales, that strong link with local communities for tackling drug dealing—visible drug dealing—is particularly important.
Alun Michael: Thank you.

Q76 Nicola Blackwood: You have described in your report the process to recovery from addiction as not an end result, but an ongoing process, and you have raised concerns about the rapid introduction of payment by results and some concerns about the problems that that may cause for different recovery and maintenance organisations. Could you explain your concerns to the Committee and tell us what you think the implications might be?
Dame Ruth Runciman: We think that in the field of drug misuse, drug treatment and so on, payment by results is a particularly complex issue because the most complex conditions will all require more than one provider. The issue of payment by results in this area does require a system whereby payments themselves are properly distributed between the various contributors, where there is a clear process for interim payments and final payments. The thing we need to remember particularly is that many of the contributors to results will be small organisations—small third-sector organisations—without the capital to sustain work while the fairly far distant outcome is achieved, so it is a particularly complex area. We think that it is possibly being introduced too quickly and that it needs to be very carefully evaluated.
Roger Howard: If I may, a couple of other quick points. One is that we worry about perverse incentives coming in and gaming the system, which is not uncommon, so I think there is a great concern about that. We are picking up, through our work, that there is a threat to the smaller voluntary organisations, and of course the Government wanted a diversity of providers and local community organisations. A lot of local commissioners are looking to this to get efficiencies of scale and things like that, and it does seem to be that some smaller organisations are suffering in that.
One of the other things that we would like to urge you to consider is that there are other different models to try to incentivise better outcomes. PBR isn't the only show in town. It is putting an awful lot of pressure on a system. We are worried about fragmentation happening, and there are other ways and there are other examples that you can begin to incentivise. We would strongly urge that, before this is applied more broadly, you get the evidence for it.

Q77 Nicola Blackwood: I am not entirely clear. The results that they are after and they are being paid for, I presume, are staying off drugs and staying either on the methadone or in the programme. Is that right? Is that the kind of results? Is that what they are being paid for?
Roger Howard: That is one. This is the problem: nowhere in the world has tried such a complicated system of outcomes. Originally they started with four outcome domains, one looking at employment, one looking at drug use, one looking at criminality and one looking at general health and wellbeing. These were four outcomes. Nobody has ever tried a PBR system with such a complicated set of outcomes. They have taken out the employment one because this has been, in a sense, the DWP.

Q78 Nicola Blackwood: So, reduction in criminality, reduction in drug use and health and wellbeing.
Roger Howard: Reduction in criminality, reduction in drug use and health and wellbeing. As Dame Ruth says, how you attribute each of those to different parts of the treatment journey is very difficult.
Dame Ruth Runciman: There has already been some difficulty and discussion in terms of the offending one. The offending one, in terms of an individual, is so difficult that it might have to be a cohort, because to pay by results in terms of reoffending eight months, 10 months or two years down the line is so difficult that it may be that the cohort within an area is part of the payments by results.

Q79 Nicola Blackwood: What are the alternative payment systems that incentivise better outcomes that you propose?

Roger Howard: One that we hoped the Government would have looked at, when we met with Oliver Letwin some time ago, is the centre being able to use some financial tools to incentivise local commissioners to improve their outcomes, rather than looking just to the service provider. Keep it at one level up rather than going down to the service provider and putting all that risk down at that level. That is one of the ways and then they could have a variety of ways. Whether in Cambridge, Oxford or wherever, one would begin to look at those sorts of local needs and be able to look to local commissioners to drive what is locally needed in a much better way.

Nicola Blackwood: Thank you.

Q80 Mr Winnick: Mr Howard, very briefly, you have been involved one way or another in this policy over a long period of time—and that is nothing to be ashamed about—but can I put this question to you, to some extent following earlier questions? Do you really think there is any realistic possibility that the UK—whichever Government happen to be in office—would change its policy on drugs?

Roger Howard: Change its policy? I look to Dame Ruth, whose experience of this is probably even longer than mine. I think we have seen an evolution of policy over many years. If you go back 25 years, you would never have had drug treatment people sitting down with the police. The police and drug treatment agencies work together very well these days and I think we have seen an evolution. If you ask me whether, politically, there can be a shift, I think we have gone part of that way, if we look at cannabis warnings and penalty notices for disorder. If you look at that, I think that we have seen Parliament agree to a gradual—you might call it—decriminalisation, but inching towards that process.

Q81 Mr Winnick: Do you agree with that, Dame Ruth?

Dame Ruth Runciman: Yes. I would like to add—we have already referred to it once—that the biggest possible single change that has taken place was the change in respect of harm reduction. In 1989—I declare an interest here as I chaired the ACMD's AIDS and Drug Misuse Working Groups; the three reports that produced this change—this was extremely unpalatable to Government. Mrs Thatcher's Government took a deep breath and implemented harm reduction, which would have been unthinkable five years before that. It was a major change and it had major results. I sometimes wish the Conservative party would remember the rather noble history it has in that respect. It was a very big change and that sort of change can happen again, it seems to me.

Q82 Mr Winnick: At the end of the day, it is a long-sustained and continuing policy of criminalisation, whatever welcome changes have occurred.

Dame Ruth Runciman: Well, as Roger just said, we think we are seeing a gradual decriminalisation in this country, particularly in respect of cannabis, at the same time as cannabis prevalence is going down, which is rather encouraging. We think that it is possibly time to be more overt about this, to look at it carefully, to take a step-by-step approach to decriminalisation, and to evaluate it carefully.

Roger Howard: Could I just add, very briefly, one other point? I think the previous Government's investment in drug treatment for people going through the criminal justice system was also a major sea change, and I don't think we should underestimate again that shift towards having sensible, evidence-based policies that have delivered change.

Mr Winnick: Very helpful.

Q83 Dr Huppert: May I come back to the legal highs position, because I wasn't quite clear on that? There are new things coming out all of the time and obviously one wouldn't want to ban them immediately without knowing what they are. That would clearly not work. The current process is that the Advisory Council has to make a recommendation that there seems to be evidence that it is harmful and then a decision can be taken, which only addresses dealing rather than possession or consumption. You are suggesting instead that you use a trading standards approach so that the onus is on the person selling it. Am I right in thinking that that could be a much faster response than having to get the ACMD to deal with it, and hence it would be possible to respond more rapidly to these new compounds?

Roger Howard: Yes, is the simple answer to that.

Q84 Dr Huppert: This approach would be a faster way of dealing with the harm that there is from these new compounds.

Roger Howard: Yes. I think the European Monitoring Centre is really saying it is not the weight of response, but the speed of response and the flexibility of response, and that can provide your first line of defence. As I say, if and when the evidence subsequently becomes available that these are harmful substances, it goes through the normal trajectory of review by the ACMD or whoever.

We leave you with one other thought, because I know you need to finish. One of the things that we are concerned about is—to go back to Mr Winnick's comment about policymaking—that we finish our work at the end of this year, and one of the things that we have been very much vexed by is the process by which drug policy gets made in the UK. One of the things that we want to look at—we have currently started this work—is what we loosely call the governance of drug policy, how we make drug policy in the UK and indeed, if I may say, the role of parliamentary scrutiny, which is critical to this. We always look at the content of drug policy; we don't look at how we make drug policy and that is one of the areas we want to look at.

Q85 Chair: One question about the European Monitoring Centre, which the Committee has in the past visited. Is it doing its job effectively? There seem to be no benchmarks for this organisation. It is a fantastic idea to have European monitoring of what is happening in various countries, but is it benchmarked?

Roger Howard: We could say the same about the Advisory Council on the Misuse of Drugs. When these bodies are set up, we don't give any measures, do we, of what we expect of them?

Q86 Chair: No, but the Advisory Council is different. I don't think a lot of taxpayers' money goes into the Advisory Council.
Dame Ruth Runciman: No. That is one of its great strengths.
Roger Howard: Superb value for money.
Dame Ruth Runciman: It is incredibly cheap.
Roger Howard: Too cheap.

Q87 Chair: Yes, compared with the European Centre, which has millions and millions of euros. When the Committee visited on the last occasion we were not that impressed. There were a lot of people sitting around tables and no kind of activity—that is quite different from us today, of course.
Roger Howard: If I may say, I think that then comes back to how countries use that intelligence and information to inform their debate. I think they collect the information. This is why we have said that one of the great weaknesses of the drug strategy—we have called it, forgive our language, a knowledge pillar—is about the accumulation of evidence, intelligence, research and evaluation, and that it is missing completely from various drug strategies, not just this one.
Dame Ruth Runciman: It is one of the big weaknesses in this country.
Roger Howard: It is one of the big weaknesses and I think that comes back to parliamentary accountability.
Chair: That is extremely helpful. Thank you both for helping us launch our inquiry into drugs. We are most grateful.
Dame Ruth Runciman: Thank you for asking us.
Chair: We might come back to you with further questions, because this inquiry will last a while.
Dame Ruth Runciman: We would be very pleased and we are very grateful to you for asking us.

Tuesday 21 February 2012

Members present:

Keith Vaz (Chair)

Nicola Blackwood	Steve McCabe
Mr James Clappison	Alun Michael
Michael Ellis	Mark Reckless
Dr Julian Huppert	Mr David Winnick

Examination of Witnesses

Witnesses: **Paul Tuohy**, Mentor, and **Maryon Stewart**, the Angelus Foundation, gave evidence.

Q88 Chair: This is the next session in our inquiry into drugs, and I welcome Paul Tuohy and Maryon Stewart who are giving evidence to the Committee. Could I ask members of the Committee to declare any interests that are not in the Register of Members' Interests?

Nicola Blackwood: I am a patron of the Ley Community, which is a residential rehab centre in my constituency.

Chair: Thank you. Mr Tuohy, Mrs Stewart, thank you very much for coming to give evidence to the Committee. I am sure you have read the terms of reference of the Committee. This is quite a wide-ranging look at drugs and the Committee is very keen to hear from both of you about what your organisations are doing, especially with the focus on education. Mr Tuohy, do you think we have it right as far as drugs education is concerned or is there more that we can do?

Paul Tuohy: Do we have it right? Absolutely not. Is there more we can do? There are vast amounts more we can do.

Q89 Chair: What?

Paul Tuohy: First of all, I think it was a great shame that the issue around PSHE in schools did not make it as a statutory requirement.

Chair: You need to explain what that means.

Paul Tuohy: Personal social health education is the area where young people are taught about sexual health, drug education and so on and so forth. It is not a mandatory requirement in schools, therefore it hardly gets taught. Our estimate at Mentor is that 60% of schools do PSHE for one hour a year, if at all, and partly the reasons for that are obviously the fact that teachers have an awful lot to do in their curriculum, but we feel very strongly that the rest of the curriculum would be greatly enhanced if the protective factors of good PSHE was brought into the curriculum, firstly, to be statutory, and secondly, that the teachers were given the proper training to deliver good PSHE. Ofsted, in their recent report, did not give one school an outstanding mark with PSHE, not one. That is a disgrace.

Q90 Chair: You have visited the United States and you have looked at some of their prevention techniques, and the focus of your organisation is very much on prevention, I believe. What can we learn from them? This Committee will be going to the United States to look at their programmes, but is there something particularly you would like to draw our attention to in respect of what they are doing on prevention?

Paul Tuohy: We went to Washington to look at some community-led programmes there. In the States they are looking at how prevention itself can be ingrained, not just from an educational point of view in a school but in a whole community, so from the policing establishments through to the schools through to parents, and it creates a different change in culture. From where we are, I think we are not at first base yet. One of the key areas for us at Mentor in terms of the learnings we have was simply to make sure that there are evidence-based programmes put into the schools, which they have a lot more of in the USA. Nearly all the research that we draw upon for evidence-based programmes comes from the USA. We hardly do any research here.

Having said that, on the positive side we do know that there are some very good programmes such as the Good Behaviour Game, which has been running in the United States for many years. The Good Behaviour Game works with children from the ages of five to seven or eight, and it builds up preventative measures that can build up that resilience that they need for the rest of their education. A study over 15 years showed that with children who went through the Good Behaviour Game, against those who did not, there was something like a 60% difference of those who obtained a university place to those who did not. The interesting thing about that particular programme is that it does not talk about drugs at all, even though that is one of the resilience factors it is building up. It is just building up resilience of youngsters to do well in terms of their aspirations and so on and so forth. If you have a child coming in to education at age five who is bouncing off the walls and needs to calm down, the Good Behaviour Game is giving techniques to teachers to do that, and consequently the children are easier to educate and they become better pupils.

Q91 Chair: Mrs Stewart, it is now three years since the death of your daughter, Hester, which of course led you into this whole area, and on behalf of this Committee our condolences. This is a terrible loss, which you must still feel very strongly indeed after this period of time. Do you think that our approach on education is the right approach or do you agree with Mr Tuohy that much more needs to be done as far as young people are concerned? Your daughter died at the age of only 21.

Maryon Stewart: Yes, she died in April 2009. It has been a very big learning curve for me since her death. I had absolutely never even heard of a legal high when she died, and my first intention was to try and get things banned, which we did, and the Angelus Foundation was formed, but we very soon came to realise that banning was not the way to travel, because as fast as you do that there are new substances—the molecules are tweaked and new substances go on the market. From our perspective, we now have a group of over 20 world-class experts on the Angelus advisory board, and our joint perspective is that the only way to deal with this awful epidemic is to educate and raise awareness.

Q92 Chair: At what age do you think it should start?
Maryon Stewart: I think the research shows that the earlier the better. As Paul was saying, there are programmes for kids as young as five and six, but equally there are programmes—there is a programme called Preventure, for example—that aim at young teenagers, and that has also been shown to dramatically reduce the use of drugs and alcohol. The thing that really shocked me, I suppose, on this learning curve, is that there have been some interventions put in place in the not so distant past that have had negative outcomes—in other words, they have resulted in more kids taking drugs. In this day and age I understand that the Government are not giving direction to the regions but I very strongly feel that in this case there should be some direction because I don't think the regions can be expected to know the difference between a positive intervention and a negative one.
I have had lots of meetings with lots of Ministers. I have even had emails from the Prime Minister offering support for all that the Angelus Foundation stands for, all that we are hoping to achieve, but what I see very clearly is that the Departments are all passing the buck.

Q93 Chair: Do you think there are too many Government Departments involved in this and therefore there is a tendency, for example, for the Home Office to say it is a Health Department issue, and the Health Department to say it is an issue for somebody else? Do you think that is the problem?
Maryon Stewart: That is exactly what is happening, and everybody is nodding and saying this needs to happen. There is good science to show that you can educate kids properly. There is good science to show that you can teach parents how to have wise conversations with their children. There is plenty of information out there, but the Departments do pass it from one to another. We have been speaking to Baroness Meacher and her All Party Group on Drug Policy Reform, and we are looking at talking about the French model, where they have a separate Ministry that gets its own independent funding and reports directly to the Prime Minister. Since they have had that in France, they have had a dramatic reduction in deaths and harm from alcohol and drugs. I think that that is going to be the way that we should be thinking in the UK, because even President Obama said last year that the legal highs and party drugs have now reached epidemic proportions.

Q94 Chair: Going back to the legal highs—and this is a final question to you on this issue—it took you a long time to ban GBL. Do you think that that process ought to be speeded up?
Maryon Stewart: Yes, we had hoped that it would be done by this—
Chair: How long did it take in the end?
Maryon Stewart: The statutory instrument should have been done within a matter of 72 hours, but the problem was that the Home Secretary had already entered into a dialogue with the chemical industry and therefore had to wait for three months, and then Government went into recess. Eventually it did not happen until later in the year, so it was about six or seven months. The problem is, what is happening now is that there is a special banning order in place so that things that look suspect can be banned, but you are talking about a year or two years. We are on the back foot. I happen to know that there is a warehouse in Manchester that supposedly has 400 substances in there. The people who are selling them are living footballers' lives. Our kids are going out thinking that this stuff is safe and taking it for fun. They are being pushed into it by their peers because they don't know any better, and we have not taught them any better.

Q95 Chair: What should be done about that? Is it a failure of the police? Is it a failure of the local authority?
Maryon Stewart: I don't think it is a failure of any one person in particular. I think the fact is that we as adults, we as wise people, Government Departments and individuals, should get together and work out the best way to sort this situation out, because it really is not being sorted out. In fact, at the House of Commons on 5 March we are announcing our forthcoming Wise Up campaign.
Chair: This is the Angelus Foundation?
Maryon Stewart: Yes.
Chair: Very, very helpful.

Q96 Dr Huppert: Firstly, if I could declare what I should have declared earlier, that I am Vice Chair of the All Party Parliamentary Group on Drug Policy Reform with Molly Meacher as well. Just to be very clear, the Government's drug strategy states that all young people need high-quality drug and alcohol education. I suspect I will receive a yes or a no—is this currently happening?
Maryon Stewart: No.
Paul Tuohy: Absolutely not.

Q97 Dr Huppert: That is what I expected. I just wanted to make sure that we were very clear on that. There was an interesting conversation there about who leads on drug policy. Currently, Britain is quite rare in Europe in having a Home Office or equivalent lead. Do you think that inhibits the ability to do proper drugs education and it should be refocused either in the Department of Health or in a separate ministry?
Paul Tuohy: Picking up on what Maryon said, if you start talking at the end part of the issue when it has

already manifested itself in terms of recreational drug use and legal highs and so on, you have young people who are taking substances they know nothing about, young people binge drinking when they don't understand quite what they are doing, this all boils back to what we are doing with young people almost from the moment they are born. It is about our culture and behaviour. The Government has made it very clear that they are in favour of really strong, good drug education. What I am wondering is where is the evidence for that. The Drug Education Forum, the main central repository for information in this country about drug education, introduced by the Conservatives in 1995, is set to close next month through lack of funding, for just £80,000, a drop in the ocean.

We are looking at prevention programmes that have been about for many years that we have been pushing at Mentor. Preventure was already mentioned by Maryon. We have been trying to get Preventure into schools for a number of years and we have not succeeded. I think at the moment the culture appears to be that the Government is very interested in treatment, which we would say is great, but we have 320,000 drug users, costing maybe £15 billion. That is an area you need to tackle, but if you put all your money into treatment, you are not turning off the tap in terms of prevention, because for every one that you get off drugs another one is ready to come in. That is why we need to see a consistent programme in schools, from the age of five all the way through, not just a one-off programme like the Good Behaviour Game. With other programmes, for example with the Department of Health and their Responsibility Deal, Mentor have put together the best four or five programmes that we consider are available in the UK and we are saying to the Department of Health that as part of that Responsibility Deal, "This is what should happen", because at the moment we are not doing any of those. We are spending the vast majority of the money we do spend on drug education on programmes that don't work.

Maryon Stewart: I agree totally with that. I was talking to Paul outside before, and he mentioned that it would cost an extra £500 per child to educate them on drugs, and when you think of the fact it may cost in the region of £1 million for each child who goes down the drug route by the time they are 30, you don't have to be a mathematician to know that it is a good idea to invest that £500.

Q98 Dr Huppert: Would you support diverting resources from the policing of low-level use—still keeping a focus on organised crime and the major dealers—towards investing in both treatment and better education?

Maryon Stewart: Sorry, I am not quite sure what you mean.

Dr Huppert: There are finite resources. Currently a lot of money is spent on policing and the criminal justice system for relatively small-scale users as well as organised crime. If one diverted the resource that was used to pick up people with small amounts, that sort of scale, if that money was diverted into education programmes, treatment programmes, is that something that you would support?

Maryon Stewart: Yes, I think that would be useful. Also bear in mind how much it costs for an ambulance callout. We worked out that if we saved just 100 ambulance callouts a week and 100 hospital beds a week, we would be saving nearly £4 million a year just on that, and then I saw a statistic last week in the press about 200,000 kids being admitted to hospital for alcohol-related problems. You would be saving vast sums of money. I think if someone did the sums, you would not be spending any more money, but you would be educating kids, and allowing them to fulfil their potential in life and to live happy lives. The side effects of some of these horrendous substances is absolutely beyond belief: psychosis, flashbacks, depression, heavy nosebleeds, difficulty breathing, and I have even interviewed kids who are now in wheelchairs as a result of having their drinks spiked. It is truly horrendous.

Q99 Chair: I am still thinking of this warehouse in Manchester, but of course all these substances in the warehouse in Manchester are legal.

Maryon Stewart: They say they are legal, and that is another problem, because our toxicologists are of the opinion from the little testing that they have done—they are limited again because of lack of resources—that very often these substances are a combination of class B drugs and other chemicals. They don't have proper labelling, and also the contents vary from batch to batch and month to month and region to region. So we don't know what our kids are taking, and they are literally playing Russian roulette with their lives.

Q100 Michael Ellis: As you have acknowledged, it is clear that the Government are in favour of drug education and have been vocally supportive of improving education when it comes to the misuse of drugs, but I think most people would accept that Governments have not historically been terribly good at getting messages to young people about drug abuse, and in fact communicating with young people on such subjects is very difficult to do. Would you accept that?

Maryon Stewart: Yes.

Q101 Michael Ellis: The question I would ask both of you is, what would your advice be about how best to get the message to young people about drugs? When do you think it should start? When do you think it should finish? In what avenue do you think the message should be transmitted? Should it be transmitted at school? Should it be transmitted by television messages or some other format? Can you elaborate on that?

Maryon Stewart: Do you want to talk about schools and I will talk out of schools?

Paul Tuohy: Yes, fine. If I start with that one then, it is a very good question. I am so pleased you asked it. I think first and foremost what we have at the moment is people going into schools ad hoc, police officers, ex-users, weird organisations, and the schools will just say, "Come on in," and that is because they are not trained to do it themselves. So when it comes to drugs, "Yes, come in and do that." We know at Mentor that, as all the research—well publicised—shows, this does not work. Even now we are hearing some concerning

stories from ministerial level about ex-users, people who are off treatment, going in to talk, and this kind of intuitive thinking is well-meant but it is not the way to go, in our opinion.

The best people to deliver drugs education in schools are the teachers, because they do other subjects really well. They do maths and English and French very well, but you don't ask the French teacher to go in and teach maths, but because PSHE is not a fully trained, recognised subject, there is a problem. It is a really simple fix. We were that close to PSHE becoming statutory a couple of years ago. That needs to be put back on the agenda.

Q102 Michael Ellis: What stopped it from becoming statutory?

Paul Tuohy: I think the slight change in Government might have had something to do with it. All I am saying is that the political will was there, and I don't know in terms of the process—Keith, you will know far better than me—but it was right on the cusp and it did not happen, and we would urge that to be relooked at. That sends a message to teachers, and teachers are very good, the education system is very good, at picking up a lead when Governments say things like that.

Q103 Michael Ellis: I think you were going to answer the—

Maryon Stewart: Yes, I was going to do the out of school bit. I agree with you totally. I think it is a very big challenge and I have come to understand in the process of all this that there are different voices for different age groups. What we are looking at doing at the moment is, we have made a whole series of films of kids that have been harmed and bereaved families and so on, and we have been going into schools and surveying to see which kind of thing touches different age groups. We are in the process of doing that at the moment, and we are doing focus groups, because I just don't think it has been done before. What we are trying to do is find something that won't shock the kids, because we know that shocking people does not work, but will touch them to the point where they will rethink.

Q104 Michael Ellis: Yes, because one has to be careful. You have already alluded to the negative outcomes, and sometime when Governments and very large entities try and communicate with young people it has the reverse effect of that which is desired. It makes something cool or fashionable.

Maryon Stewart: Yes. We are working with a group of young people and other charities that look after young people to do the focus groups and the surveys, and then to put together a programme that is run by young people for young people.

Q105 Michael Ellis: Just very quickly, are you in touch with the Prince's Trust, for example?

Maryon Stewart: Yes, the Prince's Trust—

Michael Ellis: It is an excellent organisation.

Maryon Stewart: They have asked us to train their trainers and they are testing our material for us. We are working with a number of charities including Youth—

Q106 Nicola Blackwood: I was interested to hear your comments about your opposition to ex-users going into schools. Obviously that needs to be carefully managed, but can you explain to me why pupils hearing first-hand experiences of the damage that drug use does would be bad for students?

Paul Tuohy: We are running a programme called the London Youth Involvement Project at Mentor at the moment, and we had a seminar last week. This is a programme where we listen to teenagers about what they think about drugs education. It is something we have been running with the Cruddas Foundation who have supported it for two years. We invited health professionals, teachers and so on, and they ran the seminar and they told us what they wanted. I am not a 15-year-old and so I can't answer that from their perspective, but what they said, in terms of answering your question, is that the kind of information they get about an ex-user's experience does not build up any resilience to them coping with the peer pressures that they might be under in certain situations to get involved in drug taking.

What they want is not to have education that talks about, "This is a class A drug and this is a class B drug, and take a look at it. This is what it is. It can be bad for you and I used to do it but I am okay now." That does not work in terms of protective measures for young people. What we have to do is look at what evidence there already is out there where programmes like Preventure, like the Good Behaviour Game, Unplugged—

Q107 Nicola Blackwood: How much evidence is there associated with the outcomes for these programmes? How many studies have there been? Are they available? Are we able to see them? It would be very helpful.

Paul Tuohy: Substantial evidence. Yes, all available. Yes, you can, absolutely. For example, the Preventure programme, which is a targeted intervention, was trialled in Thamesmead in southeast London to 2,000 children. They were tracked over two years, and that stopped the onset of their first alcoholic drink or drug taking by 30%. There is no other programme—

Q108 Nicola Blackwood: How was the reporting done? How did you know whether they have—

Maryon Stewart: It is all published in medical journals and peer-reviewed.

Q109 Nicola Blackwood: It is published, yes, but how did you find out whether they had or had not taken their first alcoholic drink? Did the students self-report?

Paul Tuohy: That was part of the study. These are clinical studies.

Maryon Stewart: There were psychologists involved in the study, and they were properly surveyed.

Nicola Blackwood: Psychologists. I am just trying to understand.

Maryon Stewart: Those programmes are now being implemented in Canada and in Australia very successfully.

Nicola Blackwood: That is very interesting. Thank you.

Q110 Alun Michael: You gave the example that there is not a single department or agency to deal with drug use and abuse, and Paul Tuohy mentioned earlier that you believed there is too great an emphasis on treatment. Creating a single agency implies a single budget and therefore priorities. On the one hand, that implies being joined up about how you deal with drugs policy but, as I say, it also involves priorities. What sort of proportion of spending on drug policy do you think should be in the education pocket, and how do you think we should be joined up about that and other aspects, for instance of getting people quickly into treatment?

Paul Tuohy: If you look at the costs in terms of the health costs, the sort of money we are talking about is quite extraordinary. I think that has been well documented. I don't think it is a question of more money. This is a question of where you are spending existing money, and I think the fact of the matter at the moment is that we are spending existing money in areas that are not effective. I think it is more about looking at the areas that are not effective and moving into the new areas that we are suggesting here, to find that budget from the educational point of view.

Q111 Alun Michael: Could you spell that out for us? What would you stop doing and where would you put the money?

Paul Tuohy: I don't know specifically what Government budgets are spent on the NHS that are not working. What I do know is that, in the treatment area for the last five years, we have had the same number of drug addicts, 320,000. That has not moved. So, something there is not working, and when you look at the extraordinary cost of that it would take only a tiny percentage of that to be diverted into education to stop that influx of people. It is £71,000 to educate a person in this country but for £500 more you could have protective measures in drugs education.

Q112 Alun Michael: When we looked at justice reinvestment, in other words are we spending money in the right way, as part of a piece of work by the Justice Select Committee a couple of years ago, one of the lessons appeared to be that people have to wait too long to go into treatment rather than being straight into treatment, for instance when a problem is identified, whether it is by the police or a court. So, if you like, the money was being spent but not necessarily on the right people receiving it in a timely manner. You are suggesting a shift from health into education, but what guarantee is there that that spending would be effective in having the outcome that you are suggesting would follow?

Paul Tuohy: The guarantee, for what one can say, is that all of the clinical studies done on the preventative education programmes, which are currently sitting on shelves not being used, when they were trialled showed significant—I am talking 30%, 40%—reductions in young people taking drugs or drinking alcohol. The fact at the moment is that we don't do any of it. We don't have PSHE as a mandatory subject to send the right messages to teachers. We do not have teachers trained to deliver it. It is all there waiting to happen and it would not cost a lot of money, and you would start to get your returns very quickly.

I think one of the issues might be if in a course of a term of Government you are there for five years and you want to make an impact, it would make reasonable sense to say, "Let's get involved in the treatment agenda." I think treatment is incredibly important. We have a big problem with it and we need to put money into but, for example, one of the biggest NGOs that looks at treatment has a turnover of £40 million. Mentor is one of the biggest organisations that look at prevention. We are £500,000. That in itself says a little bit about the landscape, about what we know and understand about prevention measures.

Q113 Alun Michael: Inevitably there is a level of generalisation, so it would be useful, perhaps, if you were to point to the specific examples and specific studies that lead you to that conclusion.

Paul Tuohy: Specific examples—

Alun Michael: I did not mean necessarily now. If you can—

Paul Tuohy: Sure, absolutely.

Maryon Stewart: I think the other point to take into consideration is that treatment for conventional drugs is one thing, but one of the members of our group, Dr Owen Bowden-Jones, who is the chair of the addictions faculty at the Royal College of Psychiatry, got some funding last April to set up the first club drug clinic at the Chelsea and Westminster Hospital. So he now has a resource there for young people and their parents where they can self-refer and get help. One of the difficulties is that a lot of these new substances are addictive and they have awful side effects, and the kids have nowhere to go to get help, absolutely nowhere. That is something else that we need to look at.

The parents are just bemused and bewildered, and the kids themselves—in fact, one of the toxicologists said there has been an increase in the incidence of hanging. There have been a lot of young deaths associated with that, and they suspect that it may be attributable to some of these substances. The fact is we don't know what the long-term harms are because there is no research, but there is a whole generation of kids waiting to go down the drug route and cost the taxpayers a fortune. If we can work out how to implement some of these interventions and turn them around so they have a different mindset, we will be protecting the next generation and saving a fortune.

Q114 Mr Winnick: In your written evidence to us you conclude by being very critical of Government policy. You say that what has happened is a terrible indictment of successive Government policies. Can you explain why, in your view, Governments, whichever political colour they have been, have not tackled this problem your colleague has just being speaking about, and you previously? Do you think it

is because Government does not consider this a matter of priority?
Chair: Mr Tuohy, Mr Winnick has invited you to look at successive Governments' policies. Could you do it very briefly, because we have other witnesses? Like 60 seconds.
Paul Tuohy: Indeed, 55 now.
Mr Winnick: Is that the amount of time Governments have spent on the problem?
Paul Tuohy: In brief, successive Governments have not looked at what is under their noses, that there are good preventative education programmes there. There are outstanding programmes, which have been well researched, which don't cost much to implement. Currently a drug user in the course of their life costs £820,000 to society, and if we can start spending £500 in terms of good protective education to stop that, then we should be doing it. All I am saying is that successive Governments have ignored the facts. They have ignored what is under their noses. They have ignored what organisations like Mentor and the Angelus Foundation have been saying, and it is time that they started to take a closer look and work with us in a much stronger way, to stop the words that we have been hearing but start putting some real hard practice to work. It won't take long and we will have far better protected children as a result of it.
Maryon Stewart: There has been such a huge turnover with the Minister for Crime Prevention and Drugs, if you look at the Home Office. We worked with James Brokenshire for an awfully long time, but since he went there have been two new people in post and before him there were numerous people, so there is no consistency. Nobody gets to know the area and really brings about major change.

Q115 Chair: Equally briefly, do you think that there is an argument for the re-establishment of the drugs tsar post, where there is somebody who you can go to who co-ordinates all this policy? At the moment, as you say, it seems a bit fractured.
Maryon Stewart: Yes, that is effectively what would happen with this separate ministry and it would have its own budget, which means it would be able to fund some of these positive interventions that we are talking about so we can turn things around.

Q116 Chair: Mrs Stewart, you have paid the ultimate price as a parent, your daughter has died, and you have set up this organisation to try and alert other people to what has happened and what may happen. Are you confident that if the kinds of policies that you and Mr Tuohy have suggested to this Committee were in place, Hester would still be alive today?
Maryon Stewart: Yes. If there had been adequate information at the time, as there was in France and Germany—they had poster campaigns saying that GBL plus alcohol equals death—and if the Home Secretary had done something similar in this country I do believe my daughter would still be alive.
Chair: I am sorry, we have run out of time. Mrs Stewart, Mr Tuohy, thank you very much for giving evidence. We may write to you again to get further information from you, but thank you. Please keep in touch with us. Thank you. Sorry, Mr Winnick, we have to move on.

Examination of Witnesses

Witnesses: **Wendy Dawson**, Chief Executive, the Ley Community, **Dominic Ruffy**, Rehab Grads, and **Adam Langer**, gave evidence.

Q117 Chair: Ms Dawson, Mr Ruffy and Mr Langer, thank you very much for coming to give evidence today. It is always difficult when we have three witnesses on the panel and a very short period of time, about 30 minutes. Please feel free to contribute to each of the answers that the Committee is seeking, but if you could be succinct and to the point we would be most grateful. We will try and do the same in putting our questions.
Mr Winnick: Including the Chair.
Chair: Indeed, especially the Chair. I can start with a very simple question about rehabilitation. Is residential rehabilitation the best way to deal with the treatment of people with drug problems? Mr Langer?
Adam Langer: If you want to save money in the long term, and if you want people to re-establish socially integrated lives in society, yes.

Q118 Chair: Mr Ruffy?
Dominic Ruffy: I would say absolutely, if what you are seeking is an excellent recovery outcome. The residential rehabilitation gives you that in a time-limited fashion versus community treatment, where there is no time limit. So residential rehabilitation gives you what you want in a very cost-effective and time-limited manner.

Q119 Chair: Ms Dawson?
Wendy Dawson: Residential rehab is effective because what we do is we look at addiction—we don't just look at the drug or the alcoholic substance, we look at addiction, so it is effective. It is an opportunity for people who want real recovery to live safe in an environment for a substantial period of time in order to address the issues that led them to the substance misuse in the first place. It is the beginning of the process of a path to recovery and it is also the beginning of an understanding of right living, which is critical, and the best place to get that is residential rehab.
It is all about a balanced treatment system but residential rehab has been neglected and it is the only footing that people can start to understand right living, be abstinent right from day one and have a holistic introduction to addiction rather than just a substance.

Q120 Chair: Mr Langer, can I ask you a question about what made you turn to drugs. I realise that you have transformed your life since you originally became an addict. What was it that got you involved in drugs?

Adam Langer: At the time, I had no reason. I didn't understand why I was motivated to do it. It just seemed like fun. Then in retrospect, and I have spent thousands of hours listening to the testimony of addicts, I find all of us have traumatic stories of one sort or another. I was listening to the education debate earlier, and education is key. I will give you an example. I worked for supported housing and took someone who was in an appalling state into a school—not a recovery champion; to be a recovery champion, you have to become a drug addict first, so you are saying, "If you want to be like me, you have to use drugs," and maybe that does not work. What we heard back from the school was how many of the children identified with things like sexual abuse and difficult home backgrounds and began to speak about these things. Methadone and the level of psychosocial interventions that are happening in the community don't meet that need, and so, while it is really well-intentioned and it is a good harm reduction strategy, you are just building a bigger and bigger car park of people whose problems you have not dealt with.

Chair: Thank you, that is very helpful.

Q121 Mr Winnick: The number of referrals to residential rehabilitation has dropped, as I understand, quite dramatically in the past five years. Can any of you, or all three of you, give any explanation why that in fact has been the position?

Dominic Ruffy: I think you have a treatment system that for a very long time has been focused on substitute prescribing, methadone maintenance. Within that there is no exit strategy. There is no desire to have people leave treatment drug free and there has been no focus on that. When service providers were asked to start providing that service, to maintain the number of clients they had within their service, they sought to do that themselves and they do not have the expertise for the recovery people working within their organisations to deliver that outcome. Consequently you have a treatment system where the majority of providers do not want to refer on, because they will lose their client base and therefore lose their turnover and income, and therefore the residential treatment centres have suffered as a direct result of that. Broadly, it is because you have had a system that has focused on substitute prescribing.

Q122 Mr Winnick: Mr Langer, do you want to come in?

Adam Langer: Yes, I think there is a very specific reason. The specific reason is that the NTA's target is 12-week retention and so you have a target that is equally met by someone who, essentially, has just moved his drug dealer to being the state, and sits at home watching Jeremy Kyle, using other drugs on top. You are comparing that with people who are spending every day doing group therapy, one-to-one counselling, and in terms of personal development they are changing who they are ready to come out as, and because those things are being seen as equal it makes sense to go for the cheapest version of that. The whole focus has been wrong.

Wendy Dawson: The other aspect of why there has been a demise is the fact that the NICE guidelines say that residential rehab is a last resort. It is increasingly difficult for people to jump through the hoops once they are in a tiered system.

I have been involved in drugs services for 30 years and the tiered approach was never around in the 1980s when I was a practitioner, so it means that people are kept in treatment and the previous Government drove the drug strategy through an in-treatment model. As Adam said, it was about scripting people. The problem was that we did not script people with an exit strategy; we just continued to script people. It is not unusual for us at the Ley Community to receive a referral from somebody who has been on methadone for over five years and has never been offered the opportunity of residential rehab. That is the biggest difference within the last five years.

Q123 Mr Winnick: If I could put a somewhat different question to you, in the previous evidence we had we were provided with written evidence and the criticism was that overall, bearing in mind what many people consider to be the failure of drug policy generally, there has not been the ministerial control. Indeed, it is said there have been eight Drugs Ministers in as many years. Do you feel that if there was a stronger national position where the Minister responsible stayed in the post longer it would help in dealing with the matter?

Adam Langer: I think it is a level down where there needs to be better—

Chair: Sorry, could you speak up?

Adam Langer: Sorry. There is a level down where there needs to be greater integrity. I come from Devon. The Devon DART does not have a single person with any training on working with addicts, so you have mental health workers, social workers, probation workers, from my perspective chancing their arm at working with addicts. At the level of Government, yes, maybe they will effect policy, but the important thing is that there have to be better standards of who takes this work on. Our commissioner is designing the alcohol contract for the area. He has no training; he is a manager.

Wendy Dawson: If I could just back that up. We work currently across 23 local authorities, local authority DART areas. The majority of the commissioners have been attracted to become commissioners because they like the idea of working in a health and social care field. They don't necessarily have an understanding, apart from an academic understanding, about addictions. If they have not been in the post over the past five years, their whole experience has been through maintaining people in a system rather than enabling people into recovery, which is what residential rehab is very good at doing. So we have not invested in workforce development to demonstrate that people are in recovery.

We have Rehab Grads, and Dominic is one of them. There is a massive population of people who are in recovery and the majority of those have sustained that

recovery and have had an experience of residential rehab in order to attain that and sustain that abstinence. But the workforce that is commissioning services are unaware of these people because of the tiered system, so they continue to see people in tier 3 who are just involved in maintenance or, in fact, needle exchanges.

Q124 Mr Winnick: Mr Ruffy, do you want to comment at all?

Dominic Ruffy: I think it does require a top-to-bottom approach, so you do need somebody in post who understands the agenda and wants people in recovery. That person has to be in there for a long period of time. But as the point has been made by my two colleagues here, the workforce itself that is trying to provide the treatment at the moment simply does not understand recovery. It is not their fault, it is the system they have walked into. So a large-scale re-education of that system needs to happen and organisations such as myself and others that we are working with, like RIOT in Staffordshire, are doing a lot on the ground with those service workers to teach them about recovery. In the areas that is happening it is having a significant impact on the number of referrals into treatment.

Adam Langer: These people have been in place for a very long time together. For them the change is a really traumatic thing to their own identities and careers, so there is a lot of resistance on that level because they have been doing this for so long.

Q125 Steve McCabe: What is the average length of residential period of drug rehab?

Adam Langer: I believe it is 12 weeks.

Wendy Dawson: It differs. There are so many different interventions in terms of residential rehab. You have 12-step models, you have quasi-residential. In my own case, we are a therapeutic community and we are different levels. Again, if I look at my own intervention, that is a 12 months model. It is a therapeutic community and everybody is drug and alcohol free right from day one right through the programme. They finish the programme into fulltime employment, they move back into independent living and they are no longer in treatment. The NDTMS reporting suggests that if people are sustained in treatment for 12 weeks or more they will continue in their abstinence. Where the 12 weeks came from, I am not terribly sure. Perhaps Professor Strang, when he speaks later, will be able to inform us of that.

It is all about people. We have to remember the adage, they are people, they are not statistics, and they are not all in a homogenous group. You cannot just say that somebody will enter treatment and they will be clean and sober after 12 weeks. It is about addiction and that is where residential rehab comes into its own, because what we look at is a holistic person. We do not just look at the substance, as I said earlier. 12 weeks does not really say anything. For some people the penny doesn't drop for three months, for six months, for eight months. So it is about matching that particular person to the right residential rehab and also any other support systems that that person needs to tackle the addiction.

Q126 Dr Huppert: Firstly, in terms of residential rehabilitation, how much has it changed since the 2010 drug strategy came out? Has it made any difference?

Adam Langer: Not to the people—

Dominic Ruffy: No.

Wendy Dawson: I think what has changed is the level of referral and the inappropriate level of referral. What has happened is that we have certainly experienced a kind of panic, that suddenly the workforce and commissioners have now got to roll out and interpret a recovery model. So a lot of residential rehabs have been sent inappropriate referrals; by that I mean people who are not medically able to sustain any form of intervention other than hospital. It is not unusual for clients to collapse on entry and be sent to hospital. That then skews the NDTMS figures, because it looks like it has been an unsuccessful intervention. There used to be a field in NDTMS that said "inappropriate referrals". That was recently removed, which is slightly disingenuous for residential rehab because we are providing a service and what we accept is the person that has been referred to us. Most residential rehabs have a very comprehensive assessment process that our assessment teams do very rigorously. That is not always reflective of the information that is captured in NDTMS, and it is not always reflective of the information that is supplied to the residential rehab provider. Sometimes it is very inappropriate and that is the difference that we have seen.

We were also led to believe that the payment by results pilots would be a provider-driven initiative. When it was rolled out it actually became a systems initiative, and I am not aware that any residential rehab providers have been included in the design and the development of any of the PBRs.

Q127 Dr Huppert: Thank you for that. It leads on to one of the things I was going to ask you about. I recently went to visit the Iceni project in Ipswich. They certainly impressed me with some of the things that I saw there. One of the issues that come up there was about payment by results, the idea that we should be providing support for successful outcomes rather than just for doing something for a certain number of weeks. You have touched on that, but I don't know if either of the other two have comments on how we should do payment by results. They were also quite interested in much more holistic therapies and also linking in with the IAPT programme, the Increased Access to Psychological Therapies talking treatment. Are you in favour of doing more about that as well?

Adam Langer: I think that is what treatment is. Stabilisation and detox is just the gateway to beginning drug treatment, which is that stuff.

Wendy Dawson: Talking therapy is throughout the therapeutic community, so that is why residential rehab is a particularly good intervention because most of the other interventions grew from several of the residential rehab models. The mutual self-aid grew out of 12 steps, because that is based on Alcoholics Anonymous. The therapeutic community also have mutual self-aid, have recovery communities. So a lot of what we have seen in terms of other treatment interventions actually grew out of residential rehab.

Q128 Dr Huppert: If I could ask one last question, Chair. Do you think there is a problem about getting people into the system? Not just about once they are there they are referred to the correct place, but is there a sense that, because of the criminalisation that we have, people are reluctant to get involved with any of these systems, or is it that the people you would like to see, frankly, are just getting involved regardless of that?

Adam Langer: I don't think there is a problem that way. The only problem is that the three weeks boundary for people having their first appointment is way too long. In terms of people getting in, we miss people there but, no, there is no stigma or fear of consequence in that sense.

Dominic Ruffy: I agree with that. I think the problem lies in the length of time it takes to refer somebody and get somebody into rehab, plain and simply. People die during that period of time. If you are a chaotic drug user, as I was, you have a window of opportunity when I am motivated and in a space where I am ready to get up and go. You might ask me the next day and there might be some more money in my back pocket, and in that moment it is okay. That is what you are dealing with, but if somebody is engaging in your services, full stop, you can guarantee somewhere inside them they do want to get treatment. So you need to work quickly with those individuals and get them into the right form of treatment, which in my opinion is rehab.

Wendy Dawson: That is absolutely true. You have to react now and not have a waiting time. For example, a recent case study that I just learnt about yesterday was we had a referral from a chap who had asked to go to residential rehab, had continued to ask to go to residential rehab, had been continually scripted with methadone, had asked to have his methadone reduced and in fact it was increased. He then decided to self-detoxify because he did not want to take methadone any more. He did, he became drug and alcohol free, asked to go to rehab, and he was told he was no longer a priority because he was drug and alcohol free. They are the kind of barriers that we face, because we had done our assessment, we were waiting for him, and he rang up and said, "I have been told I'm not priority." It took him to relapse for his commissioning panel to allow him—and I use that word "allow"—to come into rehab. Surely it should be about choice. The Community Care Act 2000 talked about service user choice. The Health and Social Care Act 2008 talks about service user choice. Where was the choice in treatment, whether that is a community-based treatment or a residential rehab? That is the question that I would ask.

Q129 Nicola Blackwood: One of the criticisms that is usually levelled at residential rehab is the problem that comes at the end of the residential period when the service user goes back into the community and there is the disjunction, and the real risk of relapse and the consequent problems of the body reacting more strongly to the drugs at that point. How do you manage that transition period and how successful are you in preventing relapse among your users?

Adam Langer: That example of appalling kind of practice—you mentioned. community service—is common. I hear about it all the time. What should be happening is stabilisation, detox and preparation for proper treatment, and all the preparation in place before the person is referred into treatment so that their return to the community is fully planned out, whether that is supported housing projects or back into the community in domestic situations. But that is not done, and masses is wasted.

Q130 Nicola Blackwood: That is not done by the residential rehab or that is not done by the DART?

Adam Langer: No, it is not done by the community drug service. Before the community drug service refer, it should be their work to get someone into treatment and to do the preparation for when they come out of treatment, so they come out into something that is planned, not left—yes, it is missed.

Wendy Dawson: Most residential rehab providers—and again I can talk from our personal experience at the Ley Community—provide an after-care service. That is critical, exactly as you say, for that continued abstinence, because what we do is we link people into a recovery community. In our residential rehab we encourage people to stay in the geographical area in which we are. 99.9% of people do that because of our extended peer recovery community across Oxfordshire. By being close to the residential rehab place where people have got well really does sustain their recovery, because they know that they have people who are in the programme now that they can help influence and inform and they have an after-care support team who will respond to crisis or early intervention. Many residential rehabs encourage people to move out with a peer or peers. That helps to sustain recovery as well because they are living with people who have also had that same experience and are clean and sober on exit.

Dominic Ruffy: I think it boils down to communication between the tiers. As Adam stated, tier 3, tier 2 need to work with the rehabs. There has to be a whole package approach, as opposed to saying, "Rehab sits over there, they do what they do. We have sent you over there, now we can forget about you", because that just puts the addicts at risk. I would also think that the rehab sector itself has been open to accepting some of those criticisms and is actively looking at improving our own after-care programmes and so on.

Q131 Nicola Blackwood: Your assessment would be that the problem is not with residential rehab, it is a failure to co-ordinate between the different stages of recovery?

Dominic Ruffy: I think communication between all parties could improve. That does have to be underlined. There does need to be better communication between tier 3 and the rehabs, and likewise between the rehabs and tier 3. It is a two-way street communication, so it can't all be put in one area, but there has to be strong communication.

Wendy Dawson: It is also in terms of the interpretation of "recovery". I hear a lot of community intervention people have gone through some kind of

modality and have come to the end of it and they are still on a script, but they are changing from methadone to Subutex. Well, that is still substance dependent. What residential rehab achieves is absolute total recovery. There is a lot of rhetoric about what the word "recovery" means. We have been delivering our service for 40 years, and what we mean is completely substance free, not dependent on any alcohol or drug or substitute prescribing.

Q132 Steve McCabe: I just wanted to be clear about your reference to Subutex there. Do you regard that as a maintenance drug also?
Wendy Dawson: Yes.

Q133 Michael Ellis: The Ley Community has a number of staff, I think it is 25 staff, and I understand that many of them have themselves been through a drug rehabilitation programme.
Wendy Dawson: Yes, 90% of my clinical team are recovered addicts.

Q134 Michael Ellis: So you would argue that the personal experience and ability that they bring, with their own direct experience in overcoming their addiction, is something that can aid and assist those that they are seeking to rehabilitate?
Wendy Dawson: It makes a huge difference.

Q135 Michael Ellis: I think you were present—we have heard from other witnesses who seemed less convinced that people with direct experience were equipped to go into schools, for example, and talk to children about that.
Wendy Dawson: I actually disagree with that. My early history was as a detached drugs worker and a detached youth worker, and I specialised in working with children who were glue and gas sniffers in the early 1980s. In effect, we had a fantastic role of loco parentis, so I don't necessarily agree with all of what the speaker said. I think there is a role for teachers and there is a role for youth workers, which was never mentioned.
In terms of the Ley Community, yes, most of my clinical staff are ex-addicts. They are in recovery. It makes a difference because somebody can say, "You can empathise and you can sympathise, but if you actually have travelled that road it makes a difference". It also means that you become peer role models, which is hugely impressive to a community who are trying to recover. People will often say, "I've tried it, I've tried it, I just can't cut it," and if somebody has walked that road they can say, "Look, I'm living proof, and I'm five, I'm 10, I'm 15"—my programme director, Steve Walker, is 30 years drug free, and he is the head of that programme. What phenomenal difference does that make? It makes a huge difference, because people can look up to him and say, "What, you've sustained that for 30 years and you're still working in the field and giving back?"

Q136 Michael Ellis: So you disagree quite strongly with the previous evidence that we heard about—
Wendy Dawson: I have a different opinion, and that is informed by my early experience of being a practitioner, and knowing that when I was a youth worker we did make a huge difference.
Adam Langer: For me, this shows a misunderstanding of the people who are dealing with this. You are not comparing like with like. As I say, if I go into a school and say, "I used to be a drug addict, you too can be like me," I am saying "I've recovered, but you have to become a drug addict first." But if I go to a bunch of people who are using drugs and say, "You too can be like me," they have somewhere to go to. You are not understanding what is happening there. So for me, although addicts make great counsellors, the important thing is that they also make awful counsellors, and I have seen horrible governance in tier 4. The important thing is to have proper training. If you have done the path, it is better, but it is the training that is the most important field.
Dominic Ruffy: I think it is worth noting that the same speaker said that he would not ask a French teacher to teach maths, so why would you ask a non-drug user to talk about using drugs and also to understand all of the underlying issues?

Q137 Michael Ellis: You understand, of course, that as a Committee we are hearing evidence from a number of different people and it is very interesting to hear experts in the same field coming to different views. Very briefly, could I ask you about treatment outcomes. The data on treatment outcomes, as far as the National Drug Treatment Monitoring System data is concerned, are you happy that that accurately reflects the situation regarding outcomes?
Wendy Dawson: Not really, because I think the first question has to be what is the purpose of the National Drug Treatment Monitoring System, in order to answer is it fit for purpose? Residential rehab providers, as I said earlier, gather a huge amount of data from the client before entry. A lot of that data is quite critical to recovery, and that is not included in the NDTMS monitoring. What is included, from my understanding from my admissions team, is that it is a statistical analysis, a data collation of PDUs or whatever the new name is, which is problem drug users, their blood-borne virus stats, their housing status, their employment status, their offending status. It does not actually capture what the intervention is that that client was going into, which for me is imperative to understand about recovery.
If you want to collect statistical analysis, the other aspect of the NDTMS that does not work is that we are not all given the same training in order to input and collate the data effectively and efficiently. Each area that receives training is trained differently, and we have only just realised that quite recently when we had a conference on 26 January where residential service providers were all under one roof. In a workshop in the afternoon we all talked to each other and realised we were all inputting data differently because our guidance had been different. The other aspect of NDTMS is that the fields change, and it is a very NHS-driven field, so it talks about triage, it talks about episodes, which is not the same as the input that we do in our own database fields. The NDTMS quite frequently change fields for no rhyme or reason that I can understand, but then I am not the data inputter.

But it does not capture some of the social capital that it is imperative that we get from residential rehab recovery programmes.

Chair: Thank you. Mr Langer, Mr Ruffy, Ms Dawson, thank you very much for coming together today. We would like you to keep in touch with the Committee and to follow our proceedings, and we may well write to you with further information. Thank you so much for coming. We are most grateful.

Examination of Witness

Witness: **Professor John Strang**, Director of the National Addictions Centre, gave evidence.

Q138 Chair: Professor Strang, thank you very much for giving evidence to this Committee this morning on our inquiry into drugs. The policy area of drugs is going to move to the Department of Health. Do you think this is a positive development?

Professor Strang: First of all, a disclaimer that I am not in the political realm so I might not be the best person to judge, but I would see it as a healthy move, in that the way I would see the disorder, if we are talking about people who develop problems with their drug and alcohol use, then I would conceptualise that in a health and social care domain, not in a criminal justice domain. I would see the criminal justice aspect as being hugely important to society, but I would see it as a manifestation of or a result of the disorder. So I would see that as generally healthy.

Q139 Chair: The new health and wellbeing boards are going to be created. Do you think that this is going to be a helpful sign for those who are involved in this area?

Professor Strang: I am probably less certain about that, probably because I am less certain how they will eventually pan out as an organisational system. The worry I would have is that the commitment to the field became too dispersed, and there is a resonance of that right across the field. You want the wider provision to become more sensitised to, more aware of addiction problems or drug and alcohol problems, but if you then shift too much of your commitment and energy to that generic provision, you lose the skill base for the more complex work. That would be my worry about moving to the health and—

Q140 Chair: You are a firm believer in abstinence, as opposed to people being maintained on methadone. Is that right?

Professor Strang: No. To be honest, I am interested right across the field. Along with other veterans like Wendy Dawson, I have been around a long time. Any of the interventions in the addictions field I find interesting, from self-help, abstinence movements, through to the supervised heroin prescribing clinics.

Q141 Chair: Do you know how many people are currently being maintained on methadone as opposed to getting help to recover? Or do you see that as part of the process of helping people to recover?

Professor Strang: I would like to suggest there is a different way in which you could constructively view it. I will give you an answer to the figures. Other people will give you much more accurate audit figures, but you are in the ballpark of 175,000 people on some sort of maintenance prescribing per annum. If you get correct official figures from DH then their figures are correct and I have just not reported them correctly.

But one of the things that in my view has been lost in the commitment to getting more people into treatment, which has been a drive of the last decade, is what the purpose of being in treatment is. That has to be bringing about a change in the mess that you had when you first presented to the service. I am deliberately using vague phrases at the moment like "the mess". I think one of the aspects of methadone prescribing or buprenorphine prescribing—and I view them as two versions of the same sort of approach, opiate substitution treatment—is that your purpose there is still for people to quit their street drug use. So if someone comes to me with a heroin addiction problem, if I am prescribing buprenorphine or methadone my objective is still for them to quit their street heroin use. Just as if I gave a nicotine replacement treatment to a smoker, my measure should not be, "Are they taking the patch?" My measure should be, "How does their smoking behaviour change?" That has been lost somewhere.

Q142 Chair: You are looking at a variety of ways?

Professor Strang: Yes.

Q143 Chair: On decriminalisation, we heard some very strong evidence from Sir Richard Branson and the former president of Switzerland. Is it a goer? Is it a runner? Do you think that there should be decriminalisation?

Professor Strang: My own view is that, if you look at the evidence, it is like a Rorschach inkblot. It depends what previous views you held when you look at the available evidence there.

Q144 Chair: What are your current views?

Professor Strang: If you look over the fence at the alcohol and the tobacco fields, where we have much better evidence, we know this is a price-elastic commodity, that if you make it easier for people to access these products and make it more price accessible, the levels of use will increase and the levels of harm that result from that will increase. On that basis, I would not be in favour of relaxing it.

Chair: So you are not in favour. That is very helpful.

Professor Strang: What I would be in favour of is moving away from a draconian system for how you manage somebody when they get caught up in the system. When they are caught up in the system, a diversion into a treatment or a caring response is a much better business way of handling that problem than just an incarceration option, or just a criminal—

Q145 Nicola Blackwood: I am afraid I am slightly unclear as to your assessment of the current situation for maintenance. I understand that the original purpose of substitute treatment is to initially wean an addict off their street drug of choice, with the intention of then weaning them off the substitute drug into abstinence. The claims are, however, that that has not been happening, that instead individuals have been maintained for long periods of time—we have just heard from witnesses, for five years and upwards—on substitute drugs. Is this your understanding from the work that you have been doing?
Professor Strang: Thanks for that question. I think the first bit, I would say you are entirely correct, and it is something where I think it would be healthy if there was more focus. The objective about bringing somebody into—various phrases are used—opiate substitution treatment or maintenance treatment, it is the same thing, it is just different terms, is to enable somebody to quit their street heroin use, if you are looking at opiate use. One of the unhealthy results about the preoccupation with numbers in treatment was people took their eye off the ball and they thought that the important thing was to have numbers of people in treatment. It is not, it is the number of people who benefit from being in that treatment that we need to look at. The second point you said was that there is then a phase 2 to it, and personally I would view it differently. I would view that longer bit of work actually to do with the social reconstruction work that someone is needing to do, which may or may not be helped by them stopping their opiate substitution treatment.

Q146 Nicola Blackwood: Do you think it is acceptable to remain on a substitute drug for an indefinite period of time?
Professor Strang: I fully understand that it is financially stressful to a treatment system. It is also something that an individual would not want to do if they could move on.

Q147 Nicola Blackwood: Have there been any studies as to the health impact of long-term methadone use on the individual?
Professor Strang: Yes, two aspects to it. I am not wishing to be promotional, but some of it, I think you had a PDF copy of—there is a review paper in the *Lancet* we had a few months ago, and I will also leave a copy of a book, which was a multi-author one about drug policy and the public good.
Nicola Blackwood: This is not a lecture.
Professor Strang: They are useful sources from multi-author groups. The long-term implications, as far as we are aware there are no long-term harmful effects from the long-term maintenance itself, so this is separate from—

Q148 Nicola Blackwood: Is that, we are aware because there have been long-term studies, or is that we are not aware but we don't know?
Professor Strang: Yes, there have been long-term studies. People have been studied extremely long term in the US and other countries. The second issue, is it desirable? That is not what one would want to achieve, so the second issue is do we have long-term studies of where people have been actively steered off their maintenance? There is a clear separation. It is something we have been looking at recently, because of the debate. There is harm from the forced exit and there is benefit from when that is voluntarily engaged with.

Q149 Nicola Blackwood: Have there been any studies of the long-term social impacts of long-term maintenance on methadone?
Professor Strang: There are reports of huge sample sizes, particularly from North America, of the progress that people make. There is a more recovery-orientated tone to maintenance treatments in the US than we have in the UK, and that is one of the areas that I would have thought was fit for change in the UK, to be more focused on that.

Q150 Nicola Blackwood: Is that that there are studies of the social impacts?
Professor Strang: Yes.

Q151 Nicola Blackwood: Would they be available to us?
Professor Strang: Yes, they are, and some of those are. It is pretty extensively referenced. I can send specific ones through to you. But they have huge long-term follow-up studies from the States.

Q152 Dr Huppert: Professor Strang, the paper that you mentioned earlier was a very interesting read, and for anybody who has not read it it was *Lancet* 2012, 379, 17 to 23. It starts off with a very important point for us, which is, "Debates about which policy initiatives can prevent or reduce the damage that illicit drugs cause to the public good are rarely informed by scientific evidence". It is very important that we try and move on from that. There are a number of things in it and I don't want to try and summarise it. You say at one point that wide-scale arrests and imprisonments have restricted effectiveness. Another point, "Incarcerating high-level dealers can be more cost effective than enforcement against retail sellers because retail sellers can easily be replaced". I think there is a lot there for us. To summarise, however, how would you compare the UK's use of effective interventions compared to good international practice?
Professor Strang: I am grateful to you for reading out the opening phrase. The main message I hope you would take away from my evidence is that there is a lot of scientific literature out there and we don't make sufficient use of it. So, it is not whether my opinion is right or wrong. We should use the body, particularly North American evidence. Because of the controversial nature of the field, it has been phenomenally well-studied, the whole area. We have been moderately good at utilising the available public evidence. There are areas where I think we have not scored adequately well and a lot of our provision is of adequate, but only adequate, standards. When we are looking at the issue around maintenance treatment that I was just being asked about, I think a lot of our maintenance treatment lacks sufficient drive and support to the wider recovery that people should

achieve. It lacks that sense of momentum to move on. The expert group that is currently working at the NTA and Department of Health is grappling with that.
The challenge will be how you do that without having some administrative system that dictates when somebody will be ready to move on. Having a system that encourages move on seems hugely healthy. Having a system that says, "Some external agency has said that that number of months has now passed, therefore you are now ready to progress" is not how personal growth occurs and it is not how treatment will occur. That is quite a challenge. So having that greater aspiration, having more resources—Wendy Dawson referred to social capital, which is one of the phrases that has come in—those sorts of aspects will be important to foster those growths. I do not see those as in competition with whether somebody is on or not on maintenance treatment. I would see them as a sort of parallel provision.

Q153 Dr Huppert: You described our use of effective interventions as being adequate, which doesn't sound very good. Which country do you think has the best overall intervention, the best overall set of policies? Who should we be looking at and learning from?
Professor Strang: To be honest, I think you could go to quite a number of countries, so North America, Australia, other European countries. We have slightly disadvantaged ourselves by wanting to make the treatment more widely and easily available and dispersed and hence we have self-inflicted a damage by having a lesser commitment and a lesser quality to what is then provided. You have a workforce less resolutely committed to working in the field. So I think you could look at any one of a number of countries where they have a more intensive work ethic around the work that somebody does in their treatment.

Q154 Dr Huppert: You are suggesting that the people who work in rehabilitation in the UK do not have a good worth ethic? Is that not quite what you meant?
Professor Strang: This is the terrible thing about giving evidence this sort of way. No, I am not suggesting that at all. What I am saying is that a lot of the provision of care to people with drug problems is dispersed very thinly. A lot of the people have a much lower level of contact and a lower intensity of support than would happen in other countries.

Q155 Dr Huppert: You have spoken a lot about the treatment aspect. Obviously that is not the only thing that we are looking at. Do you have any comments about the rest of drugs policy and whether there are models that we should be looking at outside treatment, rehabilitation, therapy, whatever you want to call it?
Professor Strang: By the way, when I am talking about treatment I am broadly talking about treatment and rehabilitation in a sort of basket. In the other areas like you mentioned prevention realms and such, I would want you to be bringing the same scientific scrutiny to the prevention realms and the interdiction and the law enforcement realms. It is not my area but it was the area of the other co-authors in the major report we did, and you discover in the treatment and rehabilitation fields there is much stronger evidence of benefit and a return for society for investments than in either the prevention field or in the intervention field.

Q156 Mr Winnick: Professor, if I can take you back for a moment to the response you gave—which I understand if it was a bit ambiguous, it is perfectly understandable—about decriminalisation. I would simply ask you this question. Do you think it is useful to have such a debate whether or not the community would be served better overall, although there is no panacea either way? I think you implied that quite clearly. Do you think it is useful to have such a debate in the first place?
Professor Strang: I worry that the debate becomes polarised with a typically TV-type thing of two extreme views and somehow that covering it, whereas I think the more interesting debate is in the grey area in between where you say, "With its illegal status, what are the ways of handling it that brings less use and less harm as a result of that use?" So, my answer about "with its illegal status", I would nevertheless not want to see more draconian penalties; I would want to see it being used. The Project Hope clinics of drug court diversions with mandated treatment are a clever example of where you integrate the law enforcement aspect of the illegality with a hefty nudge into changing of behaviour and becoming drug free.

Q157 Mr Winnick: Do you think successive Governments have in fact adopted the policy of having a less drastic or draconian policy?
Professor Strang: Yes. We have a more moderate view than many other countries, so it is not a criticism of where we are. I would look at small incremental changes rather than thinking that there was some revolutionary approach that was going to solve the problem, which it won't.

Q158 Mr Winnick: There was a hue and cry, of course, when cannabis was reclassified, and then the previous Government gave in. Do you have any views on that?
Professor Strang: Yes. I have a view on various things. I don't understand why we don't require those people to subject themselves to a randomised trial if you really want to know does it make a difference. I am not interested in this need for public debate, political debate, or expert debate. I want somebody to do a decent study that says, "That is what it was in those cities. We changed it in those cities for two years and look at the change that occurred". I would follow what the evidence told me to do and I don't understand why that is not similarly applied to law enforcement issues, prevention initiatives, and it could be. There are rare instances where it has been and they are a breath of fresh air when you come across them.
Mr Winnick: It would be useful if you communicated, if you have not done so, your views to the Government as well as to this Committee.

Q159 Chair: Well, the purpose of this inquiry is for us to do that.
Professor Strang: I am speaking as an individual. I am in the NHS and the academic sector. I have opportunities to give my views but they are just my views.
Chair: Thank you. That is the purpose of you coming before this Committee, so we can transmit those views.

Q160 Alun Michael: I am interested in that last remark and I wonder if you might have a look at the work of Professor Jonathan Shepherd on violence reduction in Cardiff. Perhaps it is not the sort of question that can have an immediate answer, but tell us whether you think that sort of scientific or almost engineering approach would lend itself to dealing with drug issues.
Professor Strang: I think that is exactly the sort of approach that is required and it gives you a clear finding. You have to enter it with the honesty and the integrity of not knowing which way it is going to go and you base your future practice on the evidence you get from those experiments.

Q161 Alun Michael: Could I ask you about two aspects and whether you feel that there is any great clarity. Firstly, in the provision of treatment, do you think there is enough provision of treatment for those who are addicted to substances other than heroin or crack cocaine?
Professor Strang: I don't think there is enough treatment and rehabilitative provision right across the board. My worry about then singling out a particular group is that time and again over the years I have seen a focus on one area being achieved by removing interest and attention to those other areas. In my view, treatment services should deal with the individual who presents with the problem they present. The substance will vary over time. There has been a focus in recent years on singling out which drug. Personally, I don't see that as particularly healthy and it creates an absurd two-track system of referrals.

Q162 Alun Michael: So you would argue more for a generic approach that starts with the individual than with the specific substance?
Professor Strang: I would do, and I would then expect to see some substances that seem particularly aggressive or tenacious in their problems as being more likely to be prominently represented. But it is the problem somebody has rather than whether it was heroin or cocaine or a pharmaceutical equivalent or GBL or something, and the nature of someone's problem will differ.

Q163 Alun Michael: That leads very nicely to the other question I wanted to ask. I was very impressed, when I looked at these issues as a Minister some years ago, by a project in Plymouth, the Trevi Project.
Professor Strang: Sorry, I missed what you said.
Alun Michael: The Trevi Project, which sought to provide treatment in an environment where individuals, particularly young women who are involved in a cycle between prison, the streets and back out again, were able to have their children with them, were supported by other young mothers in the same situation. So you were looking not just at the substance abuse and dependency but on the whole person. Is there any evidence that projects like that, which obviously are quite expensive to operate, have better long-term social and drug dependency outcomes, or again is this an area where we don't know enough?
Chair: Could you be as brief as possible? We are quite pushed for time.
Professor Strang: Yes, sorry. It is quite a challenging area to study because you can't do the ordinary sorts of studies you would want to do. You get very good individual evidence of people who have transformational benefits. You then crucially want to know what proportion—
Alun Michael: It is the scale of it.
Professor Strang: Yes. There is live discussion at the moment in the UK, including myself and Wendy Dawson, about could we construct properly designed studies that gave the sort of research evidence base for the future around residential rehabs and aftercare. I think that would be a hugely worthwhile investment for the future.

Q164 Dr Huppert: Two extremely quick questions, and perhaps you may want to write with the answers. One is what evaluation have you done of the success of heroin prescription trials? The other is what are your thoughts on drug courts and whether they would be a useful thing for us to have?
Chair: You are allowed 30 seconds.
Professor Strang: It has been an area of interest, the heroin clinics. We have published a paper. There is due to be a cautious rollout from the Department of Health. I would not see it as part of a large provision. I would see it for the severe tip of the iceberg for whom it seems to have the potential for being transformative. Drug courts look like one of the most encouraging things from the criminal justice sector for a long time, but that is encouraging in what is otherwise a pretty bleak environment and we don't really know how well they work in the UK environment. I would want to do the sort of tight stuff—I don't see why judges can't similarly understand the ideas of a trial design with people with exactly the same thing, some of them get one and some of them get the other. The ethics are no different from the ethics of a surgeon or a physician doing that where they have an area of uncertainty where they are willing to do a trial.
Chair: Professor Strang, thank you very much for giving evidence to us today. We will no doubt be in touch with you. This is a long inquiry and therefore we will probably be writing to you for further information. Thank you very much. We are most grateful.

Thursday 22 March 2012

Members present:

Keith Vaz (Chair)

Nicola Blackwood	Dr Julian Huppert
Michael Ellis	Steve McCabe
Lorraine Fullbrook	Mr David Winnick

Examination of Witnesses

Witnesses: **Professor Averil Mansfield**, Chair of the Board of Science, British Medical Association, **Dr Owen Bowden-Jones**, Chair, Faculty of Addictions, Royal College of Psychiatrists, and **Dr Clare Gerada**, Chair, Royal College of General Practitioners, gave evidence.

Q165 Chair: Thank you very much for coming. We will be joined shortly by our other witness. The Committee is conducting a very wide ranging review of drugs policy and that is the reason why we have you before us today. We know that the BMA will be publishing its report later on this year and obviously we will be keen to know the outcome of those deliberations. But if I could start with you, Professor Mansfield, there is a view that the amount of drug use in this country is declining at the moment. Do you share that view?

Professor Mansfield: I think hard drugs definitely have declined in incidence.

Q166 Chair: Perhaps you would be more specific? Which ones?

Professor Mansfield: I am not an expert, I cannot tell you that but I do know that the harder form of drug use has certainly declined for new users.

Dr Bowden-Jones: Yes, we have some good evidence on this now from presentations to treatment through a system called the NDTMS and what we have seen is year-on-year reductions in heroin and crack cocaine over the last two or three years, and also a decrease in powder cocaine, so very encouraging signs that some of the more dangerous drugs that are being used are in fact on the decline.

What is less clear is whether we are seeing a group of newer drugs beginning to increase. Those drugs are sometimes known as club drugs, and they include a range of drugs known as Ketamine, Mephedrone—some of you may have heard of the legal highs. It is unclear as yet in which direction those are going, but certainly the suggestion clinically from treatment services is that those are increasing rapidly.

Q167 Chair: Where do you get this information from, Dr Bowden-Jones? How do you know this is happening?

Dr Bowden-Jones: There are various different ways you can record data about drug use. Two of the main ones are the British Crime Survey, which is a population survey asking about drug use from households, and another is the one I have mentioned, which is the NDTMS, which is a National Drug Treatment Monitoring System. That system looks at the number of people presenting to treatment, so it is people attending to services for help. Those are two different ways to measure drug use. In fact, on both of those metrics we are seeing a similar pattern, so less people saying they are using, less people coming to treatment as well for heroin, crack and more recently, powder cocaine.

Q168 Chair: One of the concerns of this Committee is the length of time it takes for the Government to ban legal highs—the process that is involved when it comes to the attention of medics that these drugs are very bad. What do you think about that process?

Dr Bowden-Jones: The whole thing is problematic. I speak with some authority on this because I have opened one of the first club drug clinics in the UK, and in the year that we have been open we have treated more than 200 people using club drugs. There are a lot of difficulties around this. One difficulty is that the substance in a particular legal high changes from one month to another, so although the branding may be the same, say it may be sold as Ivory Wave, the actual chemical contents of that may differ. That leaves us in a difficult situation in being able to assess risk.

Q169 Steve McCabe: How do your respective organisations seek to inform national and international policy on drugs?

Professor Mansfield: I am chairman of a committee called the Board of Science at the BMA, and the BMA has150,000 members. We think it is extremely important that we, as an organisation, look closely at this issue—it is after all very much a medical issue—so that our members are fully informed of up-to-date evidence and knowledge and, when we have achieved that situation, that we inform as much as we possibly can any other organisations, such as your own, that are dealing with this issue. It is a bit premature in some respects for us because we have not yet published the report. We are still working on it and I would not like to pre-empt the final report. But certainly it is very important that we, as members of the BMA, fully understand the issues, talk about it and think about it in a way that perhaps doctors have not always been able to do.

Dr Bowden-Jones: From the Royal College of Psychiatrists, we inform national policy in a number of different ways. We have bi-monthly meetings with the Home Office and the Department of Health to discuss development of policy. We also regularly produce reports on issues that are pertinent to drug policy. For instance, this year we are producing something on new addictions; touching on this issue

of legal highs, over the counter medicines, and impulse control disorders.
We are also doing a report on public health and substance misuse, which hopefully will be very influential with the advent of Public Health England. Finally, we have done a report on the impact of re-tendering on addiction services. Those are the sorts of reports that we do on a regular basis to provide information to Government.
Finally, we are obviously involved in training nationally and on developing research within the field.
Dr Gerada: Thank you very much, and apologies for being delayed. The Royal College of GPs have worked over a number of years with the National Treatment Agency, with the Department of Health and with the Home Office on several fronts, including developing a national training programme for GPs, which we have now had in place for the last 10 years, and we have had over 13,000 GPs trained. Also one of our members is on the Advisory Council on the Misuse of Drugs and we are engaged in rolling out a series of education products around some of the other addictions, including gambling addiction and alcohol. So we are, through the College, clearly engaged at every level that we can.
On a personal level I used to be on the ACMD and I used to be senior policy advisor for the Department of Health in drugs and alcohol, so I take a very personal interest in all things drugs.

Q170 Steve McCabe: Can I ask about this review of Khat that the Advisory Council are undertaking? Will you be asked to contribute to that review?
Dr Gerada: Shall I pick that up, because the review of Khat builds on the Khat report that I chaired in 2005 for the ACMD, so we were asked then by the Home Secretary to look at Khat, particularly to look at whether Khat should be a restricted drug. It was particularly problematic, as you know, in some communities. Our recommendation there was not to have it as a controlled drug in the same area as the Misuse of Drugs Act, but to keep a watchful eye on it. In terms of "keeping a watchful eye on it" the use of Khat probably has not escalated in proportion to the population—clearly the at risk population has grown in proportion—but the worrying thing about Khat is it remains a drug that the elders use and the new generation are not necessarily using Khat in the way that it was used but turning to drugs such as alcohol. But we will certainly be responding. As the chair of the committee that wrote the original report I would be very interested in submitting evidence from the Royal College of GPs on that.

Q171 Steve McCabe: Will you be recommending any change?
Dr Gerada: Clearly we need to see what the new evidence shows, but if the evidence again, as I said, shows that it remains a drug that is rising because the population is rising but not necessarily its problematic use—it has problems associated with potentially domestic violence and all sorts of other issues, but I think the recommendations then of the 2005 ACMD Committee was that it should be a health issue rather than a criminal justice issue, and unless anything has substantially changed I think that would be the recommendation as well.

Q172 Dr Huppert: In terms of shaping national and international policy there are obviously resource constraints on what we can do to try to deal with harm reduction for drugs. A certain amount of resource could be allocated to the criminal justice processes, a certain amount towards health processes, a certain amount towards education processes and a range of other things. Do you have a sense as to whether that broad resource allocation is correct, the balance between those three, within the UK?
Professor Mansfield: I would not be able to comment on that, I am afraid. I do not know.
Dr Gerada: I can give you a broad comment, having been in this field now for 20 years. I think broadly speaking the more resources you give to health and the more resources you, in particular, give to prevention treatment and dealing with prevention in general terms, the more likely you are to get bangs for your money. We know that no matter how much money you throw at the criminal justice side or at enforcement and preventing drugs getting into the country, if drugs get into prisons then most borders are fairly leaky. So we know that the more money you invest in health and treatment the better your outcomes. But in respect to the exact proportions, at the moment I do not know what the proportions are.
Dr Bowden-Jones: The Royal College of Psychiatrists has been very supportive of the last decade of investment in drug treatment and we do feel that some of the changes we talked about at the beginning of the meeting in terms of drug trends may well be due to the fact that treatments have been made more available and more accessible for people, and that it is better quality. We now have a strong evidence base for what works for drug treatment and NICE guidance has produced a suite of reports saying what works and what does not. So we are in a very strong position to be able to deliver evidence-based cost-effective treatment at this moment.

Q173 Dr Huppert: Does that mean there are cost-benefit analysis-type measures for health interventions as compared with, say, education interventions, criminal justice interventions, or is it just that we have them for health?
Dr Bowden-Jones: We absolutely have them for health. When NICE did the review of both the drug and the alcohol guidance a very important component of that work was the cost-effectiveness of the interventions, and they have been shown to be hugely cost-effective.
Dr Gerada: The National Treatment Outcome Research Study, which I am sure you have heard of, the NTOR study—a fantastic randomised control study, the biggest of its kind—showed that for every £1 you spent on treatment you saved £7 to the state. The state in its broader sense, includes health and criminal justice. Some figures even put that higher and put it at £15 if you start to include everything. But for bangs for your money there are very few interventions where you get those sort of returns.

Q174 Mr Winnick: Dr Gerada, in your very interesting and informative paper you make a reference to the link between deprivation and heroin and crack cocaine use. Is that a very pronounced link for those who use in the main? Does this mean, in effect, that the majority of users of heroin and crack cocaine are in what would be described as deprived areas and are recognised as being deprived?
Dr Gerada: Yes, absolutely. In fact, again, if I can urge you to the fantastic document that was written again by the ACMD in 2000, which is called *Drug Use and the Environment*, which is one of the most eloquent studies unpicking substance misuse and deprivation in its broader sense. The overwhelming evidence is the more deprived the area, the more likely you are not just to start using drugs but to find that you are then unable to access the resources or have the resilience and environmental structures around you to become drug free or engage in treatment.
It is quite a complex interplay because it is an interplay between housing, opportunities for employment, parental influences, school influences, but on the whole, the more likely you are to come from, as put in its broader sense, a sink estate the more likely you are to take drugs and the more likely you are to stay on drugs.

Q175 Mr Winnick: That I can understand but why particularly should those in deprived areas go on to the worst type of drugs, the ones that I have mentioned, rather than cannabis, for example?
Dr Gerada: They probably do use cannabis as well. There is probably quite a—
Mr Winnick: It then escalates?
Dr Gerada: Yes, the gateway theory, which is that you start cannabis and you go on, is not proven but you are more likely in those areas to be offered drugs such as heroin and cocaine. You are more likely to not have the resilience or the peer support or the family structure to support you to not use, and you are more likely then to drop out of the educational system. So you are more likely to use those drugs because they are more available. The other issue is you are less likely to stop using because you do not have, as I said, the resilience, the peer support, the friendship networks, to help you through that.

Q176 Mr Winnick: That would explain to a large extent, would it not, the link between the use of such drugs, hard drugs and criminality?
Dr Gerada: Yes, absolutely. But I would like to say, and I am sure the others would say, the use of heroin has decreased considerably in recent years. It has plummeted and when I first started as a GP—I have been a GP for 35 years—every day a young drug user, sometimes as young as 16, 17, would come in wanting help for heroin use. I cannot think of the last time a new heroin user came to see me. Clearly that is one of one; I am only one person. What we are seeing now, as I am sure you will be picking up with Dr Bowden-Jones, are new drugs emerging, but over the last few years we have seen a tremendous success in the drug strategies, a tremendous success in drug treatment, and it has been played out on the ground—people like me, not seeing new drug users.

Q177 Mr Winnick: I wonder if I can put this question to your colleagues. There is an argument that those who use cannabis are law-abiding except obviously they are not law-abiding to the extent that they are using a drug that is illegal, but they lead ordinary lives. They are not anywhere near the category that we have been mentioning of criminality, using hard drugs, they have not escalated. They would consider themselves ordinary people who have a liking for cannabis. Do you feel that insofar as they do not escalate any further, there is any real danger to them?
Dr Gerada: Cannabis is not a particularly good drug to be on. It causes lung cancer. It causes oesophageal cancer. It causes failure at school. It is an addiction in its own right, so in terms of its health issues, I would not advocate a young person, or any person, using cannabis.

Q178 Mr Winnick: Indeed not, and I would be very surprised if you did. What I am asking is whether there is any particular danger? Health-wise you have explained, but would the decriminalisation of cannabis—perhaps that is more of a leading question. How far can people using cannabis lead lives without going into criminality in any way?
Dr Bowden-Jones: I think it would be fair to say that the different drugs tend to have different associated rates of criminality to them. For instance, heroin and crack cocaine have very strong associations with criminality. The club drugs that we talked about a bit earlier have very low rates of associated criminality, and in fact the majority of people who come into the Club Drug Clinic are working and holding down good jobs and have family networks and social networks. So there is a different rate of criminality depending on the drug and also the way the drug is used.
Mr Winnick: With health dangers that Dr Gerada has mentioned.

Q179 Michael Ellis: NHS reforms will be shifting responsibility for commissioning drug treatment and recovery services to local authorities. What are the opportunities of this approach to commissioning? How do you think that will play out?
Dr Bowden-Jones: I think the opportunities are around the integration of care, so it is the integration of health and housing. There are definite opportunities. With opportunities there are, of course, risks as well, and I think one of the risks would be that a health condition gets separated off from all of the other health conditions, and therefore may not be thought about as much because it has been separated. But I do think in terms of recovery there could be some huge opportunities for people with drug and alcohol problems as a result of the integration.

Q180 Michael Ellis: The integration positives, with everyone singing from the same hymn sheet and looking jointly at issues, might mean a more joined-up approach.
Dr Bowden-Jones: Hopefully.

Dr Gerada: For alcohol misuse, I think it is a real opportunity. I think we know that alcohol affects communities. I think we know that a lot of the interventions around alcohol can be dealt with and should be dealt with by local government, for example, enforcing the bylaws, looking at some of the environmental issues, transport, and so on, and I think joining it up at local government level is very good.
For drugs I have more concerns, because the effect of drug misuse is not so prevalent now if you look in your environment. I think now we see it through the health, and I would worry about the expertise of local government being able to commission health services for drug users. Recovering from substance misuse can take 20 to 30 years. That is in my experience with my patients and I have a worry that when you are on a commissioning cycle with change of local government, with change of politics, we might end up getting fragmentation and u-turns and changes in something that affect the patient down the track and would not help them. So I think it is quite a complex question that needs to be split into drugs and alcohol, rather than, as is often done, putting it under one umbrella.

Q181 Michael Ellis: The Health and Wellbeing Boards will invariably be more visible, won't they, than the previous treatment commissioners? Do you see this as having a potential positive impact as well?
Dr Gerada: I do not know.
Dr Bowden-Jones: I think it is difficult to say. We have to always remember this is a vulnerable stigmatised group who are not very good at advocating for themselves and they tend to get lost in systems.

Q182 Michael Ellis: But having it more visible is less likely to mean that they are lost, is it not?
Dr Gerada: We have had the drug action teams, the drugs reference teams and the drugs reference groups, and we have had all sorts of health improvement plans. We have had lots of systems. We have had joint commissioning panels. I do not know, in all honesty, how the changes in the Health and Social Care Bill will affect commissioning per se for patients around substance misuse. We need to make sure that we are there in the dialogue to ensure that, as Dr Bowden-Jones says, this invisible, very needy group, do not fall by the wayside.

Q183 Dr Huppert: Can I ask a question first about cannabis and then I would like to move on to heroin treatments. There are a range of psychoactive compounds within cannabis, some of which are more psychoharmful, some of which are psychoprotective. Have you seen any changes in terms of people using stronger forms of cannabis with less of a psychoprotective component?
Dr Bowden-Jones: Yes, in short. We are definitely seeing people using stronger strengths, skunk typically is the drug we see more commonly. There is a particularly worrying trend around some of the synthetic cannabinoids, which are potentially more harmful to health and possibly cause more psychosis, although it is very early days because these have only been on the market a relatively short time.

Q184 Dr Huppert: In California, where they have effective decriminalisation, as you probably know there are lots of local cannabis shops that display information about the psychoharmful properties, the strength properties. Do you think that sort of information would enable people to make more rational decisions?
Dr Gerada: I suspect a 17-year-old walking past a shop is not going to make a rational decision about what they are going to use. They will want to spend their money where they can get the biggest bang for their buck. I suspect anybody in this room might make a rational decision but we are here, I think, to protect people from entering a life of substance misuse that could cause them harm. I would say cannabis is not a good drug to be using at any age. We have just spent the last 60 years sorting out tobacco, let us not drop in the same problem now with cannabis and make it much more available and pretend that it is a safe drug. It is not a safe drug.
Professor Mansfield: If you are asking about information being made available to the young, obviously we would support that hugely. They need to know what it is that this drug is likely to lead them to and the complications of using cannabis. On that side of it we would solidly support the increase in information being made available.

Q185 Dr Huppert: If I can turn to heroin treatments and other opiate users. There is a discussion about whether the best way for treatment is complete abstinence, whether it is substitution, I think there are also some heroin clinic trials that have been done. What is the evidence on which of those works the best, or other treatments that may be available?
Dr Bowden-Jones: I think the starting point is there is no one size fits all. What you need is a range of treatments because you have a range of patients. What we have, and we are very lucky to have, is a very strong evidence base, as supported by NICE, for opioid substitution. We know it works, we know it saves lives, and we know it can engage people in treatment and allow them to begin to make the changes they want.
In terms of abstinence-based treatments, again that is absolutely right for some people and some people do brilliantly with that. In terms of the injectable treatments you mentioned, initial studies are very encouraging for a specific group of very hard to reach individuals.
The message is that we need all of these treatments. We need a range of treatments because we have a range of complexity and severity within this population.
Dr Gerada: There are about 1,000 randomised control trials, gold standard trials, that give evidence to the efficacy of substituted treatment for the management of opiate addition. We absolutely have to say, and these go back 70 years, but as Dr Bowden-Jones says, there are also other treatments that work, such as detoxification. I chaired the NICE guidelines on opiate detoxification and rehabilitation and abstinence

models, but you must not throw out the baby with the bathwater. In terms of patient lives, decreasing criminality, improvement in your social status, improvement in your health, reduction in mortality and morbidity, opiate substitution is the gold standard treatment.

Professor Mansfield: There is lots of evidence about the treatment and its effectiveness, but what matters most is that you get people into treatment, and this is where I think the BMA has a huge role to play in alerting the members of the BMA to the fact that there are a lot of people out there who need this treatment and in helping them to understand fully what that involves.

Q186 Dr Huppert: What stops people from seeking treatment at the moment? Is it that they are scared of it, they do not realise they have a problem, or that they are concerned about how it will be seen or that doctors will not be sympathetic?

Professor Mansfield: It could be a range of all those things, I suspect, and maybe people do not want to head for treatment, but I am afraid I am no expert on that. You probably know better than I.

Dr Bowden-Jones: I think treatment is scary. I think making change is scary for people and when they have had a particularly long history of perhaps poly-substance use, the thoughts of making change can often seem overwhelming.

Q187 Dr Huppert: What policy change could we have? What could the Government do differently to encourage people to seek treatment?

Dr Bowden-Jones: In some ways it has done some of the things already, so it has invested heavily in the availability of opioid substitution treatment. That has allowed people to know that they can come in and get treatment and not be sick coming off their drug. That has been hugely influential. So the waiting times for opioid treatment have come down to less than two weeks across the country. That is good for any treatment in the NHS, let alone treatment for drug misuse. Those are the sorts of changes: investment in providing good quality opioid substitution treatment with wraparound psychological treatments as a core part of that package. That has been hugely helpful over the last 10 years that I have been working in the field.

Q188 Lorraine Fullbrook: Just following on from that, I would like to ask what you think the main research gaps are in the pathways to addiction and assessing the impact of effective treatment?

Dr Gerada: That is quite broad. We know from quite a few studies, including by the Joseph Rowntree Trust, that the pathway to addiction is poverty and social inequality, and that some of the factors that give children resilience include stable parenting and good education. There is a body of knowledge.

We also know that there are certain drugs that then interplay that are more addictive and have more addictive potential than others, but that is quite a complex question that you ask. In terms of the gaps in evidence with respect to treatment, I think there are gaps. We are not mentioning that the biggest addiction we face at the moment is alcohol addiction, and as we have seen the fall in heroin we have seen a catastrophic rise in alcohol addiction. Research has to be focused on alcohol before it is too late because—not too late, but we already see today a massive rise in the under-40s dying of liver disease.

I slightly disagree with Dr Bowden-Jones in that I think there are very few barriers to treatment now for heroin addiction. I think that is the issue. We are not seeing heroin users in the underground passes that we used to see nodding off because they are in treatment. But alcohol is certainly an issue.

Dr Bowden-Jones: I have two that I think are important. The first is the rise of club drugs. We need to make sure that people are not engaging in a new type of drug use. We need to understand what these drugs are to understand what the risks are.

The second is recovery interventions. There has been a lot of talk about recovery. There is quite a thin evidence base on what that looks like and what a recovery intervention is. We absolutely need to make sure that we are spending our money in a way that is going to achieve the results we want. So recovery interventions, which are quite a diffuse group of interventions at the moment, need funding to work out what the active ingredients of that will be.

Q189 Lorraine Fullbrook: Taking that forward, what are the prospects for new treatments for addictions?

Dr Bowden-Jones: Incredibly positive because in the last decade there have been huge advances in the understanding of the neurobiology of addiction, and with that understanding I hope that in the next five or six years we will see a lot of new treatments come online.

Q190 Lorraine Fullbrook: I would like to go back to the beginning and the assertion that there is a reduction in drug use, particularly hard drugs, heroin, crack cocaine, powder cocaine. Glasgow University have done research on this and I think, Dr Bowden-Jones, you said the better test, if you like, would be the NDTMS, which is people presenting themselves to you for treatment, and the National Crime Survey. Is the reduction because people are not presenting to you with addictions, and that the drug users and the drug traffickers and the drug dealers are being smarter than the police are, so therefore they are not being caught and showing up on the National Crime Survey?

Professor Mansfield: I have no idea.

Dr Bowden-Jones: My feeling is that there are less people initiating heroin and crack cocaine, so younger people are not initiating heroin and crack cocaine. But what we do have is a cohort who are gradually getting older, who are continuing to use. The question for me is not whether heroin and crack cocaine are still being used because I think they are being used less. The question for me is: are the younger people who are not initiating on heroin crack initiating on something else?

Dr Gerada: I absolutely agree. I think that we are not seeing new drug users and you can say, "Is that being reflected in the British Crime Survey?" I think there is even less because the National Treatment Agency

figures have shown a big reduction but we have improved our reporting, so not only have they shown a reduction in numbers on their database, but we know that now many more people are on that reporting, so the figures are even less than we imagine, if I am making sense. Also clinically, we are not seeing, as I said, new opiate users, new crack cocaine. You will say they are not presenting to care. They are.

Q191 Lorraine Fullbrook: Is it the case? I am not saying they are, I am just asking. Is it the case that the reduction is because of this?
Dr Bowden-Jones: Services have never been more accessible than they are now.

Q192 Lorraine Fullbrook: But what about cannabis? Do you include cannabis in your research?
Dr Gerada: I would include problem cannabis use. GPs will see any substance misuse. I will even see a Coca-Cola addict if they feel they have a problem. I do not see a lot of problem cannabis users. I know that the Maudsley runs a specialist service and there are cannabis users presenting to their service, but in terms of general practice, where I practise, which is in the Elephant and Castle and Vauxhall and keeping my eyes and ears open through my college, because we run a substance misuse unit, we are not seeing a lot of cannabis users presenting for treatment. What we are seeing is a lot of alcohol and the methamphetamine, the Mephedrone and the sort of drugs Dr Bowden-Jones is talking about.

Q193 Chair: Thank you very much. Can I end with some very quick questions, which I would be grateful if we could have some very quick answers. I am not clear what the answer was to the questions posed by Mr Winnick. You are all against decriminalisation, are you? None of your organisations believes that there is any scope for decriminalising any drugs?
Professor Mansfield: We have not formed an opinion as yet. It is certainly something we will look at.
Dr Bowden-Jones: People with health problems should not be treated as criminals. If someone has a health problem they should be treated for that health problem, and not thrown in prison. That is different from saying drugs should be legalised.

Q194 Chair: That is sentencing more than decriminalisation.
Dr Bowden-Jones: What I am saying is that we should not criminalise people who have an addiction problem.
Michael Ellis: They criminalise themselves.
Chair: Sorry, Mr Ellis, can the witness just answer.
Dr Bowden-Jones: Yes.
Dr Gerada: I am not sure what the RCGP policy on this and I would hesitate to give my own view. I would urge you to the Royal College of Psychiatrists, the Royal College of GPs, and the Royal College of Paediatrics' publication of *Drug Policy in the UK* that was published in 1999 and I would say to you that of those three colleges the conclusion was we do not favour decriminalisation but we certainly do think that rather than imprison people who are engaged in substance misuse, unless they are hard-end dealers, we should be treating them through a health route.

Q195 Chair: Basically the jury is out. You want to debate, you want to make sure that these things are looked at? Is that right?
Professor Mansfield: I think we are all absolutely clear that it is a health issue and that these people must get the health care that they need, and that is the top priority.

Q196 Mr Winnick: Sending them to prison would serve no purpose?
Professor Mansfield: Unless they were getting every bit as good health care in prison, but I doubt it.

Q197 Chair: We will be coming on to that with our next witness. Can I ask another question about prescription drugs? The Committee has just returned from Colombia and Miami—
Dr Gerada: Lovely.
Chair: You should have come with us. It was not one of those types of trips, I can assure you, Dr Gerada. We had some evidence from people in the criminal justice system in the United States about the way in which doctors are just prescribing drugs and those drugs are being sold on to other people. If you look at some of the very high profile cases, the deaths of Michael Jackson and Whitney Houston recently, they were using prescription drugs. Is there a problem with either the use of prescription drugs or selling on of prescription drugs? Do you all know that this is a problem that is going on?
Dr Gerada: Absolutely, and again I would say to you that we are so far better than we were a decade ago. This is called drug diversion, and again a wonderful study was done about 12 years ago looking at this in the field, again published through the Institute of Psychiatry. I will say this now, and I will make some—

Q198 Chair: So far ahead—you are taking better control, is that right?
Dr Gerada: Far, far, far better control.

Q199 Chair: Why, what was happening? Were GPs just prescribing?
Dr Gerada: We had an escalation of prescriptions—of Benzodiazepines, of Methadone, of ampoules of Methadone. In the States you have nonsense drugs being prescribed, such as Adderall—

Q200 Chair: By doctors?
Dr Gerada: By doctors because they have a very different health service. They do not have GPs. They do not have the sort of underpinning of the National Health Service. What we have had in this country over the last decade is a fantastic training initiative, run, I hesitate to say, through the RCGP, also the RC of Psych, to educate GPs about prescribing, about safe prescribing, about giving two week prescriptions and not whole month prescriptions. I will say that in terms of diverted drugs, patients getting addicted on drugs that started life with a prescription of mine is very unusual now. Ten years ago it was very usual.

Q201 Chair: But what about the selling on of prescription drugs?
Dr Gerada: Again we have put in place supervised ingestion, daily prescribing, regular reviews, urine testing, so the risk of diversion has dramatically reduced. That is evidenced not by just me saying it but by drug related deaths that have plummeted over the last decade, and I know you will hear—

Q202 Chair: Because doctors are being charged and convicted in the United States for the mass issuing of prescriptions?
Dr Gerada: Yes, and we have also improved private prescribing of medication in this country. A few years ago we had a massive group of drugs that were coming out from the private sector, Dihydrocodeine in the north of England, which has almost gone.

Q203 Chair: I think it would be very helpful, because there is a lot of information, if you could put a note on this.
Dr Gerada: I am very happy to go to Miami and Colombia.

Q204 Chair: My final question is to the BMA about drug driving and the Prime Minister's recent statement in the House of Commons that he was proposing legislation on drug driving. The BMA, of course, have called for this since 2002 and very much led on this campaign. Has there been any progress, as far as you are aware on this?
Professor Mansfield: The most important issue is to recognise how dangerous it is and to move forward on making it easier to test people, which is probably the fundamental thing. It is easy to test for alcohol, it is not quite the same with drugs.

Q205 Chair: You want that to happen?
Professor Mansfield: We hope it will happen, most definitely.

Q206 Chair: Because I have figures that one in nine motorists, aged between 17 and 24, have driven after taking drugs.
Professor Mansfield: Yes, I am sure you are right.

Q207 Chair: Do you think those are accurate statistics?
Professor Mansfield: I have no idea. I have never looked at those statistics but I know it is there and it certainly is a dangerous thing to do and we need to stop it.
Chair: I thank all of you for coming, in particular Dr Gerada for the service you gave to the Committee earlier on, and can I congratulate you on your appointment as a Professor, which I understand has just taken place. We are most grateful. This inquiry is going on for some time so if you have any further information that you wish to put to the Committee please write to us.

Examination of Witness

Witness: **Paul Hayes**, Chief Executive, National Treatment Agency, gave evidence.

Q208 Chair: Mr Hayes, you have heard some of that evidence and if you want in passing to comment on it that would be fine by us. I want to talk about the NHS reforms first of all and the way in which these matters are being dealt with, in particular the creation of Health and Wellbeing Boards. Do you think there is a case for putting Police and Crime Commissioners on these boards?
Paul Hayes: I think that the Department of Health is keen to leave it to each local authority to determine for itself what the exact membership is. That seems entirely appropriate to me. What I think is more important than who sits on which Committee is how do those Committees work together. In relation to drugs and alcohol, and particularly in relation to drugs, the most important relationship will be between the Health and Wellbeing Board and the community safety partnerships.
Up to now drug treatment has been commissioned by local partnerships bringing together the probation service, the police, health, the local authority, and through that route we have been able to ensure that health interests are looked after, crime reduction is looked after, we maximise opportunities to get people into work, to look after their children more effectively. There is a concern that if we lose that partnership approach we might, over time, have too narrow a focus on health and public health and lose the other societal benefits.

Q209 Chair: But these proposals, do they cause you concern or do you think we are going to keep this integrated drug treatment system that we have?
Paul Hayes: We are confident that the work we are doing at the moment, with the Department of Health and the Home Office, will see guidance issued to local authorities and clinical commissioning groups about how the sub-structure of the Health and Wellbeing Boards continues to work in a partnership way to make sure that the full range of benefits can accrue from drug treatment. Most importantly for the public is that our judgment is that people having very rapid access to treatment, particularly heroin users, as you have heard from earlier witnesses, is keeping a lid on 4 million crimes a year. There would be 4 million extra crimes committed each year if the heroin users who are currently in treatment were not in treatment. So it is a very significant community benefit from continuing to get this right.

Q210 Chair: I am going to ask you about prisons because you have a vast deal of experience working in the probation service as the chief probation officer for the south-east and as a probation officer in the East

End. The concern that we have had, and continue to have, is the number of people who say that if you go to prison, maybe you did not have a drug problem before you went into prison—51% of prisoners appear to have had such a dependency—when you come out you certainly do have. Are prisons a problem in trying to deal with the rehabilitation of people?
Paul Hayes: They are a problem and an opportunity.

Q211 Chair: Tell us about the problem first. What do you think the main problems are?
Paul Hayes: The problem has been, up until recently, that drug treatment in prison was entirely segregated from drug treatment in the community. It was commissioned differently, it was delivered differently. In fact, until recently, we had three different treatment systems operating in most prisons. We have, over the past two or three years, brought those together with a new integrated system within prison and as part of that—

Q212 Chair: In every prison?
Paul Hayes: Within every prison in England.

Q213 Chair: Because I hear that only six prisons are piloting drug free wings.
Paul Hayes: That is a different initiative. The drug free wing initiative is a different programme from the IDTS programme. The IDTS programme is aimed at making sure that everyone that comes into prison is given an opportunity either to stabilise and then return to the community, minimising the risk of relapse and death from overdose, which used to happen all too frequently, which is why it is important to maintain people if they are on substitute prescribing, if they come in for a short time. But it is also vital that we exploit the opportunity of the relative safety of prison for those people who can achieve abstinence. In effect, anyone who is going to be in prison for more than a few months will be ushered down an abstinence route, anyone who is only going to be in for a few weeks, in order to minimise the chance of death on discharge, is likely to be maintained.

Q214 Chair: The Committee has not as yet been to a prison but we intend to do so. One final question from me on this.
Paul Hayes: If I can just finish that for a second. The challenge that lies ahead of us now is that responsibility for treatments under the new arrangements will fall to the National Commissioning Board for treatment in prison. Treatment in the community will fall to the local authority under the auspices of Public Health England, so it is very important that we use a mechanism within the new legislation, technically a section 7A agreement, to make sure that the Commissioning Board's £115 million is aligned with the £600 million that the local authorities have to continue to deliver a seamless service that does not have people relapsing on release—
Chair: Once they come out.
Paul Hayes:—some of them dying, but even more of them re-offending and going back into prison.

Q215 Chair: But we have heard that drugs are still a major currency in prison. Drugs are entering the prison system, not just prisoners who are dependent on drugs, but through one method or the other they are within the prison system. Is that right; is that your understanding as well?
Paul Hayes: It is. The drugs are available. My understanding is that although they are available they are not as available as they are in the community, so that most—

Q216 Chair: We would be very worried if they were more available in prisons, wouldn't we?
Paul Hayes: Absolutely. But that does mean that although some people will maintain a habit very few people will maintain a habit at the same level that they had when they went in. Now that makes them more vulnerable to overdose and death when they are released because their tolerance has diminished.
Chair: You have excited a number of members of the Committee, I will take a quick supplementary on the availability of drugs in prisons.

Q217 Steve McCabe: I just wanted to ask what the evidence base was for the assertion you have made about the availability of drugs in prison because my understanding, from talking to a range of professionals, it is probably easier to obtain drugs in prison in this country than it is on the street.
Paul Hayes: That is not my understanding.

Q218 Steve McCabe: What are you drawing from when you tell the Committee that?
Paul Hayes: From service users—the people who are drug users who are in prison, and providers as well. Very few people have access to enough heroin in prison to be able to inject three or four times a day.

Q219 Chair: But there are other drugs, are there not?
Paul Hayes: There are, but drugs are less available. Certainly if we think back 10 years ago, cannabis was much more readily available in prison 10 years ago than it is now. I think it is fair to say that there will be other witnesses who you could call from the National Offender Management Service, who will be able to give you more precise information about those mechanisms than I am able to.

Q220 Dr Huppert: I, like Mr McCabe, was rather surprised by that because it flies in the face of a lot of the written evidence and conversations that we have had. Are you, in fact, saying that for a regular heroin user it is harder to get heroin in prison than in the public as opposed to, for a member of the general public, where they might well have greater availability in prison than they would be typically exposed to? Because those are slightly different things. Presumably an established heroin user will have a very good source of heroin that they have worked out.
Paul Hayes: Absolutely.

Q221 Dr Huppert: What you are saying is it is not as easy for the already addicted but it might well be easier for everybody else?
Paul Hayes: That is an interesting distinction.

Q222 Lorraine Fullbrook: I just have a supplementary on that. I agree with Mr McCabe and Dr Huppert about the level of drugs in prisons. In your experience, whatever you think the level of drugs is in prison, what is the main route for getting drugs into prison?

Paul Hayes: Again, this is not my area of expertise but in my experience, visits, people returning from home leave and other excursions outside the prison, corrupt staff, things being thrown over prison walls and then collected.

Q223 Lorraine Fullbrook: Thank you for my supplementary, Chairman. Professor Hayes, I would like to ask you about—

Paul Hayes: Not yet, if ever

Lorraine Fullbrook: Sorry, I didn't have my specs on. Just to go back to your delivering the seamless service. Do you think the switch of emphasis from treatment to recovery in the Government's 2010 drug strategy will benefit patients?

Paul Hayes: I think it will. As we have heard from previous witnesses, significant strides have been made in treatment in this country over the last 10 years. But the treatment system, I think, had become unduly focused on the community's needs and on preventing harm for individuals, not on helping people to maximise their opportunities to recover, leave the treatment system and make a full success of their life. Clearly you have to hold those things in balance. It is important that we do not jeopardise the success that has been achieved over the last 10 years in terms of access, crime reduction, reductions in drug-related deaths, and so on, but we need to be challenging for individuals and also for service providers. Service providers became too complacent: that if people were in treatment they were less likely to die, they were healthier, they were less likely to offend. To encourage someone to leave treatment is scary, it is difficult, it is dangerous. It is demanding work. It calls for high levels of professional skill and what the 2010 drug strategy reminds us is that the benefit to society is crucial but we are talking about an individual patient. Most people come into treatment, they want to leave treatment, they want to get on with the rest of their life. We have an obligation to try to help them do that, and we are beginning to turn the treatment system round. In 2005, 11,000 people left treatment successfully and then did not return. This year we are expecting that to be 30,000 leaving treatment and then not returning. It is absolutely crucial that we keep up our efforts to try to make sure, not just that people can get in, be stable, keep them safe, but also that they then leave treatment, and the real advantage of things like Health and Wellbeing Boards, as was said earlier eloquently by Dr Gerada, is they will be able to link together jobs, houses and other social support that make it more likely that people will not relapse once they have overcome their dependency and left treatment.

Q224 Steve McCabe: I now understand the current situation treatment programme commissioned locally by the primary care groups and the local authorities working in partnership and it is the National Treatment Agency's role to allocate the funding and give some direction to it. I gather this all changes with the public health changes. At the moment there is evidence of some local commissioning so it is not as if it is a complete change, but obviously the major change, as I understand it, is local authorities are going to assume this responsibility and it will be part of the complex mixture of budget demands. Are you confident that the new approach will work fairly well or do you think there is any guidance that will have to be managed centrally in order to make sure that this area of work does not get lost?

Paul Hayes: I think that is a very interesting challenge for all of us because there is a great emphasis on localism, on local authorities as the people who understand their area as custodians of place, for that being the right place for decisions to be taken about commissioning to make sure things can be joined up and money can be spent as wisely as possible.

The particular challenge in this arena though is that we are providing services for a marginalised group who are not particularly popular with many of the rest of the community, who are not perhaps able to represent their interests by the ballot box in the way that other people will. So there is a risk that as we democratise we might undermine the services that have been provided, that not only benefit the 200,000 or so people in treatment but the millions of people whom they live among—the millions of people who will suffer harm around crime, around public health, if treatment investment is diminished.

So it is important that we balance off the ability of the local authority to make its choices legitimately about how it spends its money with some sort of confidence that the crime reduction benefits, the public health benefits will continue to accrue. So what we would envisage is Public Health England will need to have conversations with local authorities about their joint strategic needs assessments and about their decisions to allocate their resources to make sure that the whole range of community benefits will still be available, and that there will not be inappropriate disinvestment.

Steve McCabe: That is very helpful, thank you.

Q225 Dr Huppert: Mr Hayes, in your written submission, you highlight the fact that crimes committed by drug dependent offenders, particularly heroin and crack users, cost society £14 billion a year. You cite a couple of studies that confirm the offending path at the end of their treatment and a whole lot of public support for the treatment and so forth. Given all that, do we have enough funding available for treatment?

Paul Hayes: It is interesting that for the first time in my life I have heard three doctors talking for half an hour and none of them said, "We need more money", and I think that is indicative. We can always do with more money. We can always do with more money for anything, but if we go back to 2001, the amount of Central Government resource that was committed to treatment was £50 million a year, and the moment it is £400 million, so that is an eightfold increase in a decade. The total expenditure on treatment has gone up fourfold in that time. There is no other area of the public sector that has seen anything like that level of

investment and the commitment of the current Government has been demonstrated by them holding those budgets at the same level, despite 25%, 30% cuts in other aspects of activity.
In the current circumstances it would be entirely unrealistic of me to say that we need huge swathes of additional investment into drug treatment, particularly directly into drug treatment. The areas that worry us are the areas that are reflected by the 30% cuts in local authority funding, in particular. So it is what is happening to supporting people and resources. What is happening to support for troubled families. What is happening across the whole range of other agendas that need to be brought together if we are to consolidate change, not prevent the investment in treatment being frittered away because we cannot help someone get the job, the house, the stake in society, maintain their family contact. So they are the concerns for us rather than the direct treatment funding.

Q226 Dr Huppert: We have had evidence that over the last three years there has been quite a reduction in substance misuse services nationally, particularly for young people, and that this applies at all levels of treatment intervention—residential detox, rehab, community with outreach workers. Do you think that is accurate?
Paul Hayes: No, it is misleading. It is significantly misleading, but the explanation for it is in what I have just said. The actual amount for young people's treatment has been steady for the last three years at £25 million. What has reduced is there used to be ring-fenced funds in support of young people's interventions around prevention, around wider social integration activities—a total of about £30 million a year; £30 million of ring-fenced money for supportive activities and prevention for young people. That has now reduced to £20 million generic funding unring-fenced, so the cuts there have been have been cuts around the supportive activity, not cuts around the core treatment.

Q227 Dr Huppert: I am concerned you say it is misleading because it is information from somebody at the Royal College of Psychiatrists, so there is a bit of a clash there.
Paul Hayes: Everyone has a different view.

Q228 Dr Huppert: Do you think that we do enough across the whole range to support young people with substance misuse problems, either at an educational level, treatment level, environmental level, any level?
Paul Hayes: One of the difficulties across the whole drugs arena is that drugs bedazzle people and tends to prevent them seeing the other problems in people's lives. Very few under- 18s are addicted to drugs. What tends to happen is somebody has problems with offending, with school attendance, with their family, hanging round with the wrong kids, and they are also smoking cannabis and drinking alcohol, and that is exacerbating those problems but not necessarily causing them. In terms of resources the question is not, "Are we resourcing drugs enough?" The question is, "Are we supporting young people in all aspects of their lives and across the whole range of issues?"

Chair: Thank you, Mr Hayes. Dr Huppert, final question?

Q229 Dr Huppert: Thank you, Chair. Since you mentioned alcohol, do you have a sense as to how much of a problem from the NTA's perspective alcohol is now compared with illegal drugs essentially?
Chair: A brief answer, Mr Hayes.
Paul Hayes: Other than for young people we do not currently have responsibility for alcohol, although we will soon.

Q230 Dr Huppert: Should you?
Paul Hayes: We will be assuming that responsibility when Public Health England takes over, which is one of the benefits of the new arrangements. Drugs and alcohol will be brought together, which I think is very much welcome.

Q231 Mr Winnick: Previous witnesses today said, first and foremost, drug users should be considered as a health problem and certainly not as a criminal problem although they had open minds whether or not there should be decriminalisation. Do you have any views yourself on this rather controversial question?
Paul Hayes: The first thing is that an awful lot of the people we deal with need to be responded to as criminals because they break into other people's houses and they steal from shops, and we therefore need to respond to their criminality. If drug addiction lies behind that criminality we need to respond to that and we need to respond to that as a health issue, and the same types of treatment will deliver health benefit and community safety benefits, so there is no conflict in that.
In terms of responding to the drug addiction of someone who is not a drug misusing offender, it is absolutely vital that we respond to them as someone who needs health support but we also need to think what is likely to happen if we withdraw all the legal sanctions. My best guess is that if we withdrew all the legal sanctions we would be likely to see an increase in use. At the moment 0.6% of the adult population use heroin or crack cocaine, and it is a declining proportion. That means 99.4% do not. I think it is a very brave decision to tinker with a legal framework that is working 99.4% of the time and improving.

Q232 Chair: One final question, I will just take you back to prisons for a moment. Drug addiction assessments are not carried out when people leave prison, are they? They are when they enter the prison system but not when they leave prison?
Paul Hayes: Not routinely for people who are not seen to have a drug problem.

Q233 Chair: Do you think there ought to be?
Paul Hayes: I am not sure whether that would be a good use of scarce resources. It is more important to maximise—

Q234 Chair: What are the scarce resources? If someone is leaving the prison and they have a—

Paul Hayes: More important—the bits of the system I am responsible for—is to respond to the people whom we know have a problem.

Q235 Chair: How do you get an integrated system if you do not know they have the problem on the way out of prison?
Paul Hayes: If we assess them when they go in and we can identify who they are, and we can treat them while they are in, then we know who, when they are released, we need to ensure are integrated with the services outside. Whether in addition to that it would be sensible to screen everybody else who leaves prison, it would for NOMS to determine whether that was a sensible investment or not.

Q236 Chair: We will ask NOMS. Thank you so much, and thank you for your evidence. If there is anything more you need to add to what you have said, please do not hesitate to write to us.
Paul Hayes: Will do.
Chair: Thank you.

Tuesday 24 April 2012

Members present:

Keith Vaz (Chair)

Nicola Blackwood	Alun Michael
Michael Ellis	Bridget Phillipson
Lorraine Fullbrook	Mark Reckless
Dr Julian Huppert	Mr David Winnick
Steve McCabe	

Examination of Witnesses

Witnesses: **Russell Brand**, former drug-user, and **Chip Somers**, Chief Executive, Focus 12, gave evidence

Q237 Chair: Good morning, Mr Brand.
Russell Brand: Good morning.
Chair: Please have a seat. Mr Brand, Mr Somers, thank you for giving evidence to the Committee's inquiry into drugs. Mr Russell Brand, you gave written evidence to this Committee, which Members of the Committee have read. Could I start with a point about what you say in your evidence that you disagree with the legalisation of drugs because you think that a deterrent effect is necessary, is that right?
Russell Brand: I don't feel entirely qualified to talk about legislation. For me, what is more significant is the way that we socially regard the condition of addiction. It is something that I consider to be an illness and, therefore, more a health matter than a criminal or judicial matter. As I said, I don't think legalisation is something that I am particularly qualified to get into. In fact, I can see areas where decriminalisation might be considered useful and more efficient in countries, like Portugal or Switzerland, where there have been trials. It seems to have had some efficacy. But for me it is more important that we regard people suffering from addiction with compassion and that there is a pragmatic rather than symbolic approach to treating it. The legislative status of addiction, and the criminalisation of addicts, is kind of symbolic and not really functional. I don't see how it especially helps, but I am not saying, "Let's have a wacky free-for-all, let people go around taking drugs". It didn't help me much.

Q238 Chair: You are a former heroin addict.
Russell Brand: Yes.

Q239 Chair: Briefly, could you tell us how you got on to drugs and then how you managed to come off it, and how many years you were on hard drugs?
Russell Brand: I see you have incorporated the word "briefly" now into the question. As you already know, it is my propensity for verbosity. I became a drug addict, I think, because of emotional difficulties, psychological difficulties and perhaps a spiritual malady. For me, taking drugs and excessive drinking were the result of a psychological, spiritual or mental condition, so they are symptomatic. I was sad, lonely, unhappy and detached, and drugs and alcohol for me seemed like a solution to that problem.
Once I dealt with the emotional, spiritual, mental impetus, I no longer felt the need to take drugs or use drugs. Actually, I got clean at Chip Somers' facility, Focus 12, which is abstinence-based recovery. That is what we essentially believe in: if you have the disease or the illness of addiction or alcoholism, the best way to tackle it is to not use drugs in any form, whether it is state-sponsored opiates, like methadone or illegal street drugs, or a legal substance like alcohol. We see no distinction between these substances. What we believe in is that abstinence-based recovery is the best solution, for people suffering from this condition, and that support structures exist to get people to maintain recovery—abstinence-based recovery. What we want is more research and funding into abstinence-based recovery and to be able to filter people towards this new lifestyle where, actually, criminalisation becomes less of an issue, in my view, because it takes people that have to indulge in criminal activity to fund their habits and gets them into being valuable members of society.
Was that brief enough?

Q240 Chair: Very brief, thank you. You were arrested, roughly, 12 times—
Russell Brand: It was rough, yes.
Chair:—by the police and the justice system. Do you think that when you were arrested that you had the kind of support that you needed, and people like you who were arrested, being involved in drugs, the rehabilitation and the support that was needed to get you off drugs? How did the criminal justice system react to you after your arrests?
Russell Brand: From my experience, speaking to people in the criminal justice system, and from my own personal experience being arrested, there is some confusion and ignorance around addiction. That is quite understandable because a lot of drug addicts—speaking personally—are anti-social. They are a strain on society. They necessarily engage in criminal activity. They are a public nuisance in many ways.
I felt when I was arrested that the police were doing a necessary job of enforcing the laws of this country, and that they were doing what they had to do. It wasn't until I had access to abstinence-based recovery that I was able to change my behaviour and significantly reduce—all but obliterate—my criminal activity, apart from the occasional skirmish.

Q241 Chair: The final question from me on this section is the issue of legal highs. We have been very concerned in the evidence that we have received about the number of legal highs that are available, and young people who seem to be able to take legal highs. Whenever they are banned or proposed to be banned a new legal high emerges. Do you think this is something that does affect young people? Is this now the drug of choice for young people?
Russell Brand: I don't know because I am not young enough anymore. I know that young people will always want to get high, and I think that what we need is a pragmatic approach to this. For me, in a way—as I said before, Keith—it is not significant the substance they are using, whether it is alcohol or illegal street drugs. The legal status of a drug is irrelevant to a drug addict. If you are a drug addict, you are getting drugs, that's it, you are going to get them. So in a way it is probably best to make it simple.
As for legal highs, what I think we need to do is address the social, mental and spiritual problems that are leading young people, or people of all ages, into taking drugs. So I think what we need is research into abstinence-based recovery and more awareness around it.
Chair: We will come on to some of those points with other questions.

Q242 Bridget Phillipson: You are currently working on a programme about addiction and how it is viewed in society. What messages are you hoping to get across in that programme?
Russell Brand: The messages that we are hoping to get across in this programme is that maintenance of drug addiction, through state-sponsored substances, like methadone, should only be deployed as part of a reduction, with the ultimate aim of abstinence-based recovery; that we need to start regarding addiction, in all its forms, as a health issue, as opposed to a judicial and criminal issue; that we need to change the laws in this country; that we need to have more compassionate, altruistic, loving attitudes to the people with the disease of addiction and recognise that these people, with the proper help and access to the proper treatment, can become active and helpful members of society, like myself—some would argue that point—or perhaps, more obviously, Chip Somers, a man with a criminal record as long as your arm, who now runs a treatment centre and has been clean for 27 years. That is the message: that we don't want to discard people; we don't want to life them off on methadone and leave them on the sidelines. We need to bring them into society, offer them treatment and, once again, neutralise the toxic, social threat that they offer as criminals, because they have to fund their habit, or even if it is a legal drug, like alcohol, they are clattering into things, driving drunk, pain in the arse people. We need to offer them treatment and activate them and incorporate them into our society. So the message is ultimately one of pragmatism, altruism and compassion in all areas of the condition.

Q243 Chair: Thank you. Mr Somers, we will have specific questions for you, but if you want to chip in—if I may put it like that—at any stage, please feel free to do so. Is there anything you want to add to what you have heard so far?
Chip Somers: I think he is doing splendidly.
Russell Brand: Thanks, Chip. Chip runs the treatment centre where I got clean so—
Chair: Yes, we are coming on to him in a minute, Mr Brand.
Russell Brand: He is already the puppeteer behind each and every articulation.
Chair: Thank you, Mr Brand.

Q244 Michael Ellis: Mr Brand, you have said that addiction is an illness.
Russell Brand: Yes.
Michael Ellis: Would you say that it is also fair to characterise it as self-induced, to a large extent, unlike many other illnesses?
Russell Brand: Not really.

Q245 Michael Ellis: Also, that it does carry with it victims. Many people who are on drugs commit offences against other people, do they not? So it differs in that respect as well, doesn't it? When one is looking at the criminal justice system, doesn't one also have to have some compassion and consideration for the victims of crime, where those crimes are committed by people under the influence of drugs?
Russell Brand: Michael, I am very glad you have asked me that question. It is a very important question and it is one that we need to address. Of course, the victims of acquisitive drug-related crimes are important and need to be taken care of. We were with Chief Superintendent Graham Bartlett of Sussex Police the other day, a wonderful man, a good civic minded gentleman. It is his belief that by regarding addiction as an illness, by offering treatment instead of a more punitive approach, we can prevent people from committing crimes.
Just personally, I was a criminal when I was drug addict, by virtue of my addiction, and the ways that I had to acquire money to get drugs. Anecdotally, Chip was an armed robber, in and out of nick all the time—I hope you don't mind me telling them this—and other people I have met, you know, criminality is a necessary component. Of course we are not saying forget the victims, but I am saying it is better to address the social situation pragmatically. I think we all know this. By prescribing methadone to people, most people on methadone are using illegal drugs to supplement their habit. They are not addressing the root problems. We need to approach the victims with respect. Where there has been criminal behaviour it needs to be dealt with correctly, but perhaps within the penal system itself we can offer treatment to addicts, like the brilliant work that is done by RAPt in various institutions and prisons.

Q246 Michael Ellis: You would say there needs to be carrot and stick, would you?
Russell Brand: I don't think there needs to be a carrot or a stick. Both of those things are like bizarre metaphors. What there needs to be is love and compassion for everybody involved. If people are committing criminal behaviour then it needs to be dealt with legally, but you need to offer them

treatment, not simply out of some airy fairy, "Let's hold hands and hug" liberalism, but because it deals with the problem and it prevents further crimes being committed. Addicts that get clean one day at a time, through abstinence-based recovery, generally speaking, stop committing crimes. That is better for victims. It is better for the addicts. It is better for society.

Q247 Michael Ellis: The role that celebrities play in society is not insignificant. I want to ask you whether—

Russell Brand: I would argue that it is insignificant, and that is why they play that role.

Michael Ellis: Perhaps it should be more than it is, but what I want to know from you, Mr Brand, is whether, having got out of the cycle of addiction, and I congratulate you for that—

Russell Brand: Thank you.

Michael Ellis:—you would like to position yourself as a role model in society for those who might look to you as an example?

Russell Brand: As the great Tupac Shakur said, "Role is something people play, model is something that people make. Both of those things are fake". What I want to offer people is truth and authenticity in the treatment of this illness, in our regard to the criminal components of it, in assisting victims and in the way we legislate and organise our society. As you know, I can't be responsible—you lot hold committees all the time about the reprehensible behaviour of our media—what the cipher of my image is used to represent in the media, I have no control over.

Q248 Michael Ellis: You do. Forgive me, you do because your behaviour is some aspect of what is portrayed about you, isn't it?

Russell Brand: Yes, of course, but how is this going to be written up? This could be written up as, "Michael Ellis is sprawled on a pin there by the wit of Brand" or they could say, "Recalcitrant former drug addict rambled on". If you read it in *The Telegraph* it is going to say one thing; if you read it in the *Socialist Worker* it is going to say another thing.

Michael Ellis: It probably will be a combination.

Russell Brand: Of course the objective behaviour has components, but I am saying that what I want to offer people is truth and authenticity. Celebrity, as we all know, is a vapid, vacuous, toxic concept used to distract people from what is actually important, and in this case that is the treatment of people with the disease of addiction.

Chair: Yes, Mr Somers.

Chip Somers: As far as we were concerned, those people who are brave enough, who are both celebrities and recovering addicts, have a profound effect on the number of people who seek treatment because it gives out a very positive message that recovery is possible. When Russell Brand's book came out the number of referrals to our treatment centre was just hugely exaggerated because people suddenly discovered that treatment was possible, help was possible and people could get better, and it made a profound difference. I would hope that actually more people in the public eye—well, I suppose, being celebrities they are in the public eye—will come forward and have the bravery to do so, because it does encourage people.

Q249 Michael Ellis: So celebrities can be a very positive role model?

Chip Somers: Absolutely. Of course, then it can backfire as well when people make a big fuss about being in recovery and then relapse. That is unfortunate. But we are fortunate with Russell that he is maintaining a good recovery, and that continues to be a good role model.

Q250 Chair: Mr Brand, do you think more people need to know about things, like cocaine production and where cocaine comes from? The Committee went to Colombia to look at the effects that the harvesting of cocaine was having on the people of Colombia, who are extraordinarily poor and were forced to be involved in this kind of activity. Do you think if there were more focus on where it all came from, and how it affected communities, that would help to stop people getting involved?

Russell Brand: No, Keith. No more than the industrial consequences of oil production affect people using their cars. People don't care about industry. People care about getting the resource that they require. The illegality makes no difference, the consequences in the nation of origin make no difference. What we need is to address the emotional, mental and spiritual problems that lead to addiction. Of course, any illegal industry, or the cocaine manufacture in South American nations, or wherever, has a negative consequence for their nations but I don't think that that is something that individual drug addicts are going to be affected by, to be honest, because they are normally on drugs.

Q251 Lorraine Fullbrook: I would like to ask a question to Mr Somers. Focus 12 has three high profile patrons: Mr Brand, Davina McCall and Boy George. That is something that was probably unthinkable about 50 years ago. Do you think that has led to the de-stigmatisation of addiction, or do you think it has led to a wider acceptance of drug use in society generally?

Chip Somers: I don't think it has encouraged people to use drugs. I think there have been some people who have made a positive—

Russell Brand: This lady has to get by. Sorry, love.

Chip Somers: I was right in the middle of my answer then.

Russell Brand: Still a good speech. There were just some ladies going by.

Chair: I think the public is fine. Yes, Mr Somers.

Chip Somers: Do you know I have completely forgotten where I was.

Russell Brand: That is because he was flirting with them two.

Lorraine Fullbrook: It was about high profile patrons and de-stigmatisation or does it lead to a wider acceptance?

Chip Somers: Yes. There are certain celebrities who have made a positive message about drug use. It has not helped the situation at all. Most people who get better from drug addiction are a very positive

influence. But obviously there are some celebrities who have probably contributed to people using drugs, because they make it look glamorous, they make it look interesting, and I don't suppose that helps. While they are using they will tend to do that, but if they stop using then they obviously become a very positive role model. I do think there are some celebrities who have made the matter worse. I don't think on a national scale it has made a huge difference. There are one or two people who are influenced by that, but I don't think it is a—

Russell Brand: No. Who cares about bloody celebrities?

Q252 Lorraine Fullbrook: As the Chief Executive of Focus, how do you pick your celebrities?

Chip Somers: The ones that get clean, I will grab them.

Chair: Thank you, very helpful.

Q253 Nicola Blackwood: Firstly, I would like to congratulate you on your work on abstinence-based work. I think that it is very effective and I share your suspicion about long-term methadone maintenance. But I was struck by your comments about the problems of highlighting drug use in communities. Do you think that we are doing enough, or do you think that there is a risk that our harm reduction-based approaches to drugs education are giving a false impression that there are some drugs that are safe if they are used correctly?

Chip Somers: We are not doing anything like enough to give an honest answer to the problems of drugs, and I think we are giving a rather clouded message about drug use. There is a lot more that we could be doing about honestly educating people about drugs. I don't think we address it or take it on board properly enough.

Yes, I feel that we should be doing much more. Especially at an education level, we should be giving honest education and I don't think there are many schools that are giving honest education to young people. We have been educating young people now for 15 years and it has not had a major influence on the number of drug users. We need to change how we are doing the education of young people, particularly.

Q254 Nicola Blackwood: How?

Chip Somers: By giving more honest information. It is no good just going into schools and saying, "Drugs are bad. Stop it". Because in each of those schools there will be people who are using cannabis, who are using ketamine, who are using ecstasy. Not all the schools but some of them will be. If you don't give people both the good and the bad of drug use they will not listen to you. There are lots of people in schools who are smoking cannabis and not dropping dead. You have to give both the positive and the negative side of it, and I don't think we are doing that. We are giving too much of the negative side of it and not giving honest information. People won't listen unless it is honest.

Q255 Dr Huppert: Mr Somers, you are an advocate for abstinence-based approaches.

Chip Somers: Very much so.

Dr Huppert: You presumably know there has been work by Professor Strang, published in *The Lancet*—

Chip Somers: Yes.

Dr Huppert:—which showed that there was good evidence for methadone maintenance and very high cost effectiveness, fairly good for heroin maintenance, and a lack of evidence for abstinence. Do you think that abstinence is the answer for everybody or are you arguing that there are people for whom it is a very good option?

Chip Somers: I think it is an admirable aim for everybody. Not everybody can achieve it. Not everybody can give up smoking. I think there is a really good purpose for methadone usage at a certain stage. But just to park people on methadone for four to seven years and more, it is criminal, really, just to keep people locked into that addiction because methadone usage is a dependency, you are totally dependent. It has a role but I think it gets overused and we just tend to use it as a response to everything, and we don't do enough to intervene.

It would be an admirable aim for everybody. I don't think methadone usage is a good thing. I see very few people on methadone who are leading good, stable lives. Most of the people who are using methadone are also using other drugs on top. If I saw it producing good stability I would be much more in favour of it. I don't see that. What I do see is that people who are abstinent lead good, clean and decent lives, but obviously not everybody can achieve it.

Q256 Dr Huppert: I think that suggests further research is needed to check the results.

Chip Somers: Yes.

Q257 Dr Huppert: Can I also ask both of you. Obviously, we have finite resources to spend. If we are going to spend more money on treatment, and if we are going to spend more money on education, money has to be taken from somewhere. One possible suggestion is that we spend less money on doing the policing of possession, for example. Is that something that you would support or would you see things in a different way?

Russell Brand: I think that is a brilliant idea, as a matter of fact, and I think there are people within the criminal justice services that share that view. Yes, you have to appropriate these resources from somewhere, and—as has already been brought up in here, mate—penalising people for the possession of drugs is costly and expensive. A good number of the times I was arrested was simply for possession, and the administrative costs of that, yes, would be better spent on education and treatment. I think that would be a very, very sensible use of those redirected funds.

Chair: Mr Somers.

Chip Somers: I feel like I am at school now because I have forgotten the question.

Russell Brand: Like, do you think instead of nicking people for possession they should stick it into treatment and drugs education?

Chair: Thank you for that translation, Mr Brand. Mr Somers.

Chip Somers: There is an awful lot of money wasted on small time possession of small amounts of drugs, which are just part and parcel of the daily hustle and bustle of using. There is an awful lot of police time wasted on that. I am not saying that we should legalise it or anything, but I think if we could get rid of some of that because that sort of minor possession is part of the everyday life of being an addict. I certainly think there is a massive difference between decriminalising and legalising. It is good to treat it as a health issue, rather than a criminal issue but I am not in favour of legalising things. I think we do waste a lot of money, unfortunately, on minor possession.
Russell Brand: You spent quite a lot of time in prison on account of possession.
Chip Somers: I did. Yes, I did.
Russell Brand: But also armed robbery to get—
Chip Somers: Other drugs.

Q258 Nicola Blackwood: There is quite a gap between education and full blown addiction and treatment for abstinence. In that gap you have first use and so on, and what you need is intervention during that period to prevent addiction. Some of that prevention is perhaps first arrest for prevention and diversion programmes. Are you suggesting that we should be removing all spending on those intermediate steps in the drugs policy?
Chip Somers: No, I think we should do it better.

Q259 Lorraine Fullbrook: I would like to ask both gentlemen, what are your views on decriminalisation or legalisation of drugs?
Russell Brand: Chip has already been pretty clear on the subject. I am not a legal expert but I am saying that to a drug addict the legal status is irrelevant. It is at best an inconvenience. If you need to get drugs because you are a drug addict you are going to get drugs, regardless of their legal status, so the more money you waste in administering and controlling that, you know I think there is a futility to it.

Q260 Lorraine Fullbrook: So would you be in favour or not?
Russell Brand: To tell you the truth, yes, I would. I think there is a degree of cowardice and wilful ignorance around this condition. A good many people here—if you think about it—we all know someone who is affected by alcoholism or addiction, and it is something we increasingly need to handle compassionately and pragmatically. The criminal and legal status sends the wrong message. But, as I said before, I wouldn't start banging a drum to make drugs legal, because myself I don't take any drugs and I don't drink because for me they are bad. I just think we need to recognise the distinction that certain people have a condition, or a tendency, so that drugs and alcohol are going ruin their lives. We need to identify those people and offer them the correct treatment.

Q261 Lorraine Fullbrook: Mr Somers, do you agree with decriminalisation or legalisation?
Chip Somers: There is a real argument for decriminalising it so that it gets treated like a health issue rather than a legal issue. However, I think there is a massive difference between that and legalising drugs. You will find it very difficult to justify the legal use of a lot of drugs. You can't really justify the legal use of heroin, crack cocaine or any of those drugs. There is no medical or legal reason why people should be able to use those drugs, so I think you would be hard pressed to—

Q262 Chair: What about cannabis?
Chip Somers: Cannabis is probably the one you could make an argument for.

Q263 Chair: But you would not support the legalisation of cannabis?
Chip Somers: It is the one that you have a chance of actually putting forward an argument of justification for it. I don't think there is any justification for the legalisation—

Q264 Lorraine Fullbrook: If you legalise or decriminalise cannabis, you are not taking away the problem. We have seen the other end, where there is a serious organised crime issue and a narco-terrorism issue, which ruins people's lives; I mean murders people and causes conflict in countries, so we are looking at the other side of this.
Chip Somers: I am not advocating the legalisation of cannabis. I am just saying if there was any drug at all that you could put forward an argument for legalising, cannabis is the one you have the best chance with. But how on earth do you justify the usage of heroin or crack cocaine, or anything like that at all?
Russell Brand: Making it illegal is not working anyway, Chip. I just think that there needs to be honesty and authenticity around this issue so that people in Parliament don't look like they are out of touch. It is really good that you are holding this Committee, but some of this information is already accessible.
Chair: Thank you, final question from Mr Ellis.

Q265 Michael Ellis: You both referred to a preference for ignoring what you described as the more minor offending in relation to drugs. Can I suggest to you that a lot of the more minor offending leads to some of the more major offending, and that actually what one is doing, if one was to ignore those types of offences, would be to make the matter worse, both for society who is suffering under the increased levels of crime, but also for the offender who would be less likely to learn the lessons of having been arrested and be more likely to get worse.
Chair: Mr Somers.
Russell Brand: Can I just interrupt for a bit, because otherwise it is like they are telling us what to do. Being arrested isn't a lesson. It is just an administrative blip. You need to demonstrate an awareness of the situation. Yes, of course, in many ways the disease or the condition of addiction does exacerbate, and if you start taking drugs it is likely you will take worse drugs, and if you are taking expensive drugs you will end up committing crime. But again, mate, what we need to identify is a degree of authenticity and compassion in the way we deal

with this problem, otherwise you just seem like you don't know what you are talking about.

Q266 Michael Ellis: What about the victims of the crime?
Russell Brand: We talked about them. You can tell what party they are in from their questions, can't you, "What about the victims of the crime?"
Michael Ellis: I think all parties are interested in victims of crime.
Russell Brand: Of course we are. That is what we are saying. We are not saying, "Let's ignore victims".

Q267 Chair: I think we are running out of time. I have a final question about—
Russell Brand: Time is infinite. We cannot run out of time.
Chair: It is. But for this Committee, I am afraid—
Russell Brand: Who is next? Theresa May? She may not show up. Check she knows what day it is.
Chair: Mr Brand, I have a final question for you.
Mr Winnick: It is not quite a variety show, Mr Brand.
Russell Brand: You are providing a little bit of variety, though. You are making it more like *Dad's Army.*
Chair: Mr Brand, you have 4.5 million Twitter followers—
Russell Brand: Oh yes.
Chair:—and 1.5 Facebook followers. Having gone through addiction and then rehabilitation, what is your message to young people who want to get involved in drugs? What would you say to them about the effects that it has?
Russell Brand: My message isn't for young people. My message is for people that have this condition of addiction. If you have the condition of addiction there is help available for you, and I recommend abstinence-based recovery. Some people can safely take drugs, I think they can. As long as it doesn't turn them into criminals, or harm their health, then I don't feel like it is any of my business. I am not here to do some "Just Say No" stuff. The kids that sung that "Just Say No" were all taking drugs in the White House when they were visiting Nancy Reagan. It is a further demonstration of the disjunct between reality and authenticity. Let's have an authentic, truthful, honest debate and some funding for abstinence-based recovery.

Q268 Chair: Mr Somers, do you have anything to add to that with the excellent work you are doing in your charity?
Chip Somers: I get very muddled in all the kind of legalisation and decriminalisation. What I tend to do is deal with the problem when it exists. I agree completely that when those people come in for treatment they have damaged a lot of people in the public. They are harming at least four or five other people in their families, who are significantly distressed by that behaviour. I try and prevent that, and I think the best way of preventing that on a long-term basis is ultimately abstinence treatment. That is when you stop causing harm to families, stop causing harm to the public. That is your best chance, because at the moment I see people who are not in abstinence programmes still continuing to cause distress to families and the public.
Chair: Mr Somers, Mr Brand, thank you very much.
Russell Brand: Thanks for having us.
Chip Somers: Thank you.
Chair: We are most grateful, and thank you for your written evidence.

Examination of Witnesses

Witnesses: **Mary Brett**, Former Vice-President of Eurad, Member of Prisons and Addictions Forum at the Centre for Policy Studies, Trustee of CanSS, **Kathy Gyngell**, Chair, Prisons and Addictions Forum and Research Fellow at the Centre for Policy Studies, and **Peter Hitchens**, Journalist and Author, gave evidence.

Q269 Chair: Thank you very much for coming to give evidence. As you know, the Committee is conducting an inquiry into drugs policy and all aspects of drugs policy. Mr Hitchens, if I could start with you. You have been quite critical of successive Governments, including, to some extent, the terms of reference of our inquiry. Because I think you have a feeling that all this strategy does not result in Government and Parliament being tough on those who use drugs. Is that your view? Are you worried about the way in which drug strategy is developed?
Peter Hitchens: In my view, the simple summary is this. Most discussion on drug policy in Britain today is based on the following false logic: that there has been an attempt at serious prohibition of drug use, that attempt at serious prohibition has failed, therefore, we should abandon any future attempts at serious prohibition. The truth is—and it is easily examined if you look, for instance, at the arrest figures, if you look at Lord Hailsham's instructions to Magistrates, dating back to 1973—that this country abandoned any serious attempt to prohibit the use and possession, particularly of cannabis but also actually of class A drugs, many years ago. We have, informally and without admission, a system of decriminalisation in this country more advanced than in either Portugal or the Netherlands. To argue on the basis of that, that prohibition has failed and that, therefore, we should have even less of it, is not merely false and mistaken but actually unhinged.

Q270 Chair: That is very helpful. Mary Brett, the Government's overall strategy, do you think it is going in the right direction?
Mary Brett: The new strategy?
Chair: Indeed, the new strategy.
Mary Brett: The new strategy. I am in drug education, really. If they do what they say, and stop people from ever taking drugs in the first place, I will be absolutely delighted. They say that they will give accurate and reliable information, and that is not out there at the moment. But if that is altered, yes, I am happy with it.

It makes a change from the harm reduction education, which has been in vogue for the last—I don't know—10 or 15 years, something like that.

Kathy Gyngell: I agree that the war on drugs is—you would like to say, reports of my death have been much exaggerated—something that has not happened. We have de facto decriminalisation. As Mr Brand said, being arrested is an administrative blip, if it indeed happens. If anything happens after arrest you are even luckier. I think since cannabis was reclassified to class B, in effect, all we have had in the majority of cases are warnings. Children haven't been protected. There hasn't been proper intervention, and unfortunately there are not the types of intervention programmes, following that initial arrest or warning, that do help children and stop them from continuing.

Q271 Chair: Mr Hitchens, you have been absolutely clear you are against decriminalisation. But you have probably followed events in South America where, following the visit of President Obama—indeed, before he visited Colombia recently—the Heads of Government of South American countries are all saying that we have to have a debate about decriminalisation, because the so-called war on drugs—and this is where they agree with you—has not really worked. Is there no possibility, do you think, of any form of decriminalisation to try and deal with the drugs barons who tend to run these cartels?

Peter Hitchens: Mr Chairman, we have decriminalisation. We have had decriminalisation in this country since the passage of the Misuse of Drugs Act in 1971, a bipartisan measure. Particularly since its implementation, after Lord Hailsham's speech to the Magistrates' Association, in October 1973, when he instructed Magistrates to cease sending people to prison for cannabis possession. That has then grown over the years into a reduction of penalties for that drug, to such an extent that the prime police response to a cannabis arrest now is something called the "cannabis warning", which does not even have your legislative seal on it. It was created entirely administratively by the Association of Chief Police Officers and has no legislative force, nor does it have any criminal force. Cannabis in this country is effectively decriminalised. One could point out further, if you want me to go into this—

Chair: Please.

Peter Hitchens:—from an answer obtained by Nicola Blackwood, some months ago, that the actual performance of the criminal justice system towards class A drugs is not much stronger, so we have a situation of decriminalisation. To argue that to solve any problem to do with drugs you would need to decriminalise is, therefore, to argue from a position of saying we need something that we already have, which we have had for 30 years. The huge tragedies visited, particularly on South and Central America, are the result of the enormous self-indulgence of drug takers, consumers in the Western world, who happily take these revolting substances and therefore create this enormous and disastrous trade that, as we know, leads to the tragic results that we are seeing at the moment, particularly in Mexico and other countries. That is not because of prohibition policy, it is because of a long-term policy of decriminalisation under which many, many people believe that effectively these drugs are legal.

Q272 Dr Huppert: Mr Hitchens, I am fascinated by what you say. As I understand it, you have been arguing that there has been a decriminalised policy since the 1971 Act, which actually did the criminalisation in the first place.

Peter Hitchens: Yes.

Q273 Dr Huppert: Currently, around 80,000 people in the UK are convicted or cautioned for possession of an illegal drug every year. If you think that is a decriminalised policy, how many do you think should be convicted or cautioned each year under your criminal policy?

Peter Hitchens: It is not the figures of convictions or arrests that you need to look at. It is the disposals of the cases when they actually come about. I should point out that, as far back as 1994, John O'Connor, a former head of the Scotland Yard Flying Squad, said, "Cannabis has been a decriminalised drug for some time now".

Dr Huppert: That is a fascinating quote but it is not actually an answer to my question.

Peter Hitchens: No, let's move on to the situation of cannabis, right? Excuse me for a moment while I consult my note here to get this absolutely right, because it is very, very important. In 2009 there were 162,610 cannabis cases handled by the police in England and Wales. That is the latest year for which I can obtain figures. Of these, 19,137 were dealt with through police cautions, which expire after three months and need not normally even be declared to employers; 11,492 resulted in penalty notices for disorder, which is an on-the-spot review that generally results in no punishment of any kind; 22,478 actually ended in court, and many of them did so because they were only one of several charges against the defendant; 86,593 were dealt with by the cannabis warning, which I just discussed with you, which is nothing.

Dr Huppert: Mr Hitchens, firstly—

Peter Hitchens: If I could just make the point I am making, the criminal justice system goes through the motions of pretending to enforce the law against drugs but it does not actually do so. You can possess a drug that is technically illegal in this country. You can be caught in possession of it by the police and nothing whatever will happen to you, and most people know that.

Q274 Dr Huppert: But, Mr Hitchens, we are talking about 162,000 cases, which strikes me as rather a lot.

Peter Hitchens: It is.

Q275 Dr Huppert: You are saying, collectively, 80,000 go through cannabis warnings. That still leaves 80,000 who are convicted or are cautioned, and that number has been the same since before cannabis warnings.

Peter Hitchens: They are not convicted. Cannabis warning is not a conviction.

Dr Huppert: Well, exactly.

Peter Hitchens: It has no legal status whatsoever.

Q276 Dr Huppert: Mr Hitchens, I am agreeing with you on that. In round figures, there are 80,000 who have cannabis warnings and 80,000 who are convicted or cautioned. You say that is not a proper criminal policy. I would like to know how many people you think ought to be convicted otherwise, and are you aware, for example, of the European Monitoring Centre that has looked across Europe and found no association between the severity of sanctions and the amount of drug use?

Peter Hitchens: Again, it depends on how you are measuring the severity of sanctions. The sanctions exist to some extent on the statute books of the countries involved but there are no sanctions being applied. Before the 1971 Act, I think you will find that 21% of persons arrested for cannabis possession were sent to prison immediately. Before the 1971 Act completely changed our laws, there was actually a sentence of imprisonment for possession of cannabis that was frequently applied on a first offence. Now, you are caught by the police actually in possession of cannabis and they let you go and you do not even get a record.

Dr Huppert: Around 1,000 every year are jailed.

Chair: Dr Huppert, Mr Hitchens, if I just bring in Mrs Gyngell.

Kathy Gyngell: Yes. I would to like to come back to Dr Huppert. The very interesting study done by the European Monitoring Centre, which he refers to, in fact not only shows that drug use in Britain is much higher than in nearly every other Western European country, and that problem drug use is about three times higher, but it shows that the criminalisation in the other countries, which have lower drug use, is much higher. The proportion of people who get convicted and sent to prison, startlingly in this country, is much lower than in the Netherlands, which adopt quite a rigorous approach to hard drug use and to cannabis cafes that break the law, which they do all the time.

Chair: Very helpful. Ms Brett, do you wish to add anything on this?

Mary Brett: No, I think the other two are much more clued up on this.

Kathy Gyngell: Can I just add?

Chair: Yes, of course.

Kathy Gyngell: President Santos said, on the BBC before Christmas, that as long as people in the UK sniff coke here, or in New York or Paris, we will suffer here. We all know that. At the moment, 2% of people sniff coke here. People, like Russell Brand, would like us to believe that this is common. It is still not common. It is common in certain circles. If you decriminalise drugs, the chances are the risk you take is the rate of usage would go up to the rate of smoking, which is about one-fifth of the adult population. I wonder if any of the Committee have stopped to think how they would feel about one-fifth of the Cabinet, one-fifth of their children's school teachers, one-fifth of doctors or nurses, possibly being able to sniff cocaine because it is not arrestable.

Chair: Ms Gyngell, the Committee met President Santos last month and we received the same message from him. But it is good of you to remind us.

Q277 Dr Huppert: Yes. I think President Santos has been quite clear that he would like to have discussions about decriminalisation because he sees it as a way of significantly reducing the harm, and it is very clear—

Kathy Gyngell: Perhaps he has given up on us reducing demand for drugs here.

Dr Huppert: He was very clear about the discussions that he would like to see on that. But can I ask all three of you, there is a lot of question in this area as to whether people look at the actual scientific evidence of the harms, look at the actual studies that are done and then reach a conclusion, or reach a conclusion first and then look for aspects of data that will support that. Are you all in favour of the idea that you should have evidence-based policy?

Chair: If we could have a brief answer from each and then we need to move on. Mr Hitchens.

Peter Hitchens: Of course I am, yes. Who would not be?

Kathy Gyngell: I am, but it is very abused. It can be evidence-based policy or it can be scientific tunnel vision. For example, the methadone trials, previous doctors giving evidence here say this is gold plated evidence. What do they demonstrate scientifically, that opiate addicts like opiates? Quite frankly, they demonstrate that if you give free opiates to addicts you will retain them in treatment for a while. They give evidence that it minorly reduces their dependency on street drugs. Other evidence shows that methadone drug deaths have gone up dramatically since this type of medicine was being used. So we have to be very careful about what counts, what is relevant and what is translatable.

Chair: Thank you. Mary Brett.

Mary Brett: Yes, it must be given on evidence. My particular concern is cannabis. There has been quite a lot of discussion already about cannabis. The facts and figures being given out about cannabis are inaccurate. They are misleading. If I talk about FRANK giving out things, the information, there are grave omissions in the cannabis information. The scientific evidence is there but a lot of it is being ignored, and I would like the opportunity later in the meeting to tell you about the harms of cannabis.

Q278 Chair: We do have other questions for you. Just quickly, do you think FRANK is a success or a failure? The Government's initiative.

Mary Brett: There are some very good bits about FRANK. But, no, I mean there was a survey in 2010 by Addaction, which found that only 10% of children would phone FRANK, would look to FRANK. This is the sort of thing that is coming through. I personally have had very negative vibes about FRANK from all sorts of people.

Chair: Very good. We will come and ask you further questions on education.

Q279 Michael Ellis: Mr Hitchens, I think you referred to the self-indulgence in the use of drugs?

Peter Hitchens: Yes.

Q280 Michael Ellis: Would you support the premise that it is not only those who are being self-indulgent who partake in the use of drugs. Do you accept that many people, certainly when they start out using drugs, are feeling unwanted, depressed, lonely and inadequate when they get into the first use of drugs, and that they need help? That they are in effect victims, too, and that sizeable efforts need to be made towards rehabilitation rather than just punishment?
Peter Hitchens: Personally, no. I think that taking drugs is a wrong thing to do. I think there is a good reason for there being a law against it, and if people do it they should be punished accordingly to the law. If we had held to that, then we would still have the levels of drug use, which we had before the 1971 Act, which were minimal. I don't think drug users should be indulged. I do not think the advocates of drug decriminalisation should be indulged either, as the previous witnesses were.
Michael Ellis: If I could just quickly ask the others?
Kathy Gyngell: I have to say I do differ with Peter here. I agree with much of what Mr Brand said about abstinence. I don't agree with his views on the legal status or otherwise of drugs. I do think drug addicts' behaviour needs confrontation, and then the follow on should be correct and it should be supportive. But I do think it should be quite conditional on a level of compliance and co-operation. I think the drug courts in America have been hugely successful, about 3,500 of them, and they have sentenced abstinence treatment. Our problem is we do not sentence abstinence treatment. We sentence people to further use synthetic opiates.

Q281 Lorraine Fullbrook: A quick clarification from Ms Gyngell. You were mentioning about coke use, for example, and how it would increase to the level of smokers if it was decriminalised, or legalised, and that the Committee should think about that. This has been a long inquiry and we have searched all over the world on this subject. Are you making the assumption that the Committee are in favour of decriminalisation or legalisation?
Kathy Gyngell: I was worried that you took your terms of reference, or apparently appeared to—and I indeed wrote to Mr Vaz about it—from the Global Commission on Drugs policy, which is basically a highly financed legalising lobby. That did disturb me because, equally, they had given out—and they were widely disseminated in the press—incorrect figures about drug use spiralling out of control globally when, indeed, the UNODC shows quite clearly that it has been stable. So, that did concern me that your direction of travel may have been influenced by lobbies who are very much in favour of decriminalisation, and if that is not the case I am very happy to hear it.

Q282 Lorraine Fullbrook: Can I just say, we have travelled to Turkey, to the United States, to Colombia, and we will go to Portugal as well, and we have seen many witnesses, and I think it is fair to say that every person we have seen has given us different figures. So no two figures have been the same, whoever we speak to.
Kathy Gyngell: No, but there is only one. You either have to accept the statistics that are collected and used, and that is by the United Nations. That is reported in a huge report every year, and unfortunately the Global Commission slightly misused these figures, or reported them incorrectly, and it was a difference of 30% in the case of hard drugs. So that is my only point, and you did mention this particular body in the terms of reference of your inquiry.
Chair: Thank you. Please be assured that the Committee has not taken a view on any of these issues—that is why we are seeking evidence from the widest possible sources of witnesses—and at the end of the day we will then publish our results. We are not under the control of any individual group, as Mr Steve McCabe will show.

Q283 Steve McCabe: If I could ask Mr Hitchens and Ms Gyngell this question: from your experience, what do you think is the most effective way of schools warning children about the dangers of drugs?
Chair: Start with Mary Brett.
Steve McCabe: No. I will come to Mary Brett, but I was asking Mr Hitchens and Ms Gyngell, Chair.
Peter Hitchens: I don't claim any particular expertise in what schools should do. But I think if you have a properly enforced law, where cannabis possession, which is illegal, is punished when detected, then one of the most important things you will do is you will armour people, who are under strong peer pressure from their school fellows to take drugs, against that. You will give them a good reason. They can turn around and say, "No, I will not do that. I don't want to risk having a criminal record. I don't want to risk never being able to travel to the United States for the rest of my life. I don't think it's worth it". The whole purpose of a strongly enforced and clearly set out legal prohibition on drugs is to strengthen people against that sort of pressure. In schools it would be enormously useful if we had a proper law, if we enforced it and if it was seen to be enforced.
Kathy Gyngell: I agree. A clear statement about the law, by people who are responsible, is the thing that makes the most difference to children. The thing I found most difficult, when my teenage sons were growing up, was to find that cannabis had been declassified, and at one point I had a son telling me, "It's not against the law". I said, "Well, it is against the law". I think parents need the support of the law, in order to be very clear with their children, and being very clear with your children is the most effective way to prevent them using drugs in the first place. That is my own experience, and it has been borne out by my own experience, absolute clarity about the law and the wrongness of doing this and we have lost sight of that. We are very liberal. We are very casual.

Q284 Steve McCabe: Thank you very much. Ms Brett, I read that you had said that harm prevention has no place in the classroom, and I wondered if you could explain to the Committee what you meant by that and what you think about the comments we have just heard?
Mary Brett: Harm reduction has its place. If you have an addict, somebody dependent on something, then

you can reduce the dose gradually and get them off. In my opinion, that is where harm reduction belongs, not in the classroom. You stand in front of a class, you have 30 children there, 90%-odd of them have absolutely no intention of taking drugs. The policy has been harm reduction for the last—I don't know—10 to 15 years, something like that, and harm reduction assumes that children will take drugs anyway so we need to show them how to do it safely. Now, we know there is no guaranteed safe way of taking any drug.

The other phrase that keeps cropping up all over the place is "informed choice". I hope to be able to explain that they are not being properly informed at the moment, and—hold on—we are giving them the choice to do an illegal act? We don't give them a choice to pilfer or spray graffiti or anything like that. The choice in the QCA and DfES guidelines is from age seven. Seven-year-olds have extremely immature brains—I don't need to tell you that. The other thing about children choosing is they are completely incapable, because the risk-taking part of the brain develops before the inhibitory part of the brain, so the children are most likely going to take this risk. If you go in and give harm reduction advice to children, on the assumption they are going to take drugs anyway, which is rubbish because 30% or 40% of children may try them but the actual use of cannabis, in the 11 to 15-year-olds, regular use in the last year was 4.4%. It was very, very low. So you should not assume that they are going to take it.

So you give harm reduction advice—and on FRANK there still is harm reduction advice—in other words, this is the amount of mushrooms that people use, ecstasy, drink water, sip it. That is all harm reduction advice, and that sort of thing acts as a green light for children. I know instances where it has happened. They have gone on to FRANK's website. They have looked up the advice. They have taken the advice—and in the case of cannabis it has been removed now—but they have become psychotic.

Q285 Steve McCabe: I think the statement about the clear legal position is obvious. Mr Somers seemed to suggest that one of the problems of giving advice that young people might know not to be entirely accurate, is that it weakens the whole impact of your message. Do you have any sympathy with that view?

Mary Brett: With not giving advice—

Steve McCabe: He suggested that if youngsters are told things about drugs, which they know perfectly well are not entirely accurate, it may lead to them dismissing the entire message that you are trying to convey. I wondered if you had any sympathy with that view.

Mary Brett: If drug education is done properly. I was a biology teacher and I taught in a boys' grammar school for 30 years. I have researched cannabis for years now, I wrote a huge report in 2006 and I keep it updated. I have really gone into this in a big way. If you talk to children and explain it in a scientific way, but age appropriate obviously—because it was a boys' school of course they were interested in the scientific side anyway, give them the truth, don't exaggerate, don't patronise, just talk to them as sort of equals and give them the truth, the scientific truth—they will not take drugs. People get children wrong. The vast majority of children have no intention of taking drugs. What they want is good, accurate, really reliable information about drugs, so that they can say "No" to their peer group. Someone mentioned the peer groups earlier. Kids want excuses. I know this. They used to tell me, "Give us more information". Parents used to take information away with them, so that they could talk to their children. If you do it honestly, clearly, are willing to be challenged, have your evidence, then you are 90%-odd there.

Steve McCabe: Thank you.

Q286 Mr Winnick: Mr Hitchens, is it your view that if there were a real hard line policy, more hard line than successive Governments have perceived, the number of people taking drugs would substantially fall?

Peter Hitchens: Yes, it is. I think it was the case. Obviously the arrival of cannabis in this country after the Second World War was a slow business. In 1945 the number of convictions for cannabis possession in the whole United Kingdom was four and in 1960 it was 235. Even in the early and mid 1960s it was only at a level of about 1,000. Since the 1971 Misuse of Drugs Act, which was itself an implementation of Baroness Wootton's report—which was not a call to legalisation but was in effect a call for the decriminalisation of cannabis, particularly—the numbers have gone up immensely. In 1972, before the Act had begun to take full effect, 12,599 cases, now we are up to 160,000 arrests a year in England and Wales alone, not including Scotland. There has obviously been an immense change. You can put some of that down to social change but how much of that social change can you attribute to the legal change and the increasing unwillingness of the legal system, and the police, to arrest, prosecute or punish for cannabis possession? I think they have to be linked.

Q287 Mr Winnick: The figures do confirm more or less what you have been saying. For example, the 2010–2011 British Crime Survey showed that some 2.2 million people were using cannabis, and one in six young people took cannabis. Are you really saying to this Committee that, if there were a harder policy, a large number of those people would simply stop because they would be frightened of being convicted in court and going to prison?

Peter Hitchens: Yes. But you must understand this has been a long, slow process of change that has been very gradual. The interesting thing about the 1971 Act is that it contained various mechanisms, including the ACMD, to put its provisions under constant review. The powers, as originally set out in 1971, have been substantially reduced, again and again, until the introduction—as I say, without legislation—of the cannabis warning, after the Brixton experiment of the early 1990s and the Runciman report. There has been a long, slow conveyor belt downwards, during which the penalties have been reduced. As a result, the police have found it increasingly tiresome and time wasting to bother enforcing a law that does not have any penalties. So you could not immediately reintroduce the provisions of 1971 and expect a revolutionary

change, but what you certainly should not be thinking of doing is reducing those penalties still further and imagining that, by doing so, you are going to make anything better.

It is quite clear that, during the time when penalties have been reduced, things have grown worse. To argue, as so many people do—and I name this the Simon Jenkins' tendency above all—to say, over and over again, that we have a serious problem of over-enforced prohibition, "This is failing. Therefore, we must resort to total decriminalisation", it is just not logical because the facts do not support it. We have not been prohibiting cannabis or indeed the class A drugs during that time.

Q288 Mr Winnick: So what you would be saying, Mr Hitchens—obviously you will correct me if I am wrong, heaven forbid that I should put words into your mouth—that if there were a far firmer policy by Government in effect what would be the position is that the drug war, as it is described, would be won?

Peter Hitchens: No. I don't think you can win it. That is trying to defeat human nature entirely. But you would certainly have much less drug abuse in this country.

If it is travelling abroad, I hope your Committee will be visiting Sweden, which is the one European country that has not generally taken the position of harm reduction and decriminalisation, either formal or informal. As a result, it has rather lower drug use, particularly of cannabis, than we do or I think than any other major European country.

Q289 Mr Winnick: I doubt if there is anyone here, certainly not on this Committee and I doubt in the House of Commons, who would have any sympathy with drug taking. I would be most surprised. Be that as it may, what would be your response to the view that prohibition rarely works? The example that is given time and again, whether it is one that you would accept, is prohibition of alcohol in the States that collapsed totally. You would say there is no comparison between the two?

Peter Hitchens: You can certainly put those words into my mouth. There is an enormous difference, for instance, between them. If you have all day we can go into the problem of alcohol, which I think in this country should be much more severely restricted. I think we should return to the 1915 licensing laws, at the very least. But to prohibit a drug that had been in common use for hundreds or indeed thousands of years—or in the case of the United States had never been illegal—and to try and introduce laws prohibiting it; laws, I might add, that had exactly the same failure as our anti-drug laws, in that they prosecuted supply and transport but not possession. So to appeal to that, and say that failed and, therefore, any attempt to not so much prohibit as to interdict and discourage the use of drugs, to say that, because of that one particular, individual, specific failure, in a culture very different to our own, we can never attempt, ever again in the rest of the history of the human race, to try and prevent the spread of unpleasant, damaging and dangerous drugs, just seems to me to be, again, illogical and not evidence-based.

Q290 Mr Winnick: One more question. Heaven forbid, as I said before, that I should put words into your mouth but it was a question. There is another view that obviously I would assume you don't accept, namely that the drug traders, the arch criminals—and they are among the worst kind of criminals—who do their utmost to encourage people to take drugs, would they not be rather keen on a policy that Governments have pursued? But if it were different, if it were legalised—and this is where I give a view, I am not suggesting it is mine—if it were decriminalised the drug dealers would be rather upset, to say the least?

Peter Hitchens: I don't believe so. For instance, alcohol and cigarettes are both legal in this country. Yet both are either smuggled, or produced illicitly, by criminal gangs in this country in quite large quantities. Unless you made drugs free of charge, and gave them away on street corners, there would still be plenty. Given the fact that a lot of the people who like to take drugs are, by the nature of the lives they lead, unable to afford them out of their own productive activity, the chances are there would always be an opportunity for criminal gangs. Also it is—

Q291 Mr Winnick: Presumably far fewer.

Peter Hitchens: No. I don't think so. There is no reason to suppose so. What might well be the case, if you were to legalise or decriminalise drugs entirely, is that you would increase criminal activity rather than reduce it because of this precise problem: people who want to take drugs are often the kind of people who don't particularly want to pay for them. The solution we have come up with for this at the moment—the methadone programme and various adjuncts to that—instead of drug takers and abusers stealing from individuals to fund their habit, Government steals from the taxpayer to fund the habit of the drug takers, and we are told that this is some kind of advance.

Chair: Thank you. We have to move on.

Peter Hitchens: If that is not organised crime I don't know what is.

Q292 Bridget Phillipson: Just returning to the area of education. Obviously we have talked a lot about illegal drug use, but I would be interested to hear your views about alcohol and education for young people. Because often alcohol is a drug that is most easily accessible to young people and often gives rise to the most obvious harm in communities, such as anti-social behaviour. What role do you feel education has in terms of alcohol and drugs and the linkages there?

Mary Brett: I used to do the same amount of time on alcohol and tobacco as I did on the whole of the drugs. I had very little time; a high academic school, very little time for anything like this. But I used to talk about alcohol in the same way and explain exactly what it does to the brain, the body and everything. One thing that used to amaze the children—I did this in year 9, which is 13 to 14—a lot of them were never told that alcohol can actually kill them, they can overdose and the respiration muscles are suppressed and they can die.

So again, you give them all the facts, the true scientific facts, whatever, you throw in a few social things and so on. I have approached the whole of the health

education I was in charge of, in the same way, in the same scientific, factual way, speaking as equals and not patronising, not talking down to them, and just explaining exactly what would happen. That has a huge effect on children. If they know exactly how alcohol or drugs is going to affect the body then they are with you.

Peter Hitchens: Just a very small point about this. One thing that is very dangerous is to link legal alcohol with illegal drugs. They should be dealt with separately. The fact that some drugs are illegal should be repeatedly stressed, and to confuse the legal and the illegal drug is actually to confuse the mind of the child.

Kathy Gyngell: I certainly think that the idea that legal sanctions have no impact is, of course, not true and I think the risk of removing those sanctions would definitely be a significant increase in use. As Paul Hayes said to your Committee the other week, at the moment 0.6% of the population use heroin and crack, and it is a declining proportion. That means 99.4% do not. We know that only a few percent use cannabis, 2% use cocaine. The idea that you would risk increasing use and, therefore, increasing the demand that would then impact on countries abroad, to which we also have a moral responsibility, I find extraordinary. That you would be at this point of still fairly low usage, but disproportionately damaging usage, that you will be thinking of putting the white flag up to use and risk it rising to levels that are something like smoking, I find this a very strange way to think at all.

Certainly, with education for children on cannabis I think the most important thing now is that we should be focusing on the domestic skunk market, which is the pressing problem in this country that is within our power to deal with. We have blithely stopped protecting children. We know skunk now causes psychosis. We don't know what is happening in gangs in South London and knife crime, and what role psychosis is playing there. This is something that I think should be the pressing concern of the Committee. This is stuff we can deal with here at home.

Chair: The Committee is going to deal with all these issues. This is a long, detailed inquiry and that is very helpful. Nicola Blackwood has the final question.

Q293 Nicola Blackwood: If along the lines of this debate more people are being convicted and sent to prison, one of the big problems that we have is the wide availability of drugs in prison, which is reported and rumoured but there is very little solid evidence for. I understand the Policy Exchange published a report in January, which claims that one of the big problems was corrupt staff, in particular, alleging that around 1,000 corrupt members of staff were involved in this issue, which is about seven prison officers per prison. Do you think that this is accurate and do you have any evidence to support these claims?

Kathy Gyngell: The Centre for Policy Studies, prior to that paper, we also published our own paper about keeping drugs out of prisons. There are a number of issues involved that could be addressed, and one very big one would be the consistent and comprehensive use of sniffer dogs. At the moment there are not that many teams of dogs, they are laid off, it can be judged when they are on or off. There are so many holes in the system for keeping drugs out of prison. What we have done over the last few years is spent more than £100 million on introducing methadone into prisons as the first line treatment. There have been huge worries that that itself is adding to the illicit currency, drugs currency, and putting prisoners at risk. Maybe you would like to ask the question: how would it have been in those years that £100 million was spent on plugging the holes, whether it is over the wall, whether it is corrupt staff, lack of sniffer dogs, lack of control over mobile phones? If the money had been spent to toughen up all those things, it would be interesting to know what would have happened in the prisons since then.

Chair: Thank you. Mr Hitchens.

Peter Hitchens: It is a measure of the moral and legal disarmament of this country, in the face of drug use, that in prisons, which above all should be under the control of the law and the Government, we have serious drug abuse. I think it tells you probably more clearly than anything else how far the de facto decriminalisation of drugs has gone in this country that they are prevalent in our prisons.

Q294 Chair: Yes, Mr Hitchens, you are absolutely right, prisons are one of the areas that this Committee will look at very, very carefully. You are absolutely right to raise it with us. Do you want to add anything, Mary Brett, to Nicola Blackwood's question?

Mary Brett: Not really, but I have a few burning points I would really like to make.

Chair: Could you give them very quickly. I have the Home Secretary hanging around in the corridor outside, and I do not want to keep her waiting any longer.

Mary Brett: You are putting me under pressure.

Chair: You could always write to us with these points, but the main points if you could tell us what they are.

Mary Brett: Can I just say a few points about cannabis, which are not understood?

Chair: Of course.

Mary Brett: One is the strength. There are a lot of myths about the strength of it. The last proper Home Office potency study was in 2008. At that time skunk, which is 80% of our cannabis market, was 16.2% THC, which is the psycho-active drug. Herbal cannabis in the 1960s and 1970s was 1% to 2%. You see, FRANK says skunk is two to four times stronger than herbal cannabis. Wrong. You can hardly get herbal cannabis now. The other 20% of the market is hash, which is about 4% to 6%. With this huge THC strength with skunk this is doing an awful lot more damage. The Dutch have just banned any THC over 15%, because they are now looking at skunk as a hard drug and we should be doing the same.

Chair: That is extremely helpful, and I think on the other points that you wish to raise with us, if you could write to us. That would be extremely helpful indeed.

Mary Brett: I will. Thank you very much.

Chair: I am afraid I am going to have to call this session to a close, as I say, because, we have other witnesses. Thank you very much for coming in, all three of you, Mr Hitchens, Ms Gyngell and Ms Brett. We may well write to you again, and please feel free to write to me if you think the Committee is going off in the wrong direction. We are very keen to know this because we want to make sure that this is a very thorough inquiry, and it will go on several months. Thank you very much for coming in.

Tuesday 19 June 2012

Members present:

Keith Vaz (Chair)

Nicola Blackwood
Mr James Clappison
Michael Ellis
Lorraine Fullbrook
Dr Julian Huppert
Alun Michael
Bridget Phillipson
Mark Reckless
Mr David Winnick

Examination of Witnesses

Witnesses: **Professor David Nutt**, Independent Scientific Committee on Drugs and former Chairman of the Advisory Council on the Misuse of Drugs, and **Dr Les King**, former ISCD and former ACMD member, gave evidence.

Q295 Chair: Professor Nutt, Dr King, welcome to the Home Affairs Select Committee. Welcome back, I should say to you, Professor Nutt. The Committee is conducting its inquiry into drugs. It is a very wide and varied subject, but we would like to concentrate today on comments that both of you have made and the work and recommendations of the advisory group that you headed until 2008. Perhaps I can start with you, Professor Nutt. You became famous in 2008 for your comments about horse deaths and ecstasy: 100 people had died from horse-related deaths and 30 from ecstasy. That was your comment then. Are you still of the view that this is a valid comparison when we look at something like drugs?
Professor Nutt: Very much so. It was not an arbitrary choice of horse-riding as a comparator, it came from a patient I had seen who had suffered irreversible brain damage from falling off her horse, and she came to me for treatment. In fact I did treat her; I treated her with amphetamine. It did not help greatly but it controlled some of her impulsivity. But it got me thinking, "How dangerous is horse-riding?" I discovered, remarkably, that it was considerably more dangerous than I had thought. Then I thought that it was an interesting comparison because it is something that people do—young people do—and it is popular but dangerous. It is probably addictive as well; many riders find it difficult not to ride. I thought it would be an interesting experiment to compare this pseudo-drug, equasy (equine addiction syndrome), which a lot of people think is a drug now.

Q296 Chair: Is this because you believe that there is a lot of comment and speculation about drugs that is not based on fact, that there is not evidence to back up what people are saying?
Professor Nutt: Yes. I think people have a very exaggerated perception of the harms of drugs and they tend to minimise the harms of other activities that particularly young people engage in that are potentially as harmful or more harmful. I thought it is important if we are going to debate drugs and make laws about whether people should or shouldn't use drugs and if these are going to be based on harms, we should know about proportionate harms. We cannot see drugs in a bubble; they are part of life, and they are part of the world.

Q297 Chair: Who is the best person or which is the best organisation to be able to put out a definitive list of drugs that are used and the effects, harmful or otherwise, of those drugs?
Professor Nutt: What we have recently is the new committee that I have set up and I am part of. I think our recent paper in the *Lancet*, which uses the multi-criteria decision analysis, is a very sophisticated approach to assess a range of drugs using 16 parameters. I think that is the state of the art at present. I think that *Lancet* paper, which you have, is as good as it gets. To be honest, it has been validated now by a number of studies in other countries and I think that is probably the status quo for at least the next decade.

Q298 Chair: Going back to your role as Chairman of the Advisory Council, do you think there ought to be a statutory requirement that will mean that Governments have to follow the recommendations of the Council?
Professor Nutt: If the Council was independent and properly constructed so as to represent the full range of expertise necessary to adjudicate in this field then, yes, I think there should be statutory powers. I like the model that we have now with the Bank of England. The Bank of England makes decisions about interest rates free of political interference, specifically to stop party politics contaminating sensible decision making. I think the ACMD or some other equivalent, maybe ISCD, an independent body should be constructed to do that.

Q299 Chair: But do you think it is the meddling politicians that get in the way of the science?
Professor Nutt: The reason the Misuse of Drugs Act was set up in the first place was to stop people playing politics with drugs, because it is such an easy area in which to score political points.

Q300 Chair: Do you think there is too much party politics?
Professor Nutt: Unquestionably, there is no issue whatsoever. In the 10 years I worked on the ACMD, politics dominated decision making much more than science.

Q301 Chair: You would make recommendations, Home Secretaries would look at them and then, because of a political decision, they would decide not to support your recommendations. Do you think that is wrong?
Professor Nutt: They would only support recommendations that made drugs more illegal or increased the sanctions. There was only one drug downgraded in the whole history of the Act, i.e. 40 years, which was cannabis; this used to be class A or B, depending on its formulation, that was reduced to class C. That is the only drug that has ever moved appropriately in the Act downwards. Lots of other drugs have come in and some have moved to absurd situations. Putting magic mushrooms as class A was almost a final nail in the coffin of any rationality in the Act. Politicians, essentially, are very happy if you have made drugs illegal or put them in a higher class; they are very, very unhappy to move them down. Only David Blunkett had the courage to actually allow a drug to move down.

Q302 Chair: You have said that 25% of the British public would switch to smoking the drug cannabis rather than drinking alcohol if it were to be available at Amsterdam-style cannabis cafes.
Professor Nutt: That is my estimate, and I think—
Chair: So you think it should be decriminalised?
Professor Nutt: Absolutely, yes, no question about that. I think the Dutch model, the Portuguese model, the current Spanish model are all very rational approaches. They would reduce harm in society because what we see now is a rising, rising, rising tide of damage from alcohol. There is no doubt a lot of people drink because it is legal and if there was an opportunity to use cannabis in a coffee shop-like model, they would not drink.

Q303 Chair: You maintain that alcohol is just as dangerous or more dangerous than cannabis?
Professor Nutt: It is considerably more dangerous than cannabis, yes.

Q304 Chair: Is cannabis a special case, or are there other drugs that you would like to see decriminalised?
Professor Nutt: My own view is that if society allows people to market the drug alcohol, then if people want to make a rational decision to use a drug that is less toxic than alcohol, they should be able to do that.

Q305 Dr Huppert: One of the questions we asked ISCD was whether detailed consideration ought to be given to alternative ways of tackling the drugs dilemma. The response was, very briefly, "Absolutely. The current approach to the issue of drugs has not reduced use or harms significantly at all." I know your book goes into this in much greater detail. I believe you have also published an analysis of lots of drugs, where alcohol, rated on a harm score, I think scored 72 and cannabis scored a total of 20 with lower harms to users and to others. Could you talk us through more about how that was calculated and how rigorous that assessment is of the comparative harms?
Professor Nutt: This uses a technique called multi-criteria decision analysis. It is, as far as we know, the best methodology for comparing harms across different dimensions. So here we are looking at harms from death at one extreme to international damage by wiping out jungles in Columbia at the other. These are completely different dimensions of evidence. Multi-criteria decision analysis allows us to pull those together in this sophisticated way. We went to Larry Phillips at the LSE, who is a world expert on this. We got him to chair the meetings in which we did this analysis. We used the very sophisticated 16-point scale that had been developed with me at the Home Office before I was sacked, to look at the harms to the individual and the harms to society. Essentially what you do is you score each harm for each drug on a ratio scale from zero to 100, and that then allows you to compare the relative harms across the different parameters. The key point about this process is that you can then weight it. You can make a decision as a group about which matters most and which matters least. You will see from the *Lancet* paper, if you look at the very detailed figure, that we decided that economic damage was the most important variable of all those 16 in the UK. You will see that is a significant contributor to the harms of alcohol. That analysis can be applied by anyone. We applied it as an expert group. It is an analysis that I would be very happy to work through with you. We can do that with you if you like.
Chair: Professor Nutt, this is absolutely fascinating and we are most grateful, but could we have just slightly briefer answers, because some of this stuff is going to be covered later on in the session.

Q306 Dr Huppert: The conclusions are obviously highly controversial, but how controversial are those particular ratings? Would most experts in the field agree that alcohol is roughly three times as harmful as cannabis?
Professor Nutt: Yes. As I said, we know that the Dutch have done a similar process and the Portuguese. Essentially, when people use this kind of analysis they come up with roughly the same scaling. I think this is as good as it gets. We have done a sensitivity analysis on that and if you were, for instance, to say you did not care whether alcohol killed people in road traffic accidents, you took that out completely, it would not change the overall ranking very much.

Q307 Chair: On traffic accidents, you know the Government's proposals that somebody who is high on drugs should have the same penalties as someone who is drunk. Are you quite happy with that?
Professor Nutt: Provided you know what they are on and you know that it is harming them or impairing their ability, yes.

Q308 Alun Michael: I ought to declare that I am now a candidate for the role of police commissioner in south Wales.
In the suggestion of the way that things ought to go going forward, you made a comparison to the regulation of banking by the Bank of England. It is an interesting comparison because, of course, the banking failure if nothing else was essentially a failure of governance. We know your professional

background and qualifications, but what is the governance of the Independent Scientific Committee on Drugs? How is it financed, how is it governed, how are its decisions and recommendations managed?
Professor Nutt: It has been set up as a charity. It is vested in a charity but will soon have charitable status of its own. We have a group of trustees, including members of this House, The Lords Rea and Taverne, the ex head of the MRC, Colin Blakemore, and other senior people. They monitor what we do.

Q309 Alun Michael: How did they become members of that? How were they selected?
Professor Nutt: We put out a public advertisement and people applied to be trustees. What we do is transparent. Everything we decide is on our website. People apply to be members, we have positions ranging from social scientists right through to forensic scientists, like Les King was. If positions become vacant they apply and we interview them.

Q310 Alun Michael: Is the decision made by the trustees?
Professor Nutt: The decision is made by the committee but ratified by the trustees.

Q311 Mr Winnick: You spoke about politicians; we are all politicians on this side of the fence, Professor. Do you think the problem to some extent, from what occurred and the fact that you were dismissed, arises from the fact that if one particular Government decides to relax the law, say on cannabis, the other side immediately, whoever the Opposition may be at any given time, jumps on the bandwagon and says, in effect, the Government is giving in to drug users? Do you think that is part of the problem?
Professor Nutt: I think that is the large part of the problem, yes. It is easy to score political points around drugs and that is why we have ratcheted up sanctions and classes over the last 40 years, because people have not had the courage to say, "No, it is wrong, drugs are in the wrong classes. MPs shouldn't be simply trying to be more macho than the other parties on drugs."

Q312 Mr Winnick: From your point of view—obviously, Dr King will have a view—if there was a possibility of a political consensus, remote as that may be, presumably that would be very useful in dealing with the issue?
Professor Nutt: Totally, absolutely. It seems to me that drugs should be subject to that; political consensus is necessary to move this field on. We have got far too entrenched in these old positions.

Q313 Chair: You are absolutely clear that cannabis has no harmful effects?
Professor Nutt: Of course cannabis is harmful. All drugs are harmful. This water is harmful if you drink far too much of it. You cannot have a harm-free drug. Cannabis is clearly harmful, but proportionately it is less harmful than alcohol.

Q314 Michael Ellis: Professor, isn't it irresponsible to play down the effect of drugs, as you are wont to do? Isn't it also irresponsible to make some moral equivalency between things like horse-riding or bike-riding and the taking of drugs? For example, is it not the case that the misuse of drugs very regularly involves criminality and therefore affects others and that that cannot be said for the innocuous use of a horse or a motorbike? We are told that 50% of all organised crime groups are involved in drugs, 35% of prisoners admit injecting behaviour and 51% complain of dependency on drugs when they are in prison. What do you say to those who would suggest to you that making this moral equivalency is seriously flawed?
Chair: Dr King, feel free to come in on Mr Ellis's questions. We will have specific questions to you so if you wish to come in.
Dr King: You mentioned criminality and drugs, but from my own area of expertise with new substances, there is very little criminality. The criminality is largely associated with heroin and cocaine. It is an important point that we must not see drugs as a single entity. They occupy a spectrum of harm, a spectrum of associated criminality, from heroin and cocaine at one end to new substances at the other end where there is very little other social damage going on. Most people who take ecstasy are not harming either themselves or anybody else in society.

Q315 Michael Ellis: Is there not an addictive behaviour to the misuse of drugs and cannot that very addiction lead to compulsive behaviour that involves the expenditure of monies that the user does not legitimately regularly have and that results in criminality?
Professor Nutt: Some drugs are addictive.
Dr King: Some drugs are not. Many new substances, mephedrone and so on, are not addictive substances in the sense that heroin and cocaine are. Remember alcohol is also an addictive substance, as is nicotine.
Professor Nutt: Just to get back to your point, I do not think it is irresponsible; I think it is completely appropriate. Activities like horse-riding, bungee-jumping, mountain climbing, and sun tanning are all activities that people do because they enjoy doing them. It is completely arbitrary to say that you should allow someone to ride a horse and not worry about the cost to the NHS when they fall off and break their brains. In fact, horse riders create quite a lot of road traffic accidents; maybe 100 major accidents a year are caused by horses losing control on the main road. So horse-riding is not simply putting the riders at risk; it is putting the public at risk. I think it is completely appropriate to say in the broader sense, if people want to make a decision about what they do with their life, if drugs is their decision, they should at least know how the harms of a drug compare with all the other activities they might do. I think that is completely appropriate.

Q316 Michael Ellis: The use of a drug, if it results in burglarising a house, affects other people.
Professor Nutt: It does, and of course the criminality of drugs is largely due to the fact that they are illegal. There is not much so criminality with alcohol because it is legal. If drugs were regulated in the way the Dutch have done and the Portuguese and the

Spaniards are doing with cannabis, then they would not be illegal and there would not be criminality associated.

Q317 Michael Ellis: Could I suggest to you there is a flaw in your argument because there is criminality with the misuse of alcohol and that is a legal substance? A lot of the expenditure to the public purse of the National Health Service and law and order is from the misuse of alcohol.

Professor Nutt: That is the nature of alcohol. That is true. I think that is an excellent point and that is one of the reasons I made the comparison between alcohol and cannabis. We know the police would much rather people were stoned than drunk, because there is much less violence if people smoke cannabis than if they drink.

Q318 Mr Winnick: Professor Nutt, you are broadly critical of the Government stance on alcohol, and you have rated it as the most harmful drug in an article in the *Lancet* in 2010. If that is so, are you saying in effect that heroin and cocaine are less dangerous than alcohol?

Professor Nutt: No. Let's be clear, that is the scale of harms in the UK at present. The point of that paper is to say if we really want to do something to reduce the harms of drugs, to stop the fact that within 10 years alcoholic liver disease will kill more men than heart disease, if we want to stop this rising, rising tide of alcohol admissions to hospital—over 1 million admissions last year—we have got to do something about alcohol because that is the most harmful drug at present. The harms are largely the harms to society. You will see from the scale that certainly heroin and crack are more harmful to the individual, but then there is the vast use of alcohol and the violence it causes—it is responsible for most spousal violence, most child abuse, a lot of other violence on the streets, it costs £6 billion a year to police the public disorder from alcohol. You compare it with cannabis. The recent research of Steve Pudney suggests that policing cannabis costs £500 million per year and that is largely arresting people for possession. Policing alcohol costs £6 billion, and that is arresting people because they are drunk and disorderly. So the huge harms of alcohol are driven by the public use and the disorder it produces.

Q319 Mr Winnick: If one takes the view, which obviously you do, that the laws should be relaxed—and I have a good deal of sympathy, as some of my colleagues know, with that view—do you accept that the regulations and prohibition on these more dangerous drugs should remain on cocaine, crack and so on and so forth? You are not suggesting—

Professor Nutt: I am suggesting we decriminalise possession of all drugs, frankly, but I am not suggesting we regulate access to drugs like heroin and cocaine except in medical circumstances. But I think we could certainly go down, with cannabis and the legal highs, a much more sensible, rational decriminalisation regulation route such as the Dutch and Portuguese have done.

Dr King: We do not need to just focus on cannabis. We can, for example, think about reclassifying MDMA and see what effect that has on usage and prevalence. We can take the example of methoxetamine, which is currently subject to a temporary class drug order. At the end of that period, which will be early next year, there may be a decision to classify it under the Act but what I would suggest is that we continue to have no possession offence there. We just put it into Part II of Schedule 4 of the Misuse of Drugs Regulations and see what happens. If the sky does not fall in that might advise us as to how we might next proceed. We might next move on to cannabis. But I think there is opportunity here for experimentation with appropriate monitoring of the situation before we get to that stage.

Q320 Mr Winnick: Thank you, Dr King. If I may come back to Professor Nutt, you have said you are in favour, if we can just state on the record, of the decriminalisation of all drugs?

Professor Nutt: Yes. I do not think you should criminalise drug use and personal possession because I think that they are either addicted, in which case they should be in treatment, or they are not addicted, in which case if you criminalise them the harms of criminal sanctions will have much greater impact on most people's lives than the harms of the drug. We are seeing this in large communities of black men in this country who are being criminalised for cannabis possession and who, therefore, have much reduced aspirations in life because of their criminal records. That is wrong and it is destructive to society.

Q321 Mr Winnick: Presumably you take the view that the drug barons, the arch criminals, those who do everything possible to get people on drugs, harder drugs, would certainly be in favour of the present situation?

Professor Nutt: Unquestionably. Most economic analysis shows that prohibition actually favours crime, it favours profiteering and it increases harm.

Chair: Can I just say to colleagues, we are really slipping on time, partly because of you, Professor Nutt.

Professor Nutt: Sorry.

Chair: Not that you are not saying interesting things but we do have other witnesses that we need to deal with.

Q322 Mark Reckless: On that last point, Professor Nutt, the elasticity of demand, for addictive drugs—let us perhaps take heroin as an example. Do you consider that the success of enforcement activity, raising the price of it, is likely to lead to more or less acquisitive crime? Is the reduction in volume bought greater or less than the increase in the price, contingent on enforcement activity?

Professor Nutt: I think generally there is very little impact of pricing on use if people are addicted.

Dr King: There is good evidence that price is independent of availability. We have police officers regularly who say they have just seized 200 kg of heroin, "This will restrict availability in London, won't it, the price will go up, won't it", but it doesn't.

Price seems to be independent, and it is actually falling. All studies show that the price of drugs continues to fall, regardless of enforcement activity.

Q323 Nicola Blackwood: I share your concern about the problem of consumption of alcohol and the impact that it is having on society and I agree that action needs to be taken on that. Where I do not quite follow the argument is that the action that needs to be taken is to make another harmful substance more readily available in the form of cannabis.
Professor Nutt: I am certainly not just saying that.
Nicola Blackwood: Can you explain to me how that is going to address the problem of alcohol? Why do you not address the problem of alcohol consumption rather than making cannabis more readily available?
Professor Nutt: I think we should have a completely rational approach to all drugs. Separating the two is a mistake; we have to look at how we can minimise the harms of all drugs. With alcohol we know better regulation, reducing sales in supermarkets, increasing price will reduce use and reduce harms. Also a significant proportion of people use alcohol because cannabis is illegal so if cannabis was at least regulated and accessible people would switch from alcohol to cannabis. That would also reduce the harms of alcohol. My suggestion to you all is that a regulated market for those drugs is the best way forward.

Q324 Nicola Blackwood: What kind of percentages would smoke rather than drink?
Professor Nutt: I think you might find perhaps you would reduce alcohol consumption by about a quarter if we went to the Dutch model of allowing cannabis in something like a coffee shop.

Q325 Nicola Blackwood: So it is better for people to have lung cancer rather than liver cancer?
Professor Nutt: The point is that the harms of cannabis are less than the harms of alcohol.
Nicola Blackwood: All right, but they are still smoking, they are inhaling particles into their lungs.
Professor Nutt: They are. Cannabis is not safe. I am saying that in population terms I believe that that kind of regulation would have a net benefit on population health.

Q326 Nicola Blackwood: Can I ask a second question that is peripherally related to this? You have made quite a lot of complaints about the responses of politicians to the evidence base. I share those concerns, but I also have a big concern that there are too few scientists in Parliament. In fact, this is our only scientist in Parliament sitting right here. I wondered why you think that might be and why perhaps you think scientists are not more ready to stand for Parliament, given that many are willing to speak out about political issues?
Professor Nutt: I think politics is a different discipline. Maybe you have discovered that.

Q327 Nicola Blackwood: I am a musician by training, but I am still standing as an MP.
Professor Nutt: It is disappointing. We lost five scientists in the last Government. I do not know; it may be that there is disillusion among scientists that politics is not the place for them because political people are not interested in science.
Mr Winnick: You are being invited to join the Conservative Party.
Chair: Professor Nutt, on that subject, this is the House of Commons best scientist, Dr Julian Huppert. You are next, Dr Huppert. Impress the Professor.

Q328 Dr Huppert: I should be clear, there are other people with science qualifications in Parliament. Dr King, can I move us on slightly to new substances and how to deal with those? You have commented about the fact that the UK notifies a huge number of these. There is a real weakness in statistics. You have presumably seen the UK Drug Policy Commission's report *How should we regulate legal highs?* and the ACMD's report on taking drugs seriously. Both proposed the idea of using trading standards laws to deal with new drugs. What is your assessment of that?
Dr King: There are a number of options open beyond straightforward drugs laws. That document, which I contributed to, certainly talks about consumer protection legislation. It is a model that has been advocated by the New Zealand Law Commission, for example. There are other examples, but there are other possibilities. We could have unique legislation such as that enacted in the Republic of Ireland two years ago, which is the Psychoactive Substances Act, which is separate from the Misuse of Drugs Act of Ireland. Then we have the case of Sweden where they have modified the health and safety legislation to accommodate certain new substances. A general feeling around the world is that drugs legislation should be there to control harmful substances, and that is a principle that comes down from the United Nations international drug policies. With many of these new substances we cannot properly assess their harms so the feeling in many countries—and it should be here as well—is that we can't properly put them into the Misuse of Drugs Act.

Q329 Dr Huppert: Ultimately there is a question on whose task it is to judge the safety. The current system in the UK essentially means that the state, through the ACMD, has to judge the safety of every new substance, whereas some of these other models—health and safety, trading standards—would involve the designer of the drug, the person supplying the drug, to have that onus. Who ought to have that responsibility? Who is better equipped to do so?
Dr King: I think at the moment we have a difficult problem that trading standards is controlled locally and we may have to move that to a model where it is controlled centrally, but we are not ever going to be in a position of demonstrating that these substances are safe, which is a requirement for consumer protection legislation. The world does not have very much experience yet of all these alternatives, and there are others. I have not mentioned medicines legislation, for example, which is possible and has been varied in some countries as another way of controlling these substances. We do not have a great deal of experience of these examples in the rest of the world at the moment, but I would suggest that we

should look at them in more detail and see how they are working.

Q330 Dr Huppert: How can we improve the data available on these new drugs to work out which ones are worse than others, which ones we should—
Dr King: My comment on the official statistics is varied. First of all, could I start with the Home Office seizure statistics, which were last published in August 2011? There is no specific mention of new substances there. Mephedrone, for example, which was controlled in early 2010, is just bundled up with other class B drugs, and the same goes for some of the class C substances, the cannabimimetics and the piperazines. I had to put a freedom of information request into the Home Office to get this information. It was available but not published. That surprised me because I thought we had a Government that was seriously interested in the impact of new substances and yet it was not giving the detail in the seizure statistics.
Then if I move on to the offender statistics published by the Ministry of Justice, again when I came to write a submission to your Committee in November-December last year I found no information on offender statistics for new substances. So again I had to put a freedom of information request in to the Ministry of Justice. That information was there but at that stage—perhaps it has now been—it had not been published.
Chair: Dr King, it might be useful if you let us have a list of this and perhaps a note of all the areas you think information ought to be published when it has not been published and we, as a Committee, will pursue it.
Dr King: Certainly, yes.

Q331 Mr Clappison: I am very much a layman in these matters but I approach them with an open mind. I have to say I was not convinced by your response to the point my colleague, Nicola Blackwood, made that, because some present illegal substances can cause harm, we should therefore make legal presently illegal substances and thereby increase their consumption when we know that they will also cause harm. Perhaps you could have another go at that one.
Professor Nutt: It is not inevitably the case that decriminalising a drug will lead to increased harm. One of the interesting results of the Dutch experiment was that, having made cannabis available in the coffee shops, we discover there is actually less use of cannabis by Dutch youth than there is in the UK. It may simply be that they are not being pressured to use it because it is illegal, they do not have dealers selling it to them. It is not inevitably the case that there would be an increase.

Q332 Mr Clappison: We visited one of these coffee shops as a Select Committee and we got a bit of fun made of us as a result, but there we are. The Dutch do not seem to be embracing this at the moment. They seem to be rather going back on it.
Professor Nutt: No, as you know, there is an interesting political tension and they have quite a right-wing Government. I think, as with many governments, it is very easy to see drugs as a way of differentiating between the right and the left, and that is what is happening there. I do not think they are going to get rid of it.

Q333 Mr Clappison: You would agree that, for example, just taking cannabis which does cause harm, the world would not be a better place if more people smoked cannabis?
Professor Nutt: The world would be a lot better place if a lot less people drank alcohol.
Mr Clappison: No, that was not my question. That is the point that I am making.
Professor Nutt: Of course. What I am interested in is the net benefit to society of having rational drug laws. If we had rational laws, rational regulation, my anticipation is that there would be significantly less harm from alcohol, there would be somewhat more harm from cannabis, but the net benefit would be overwhelmingly positive.
Dr King: If cannabis were decriminalised, there would not be the harm resulting from criminalisation of many young people getting a criminal record. That is harm.

Q334 Mr Clappison: That may be another point. Can I pursue that a little further, and I have another point as well? Another thing as a layman I find very surprising is that in your multi-criteria decision analysis you rate alcohol as being much more dangerous both to users and to other people than tobacco, and I find that a surprise.
Professor Nutt: The reason for that is that alcohol harms a lot of other people in society through traffic accidents, through violence, domestic violence. Tobacco, by and large, just kills the people who smoke. Now we have legislation to stop people smoking in private places. Most tobacco smokers just harm themselves.

Q335 Mr Clappison: Hang on a minute, what about the misery that is caused to people when they lose close relatives because they have smoked tobacco and get lung cancer?
Professor Nutt: Of course. Tobacco is harmful, we know that. It tends to kill people later in life. Alcohol is the biggest cause of death in young men under 50 in this country.

Q336 Mr Clappison: I just find your analysis here surprising and I don't—
Professor Nutt: It is surprising.
Mr Clappison: I am anti-tobacco. If I were the tobacco companies, I would be rushing out with this and saying, "Hey, look guys, tobacco isn't as bad as alcohol." I think you will find there is a lot of public opinion and a lot of people with personal experience of close relatives who have died as a result of tobacco.
Professor Nutt: That is because you are rating lung cancer deaths much higher than the other 15 parameters. As I say, I am very happy to work with you on this to go through the process if you like.
Chair: That would be very helpful indeed.

Q337 Lorraine Fullbrook: Professor Nutt, your recent research deals mainly with the medical and

social issues of misuse of illegal drugs. What you do not talk about—or there is one bullet point in your report—is the other side of the medical and social issues. The Committee has been to Turkey, the United States and Colombia to see first hand drugs coming in through Turkey, from Iran, Afghanistan, China. We have seen first hand the drug gangs in Colombia and the United States and the extreme violence that happens because of drug misuse and dealing by these gangs. Along with the misuse of drugs comes money laundering, illegal trade in firearms, people trafficking, people smuggling, and you do not talk about the other side of it. In the United States, we met six groups who were just like yourselves talking about the decriminalisation and the legalisation of drugs, all drugs—heroin, LSD, cocaine, cannabis—and you all talk about the existing people who are taking drugs and the treatment and rehabilitation of those people. None of you talk about the new entrants to the market if drugs were decriminalised or legalised.

Chair: Could you get to your question, please?

Lorraine Fullbrook: Yes. So you talk a lot about the Dutch. The Dutch have recently asked for their residents to be registered and have stopped drug tourism because of the crime that comes along with it to the residents. So what do you say to the other side of it? You talk about the social side, what about the extreme violence side and the misery that causes?

Professor Nutt: It is a big question; the short answer is this—

Chair: Please, a very short answer.

Professor Nutt: Most of this huge business of drugs, crack and heroin particularly, is illegal because the drugs are illegal and therefore it is beyond normal regulation. We are just saying a more rational approach might allow us to get more regulated access and that might do a lot of good for those—

Q338 Lorraine Fullbrook: But you said that you wanted drugs decriminalised or legalised.

Professor Nutt: I wanted drug use decriminalised, yes. I did not say legalised.

Lorraine Fullbrook: That does not take any account of the other side of the coin.

Professor Nutt: All I am saying is most South American Governments now agree with us that the criminalisation approach has led to the problem in South America, it is not solving the problem and it probably can never solve the problem. So we have to do something different, because the drugs trade is the second biggest trade in the world after oil and it is completely without any regulation.

Q339 Lorraine Fullbrook: So you are of the view that we are losing the war on drugs, not that we have not won the war on drugs?

Professor Nutt: We will never win. It is impossible to win the war on drugs the way we are fighting it at present.

Q340 Chair: On page 281 of your book you quote, "An ambitious UK back-bencher called David Cameron" and you go on to criticise President Obama as well. Lots of words from politicians, you are saying, but not enough action?

Professor Nutt: Precisely. That report is from this Committee 10 years ago saying it was not working then; it has got a lot worse now. We have had 100,000 Mexicans dead in those 10 years and nothing has been done. It will not get better the way we are doing it at present.

Q341 Lorraine Fullbrook: I have not had an answer to my question. What about the new entrants to the market? You talk about people who are currently taking drugs and the rehabilitation and treatment of those. What about the new entrants to the market if we have cocaine, heroin and cannabis free in the local shops?

Professor Nutt: No, I am not remotely saying that. What I am saying is that certainly I think it is worth experimentation with regulated access to cannabis. That might stop people using heroin and cocaine. The reason for the Dutch experiment was to stop young people who wanted cannabis having to go to a dealer who would try to get them on heroin. In this country most dealers deal crack, heroin and cannabis so if you want cannabis you are always vulnerable to getting addicted to something else. The Dutch experiment seems to have worked because they have lower levels of heroin and crack use in young people than we have in this country because of separating the markets.

Chair: If I could say to colleagues, we have another three sets of witnesses to come in and we do need to cut down on the length of our questions.

Q342 Bridget Phillipson: Apologies, Professor Nutt, that I have not been here for all your evidence. I agree entirely with you that alcohol is a major cause of social harm and I agree with many of your comments, but I would like to raise one note of concern in the suggestion that somehow alcohol causes domestic violence. I accept it is a factor, but would you not agree that, while it is a factor, individuals have to take individual personal responsibility for criminal behaviour and it is not simply a case of there being a direct causal link?

Professor Nutt: Most domestic violence is alcohol-fuelled. Okay, you can debate whether it is causal or not but the fact is less alcohol in the home equates to less violence. There is a beautiful study recently published from Glasgow showing that when people go and get drunk at football matches they come back and beat up their wives. Alcohol is a major factor in violence across society, in the home, on the streets, at social events. It is not causal but it is an unfortunate aggravating factor so if you reduce the amount of intoxication you will reduce violence, we know that. There is a great example in my book about Euro 2000 when two separate countries had two different ways of dealing with the drinking British football supporter. The country that gave them less strong alcohol, the Netherlands, had much less violence than the country that gave them strong alcohol, Belgium. We know therefore that less alcohol means less violence; that is a fact.

Q343 Bridget Phillipson: I agree in terms of the heightened incidents you often see around football tournaments, the role that alcohol can play, but my

understanding is the evidence is quite mixed and that domestic violence will often be happening in those families anyway. It is sometimes exacerbated, it is sometimes worsened or perhaps the violence is more extreme, not necessarily—

Professor Nutt: Yes, I think you are right. Drugs do not cause people to do something that they would not have a tendency to do. Alcohol tends to disinhibit people and allows them to do things they would regret subsequently, but nevertheless it does increase harm.

Q344 Dr Huppert: Evidence on what would happen is obviously very hard to find, but are you aware of the studies in the Czech Republic when they penalised possession in 1998? They expected less illicit drug use and some very detailed studies found that availability didn't increase, the price on the black market wasn't changed, the use of illicit drugs didn't decrease, it went slightly up, and it had no measurable effect on health indicators. Is that accurate?

Professor Nutt: Yes, it is. It is a very interesting experiment and it does show that you need a different approach. That is probably the best control trial we have of criminalisation. The Poles did the same and there was a very graphic apology from the Polish President a couple of months ago saying something along the lines of—"We got it so wrong. All we achieved by trying to crush drug use in young people through criminal sanctions is that we just criminalised a lot of young people and so screwed their lives over, and we shouldn't have done it", and this country has now retracted that penalisation approach as well.

Q345 Lorraine Fullbrook: Professor Nutt, you have highlighted research into the effectiveness of ecstasy when treating post-traumatic stress disorder and LSD in treating addiction, which is ironic, and depression. Do you think there is enough support for research into the medical use of drugs that are considered to be recreational drugs?

Professor Nutt: I am so pleased you asked that question because this is one of my key concerns at present. What we have discovered—and this is an area I am working in at present—is that when drugs become illegal people stop researching them. So there were 1,000 studies on LSD before it was made illegal; there has not been one since. We have just done the first ever study of psilocybin in the UK and we have discovered that it may well be useful for treating depression because it produces the same changes in the brain as antidepressant drugs, and so we now have MRC funding to pursue that.

I think it is one of the great scientific scandals that we have not researched these drugs that have profound brain effects and the reason we have not is because the regulations make it almost impossible. They make it very expensive and going through the regulations is so time consuming that most institutions and most individuals will not do it. So we have this paradox now. We are in the process of setting up a trial to do MDMA in veterans with PTSD from Afghanistan. That study will be done with an expert, Jonathan Bisson in Cardiff. If it works, which I hope it will, we will then have the really bizarre situation that no doctor could use the drug because MDMA is a schedule 1 drug and it is not allowed to be used outside of research. So we do have to change the way we regulate at least these drugs in terms of research otherwise we will not utilise the full benefits.

Q346 Lorraine Fullbrook: You do not have to make drugs decriminalised or legal to do that, you just have to make them available to doctors to prescribe.

Professor Nutt: Exactly, but currently most of the interesting drugs are in schedule 1 and it is almost impossible, even for researchers like me who have a lot of willpower, to use them. We have to change those regulations. That would be a very powerful thing your Committee could recommend.

Chair: Professor Nutt, Dr King, thank you for coming in. You have made an offer to this Committee that we would like to take up. If you have any further information that is going to be helpful to us in our inquiry, please do let us know. We would like to have the list of information that you feel the Government has not published. We would like to get it published because we think it is in the public interest to do so. Thank you very much.

Examination of Witnesses

Witnesses: **Professor Les Iversen**, Chairman, Advisory Council on the Misuse of Drugs, **Professor Ray Hill**, Advisory Council on the Misuse of Drugs, and **Annette Dale-Perera**, Advisory Council on the Misuse of Drugs, gave evidence.

Q347 Chair: Professor Iverson, I apologise we are running a little late. You now chair the Advisory Council. Do you have politicians meddling in your affairs or are you able to make your recommendations with the full knowledge that no one is going to start meddling?
Professor Iversen: I would like to correct David Nutt's statement that his committee is the only independent advisory group. The Advisory Council is an independent group, independent of Government—
Chair: Sorry, Professor, you will need to speak up because the acoustics are not very good in here.
Professor Iversen: We are independent of Government and therefore we are the expert advisory group and David Nutt is supplementing it in a useful way, but his is not the only one. On my left is Annette Dale-Perera who is chairing the new recovery committee looking at the best ways of recovery from addiction, and on my right is Raymond Hill, a pharmacologist, all council members.
Chair: My question was meddling politicians.
Professor Iversen: Yes. Well, that is not the way we look at it. We work with Government in the sense that we like to know what issues Ministers feel to be important. The Home Secretary every year sends out a letter suggesting our agenda and if we agree, we accept it, but we also have the ability to form our own agenda items. For example, we have done a very large review of cocaine recently—we are about to report on this in July—and the reason we took that up was our council members are worried about the increase in cocaine use in this country over the last decade and we are also worried about—

Q348 Chair: We look forward to receiving a list of all the things you are doing. If I could ask you specifically about prescription drugs. When the Committee went to Miami, we were shocked at the level of misuse of prescription drugs, doctors in America prescribing drugs that were then sold on to others. It has become a huge industry. Is this a problem in this country as compared with the use of cocaine and heroin?
Professor Iversen: We are aware that the US has declared an epidemic, which was the title of the report recently issued by the White House, and they have had particular problems with a new opiate painkiller called Oxycodone that has generated hundreds, if not thousands, of new addicts in the US and they are facing a very challenging situation. We are not aware—

Q349 Chair: What about us here?
Professor Iversen: We are not aware that the situation is as bad here. Nevertheless, we have the intention, as the council, to do a review of prescription medicine diversion to recreational use. We will be doing that next year. I might point out that most drugs, even class A drugs like heroin and cocaine, also have medical uses so there is no reason why a substance cannot both be a medicine and be a banned, illegal recreational drug.

Q350 Chair: One final question from me about the use of legal highs and the ability of your committee to look at these issues with the speed that is required. Obviously these come on the market very regularly. We had a witness previously whose daughter had died using a legal high who referred the Committee to a warehouse in Manchester that in her evidence was full of legal highs. As soon as one substance is banned another substance is created. Is this a problem?
Professor Iversen: Yes.

Q351 Chair: Why does it take so long?
Professor Iversen: You are quite right to say it is a problem. It is very high on our agenda and has been for some years. If I may, I will ask my colleague, Ray Hill, to give more detail.
Professor Hill: Sadly, there is no limit to the ingenuity of chemists all over the world to look at those substances that are controlled and to design another substance that has similar pharmacology but evades the controls. We see this as almost a continuing task, unless you institute something like the Analog Act that they have in the United States where you are allowed to cover not just the drug that you know about but any other drug that would act in the same way.

Q352 Chair: That is what you would like to see here?
Professor Hill: We would like to see this.

Q353 Chair: What about the speed with which you are able to ban these legal highs? We only get to know they are dangerous when someone dies and when that happens there is a huge public demand for them to be banned.
Professor Hill: I think there are two main problems. One is that often the drugs are not known by a defined chemical name and the first step you have to do is to find out actually what the chemical is in, for example, Ivory Wave or Black Mamba or whatever it is being sold as by the dealers. Even when you do have a chemical name, like in the recent substance methoxetamine, you still have a very limited amount of information on what that drug does. We are in the bizarre situation of getting dribs and drabs of information from clinical reports from clinical toxicologists that tell us all we know about those substances.

Q354 Chair: What would you like to see to improve that?
Professor Hill: We would like to be able to do research on these substances and find some way of paying scientists to investigate exactly what these substances do. Methoxetamine is a good example because it is an analogy of ketamine, which is a drug with known properties. It is being sold as supposedly a safer ketamine even though there is no evidence for

that, and yet some of the clinical reports we are seeing suggest there are effects on the cerebellum leading to difficulties with walking, for example, which are seen with this new drug that have not been seen with ketamine. So it is clearly not just a clone of ketamine but we know very little about the mechanism.

Q355 Chair: Do you know where these scientists are who are producing these legal highs?
Professor Hill: All over the world. I think probably the biggest concentration is in China because that seems to be where most innovation goes.
Chair: That is what the Committee has been told. It is happening in the UK as well, is it?
Professor Hill: Yes. I think there are people in the UK and everywhere doing it, yes.
Chair: Dr Huppert, could we have brief supplementaries because we have a list of questions.

Q356 Dr Huppert: I will try to be very brief. Firstly, just as a matter of factual accuracy, as I understand it the current legislation allows you to describe things like alcohol derivatives or particular compounds so you do have some analogues that are—
Professor Hill: Yes, the problem is that you have to rely on the expertise of your chemist covering all the possible permutations of that molecule. Of course, it is like a game between the chemist making the illegal substance to think, "Well, he didn't cover a methyl ester so I will put that in and that is now outside the coverage."

Q357 Dr Huppert: We heard earlier some suggestions about other methods that are used around the world that do not rely on a central body determining what is safe or not but options about health and safety, trading standards. Are you attracted by any of those?
Professor Hill: I think any system as long as it works, really. I would not claim that one is better than another but certainly I think as a pharmacologist you might expect me to say the pharmacological definition is probably the best one. If, for example, rather than defining the structure of substances that act like cannabis, you said everything that binds to the CB1 receptor, which we know is the site of action, is a controlled substance then at a stroke you have done it.

Q358 Michael Ellis: Legislators like Parliament cannot keep up with scientists who on the back of an envelope in a lab somewhere can put a couple of chemicals together and make something slightly different from what they had before and, hey presto, we have a new so-called legal high. So jurisdictions like those in the United States have this catch-all legislation that allows them to say that key constituent parts of these so-called legal highs are controlled in and of themselves. Is that right?
Professor Hill: Yes.

Q359 Michael Ellis: Can you therefore see that as being an effective method for this country so that rather than waiting to proscribe a new so-called fashion item drug like a Black Mamba or whatever it is called, you can then say, "Well if it has this constituent part in it it's automatically controlled and we do not have to have separate legislation for each thing"?
Professor Hill: I think in theory what you say is absolutely true, but in practice there are no limits to what you can do in chemistry and the number of permutations is virtually endless.
Professor Iversen: The idea of a legal high is to mimic an existing illegal drug, so nearly all of these legal highs are mimicking one or other of the controlled substances. The American Analog Act is working quite well. They now have their own legal high problem with a product sold as bath salts—in this country they are sold as garden food—and the Americans have successfully closed down a number of internet sites selling these substances. As recently as Friday of last week they closed down a site using the Analog Act. So the Act is being used very effectively across the water.

Q360 Chair: Would you like to see this Act replicated in our legislation?
Professor Iversen: We would like to see something not necessarily identical to the US but along those principles.

Q361 Alun Michael: There has been a reference to the establishment of a recovery committee as a standing committee and I wonder if you can tell us a bit about that. How often will it meet, what is its brief, what is it currently working on?
Professor Iversen: Yes, it is a very important new committee for us. Annette here is one of the co-chairs so I will let her speak to that.
Annette Dale-Perera: The Inter-Ministerial Group on Drugs has asked the ACMD to set up a committee on recovery. That ACMD already had a committee looking at drug treatment and it was looking at some of the issues, but what we have done is constituted a totally new group and we are very pleased to be able to do that. The group will focus on two things, firstly, how can people be best supported to recover from dependence on drugs and alcohol—so for the first time ever we are looking at drugs and alcohol, which could be very beneficial—and, secondly, to look at how to prevent drug and alcohol misuse. The committee will set its own agenda but we have had a listening exercise where we have been consulting Government Departments to see what their priorities are. Our agenda will be both proactive and then also responsive to what the Government want us to look at, and the Government have asked us to prioritise focusing on recovery from dependence and then look at prevention further down the line.

Q362 Alun Michael: In its response to the Government's consultation on the drug strategy, the council highlighted the issue of the lack of treatment options for non-opiate addicts. Is that therefore going to be something that the recovery committee is going to be looking at?
Annette Dale-Perera: We will certainly look at this. The last Government prioritised treatment for heroin and crack cocaine because of the high level of associated harms and a relatively good evidence base

in terms of treating that. Drug patterns have changed in this country, and we know this. Heroin use is going down, particularly in London, which is good news, but we know that some other types of drug use are going up. In terms of the treatment systems that we have at the moment, non-opiate use is being treated. For example, in London about 40% of everybody coming to treatment is for non-opiate use, things like stimulants, cannabis and a range of substances, but we are very mindful that the patterns of drug use and patterns of dependency are changing and we need to keep up with it.

Q363 Alun Michael: The other concern that has been expressed by the council and by a lot of other stakeholders is the issue of less money being invested in drug treatment at a local level and therefore treatment not being immediately available. Is that something that the recovery committee is going to be looking at? I am just trying to be clear about what benefits we are likely to see coming from the committee's work.

Annette Dale-Perera: The recovery committee, through the ACMD, has written to the Inter-Ministerial Group on this topic. From April of 2013—

Alun Michael: Yes, sorry, but my question was whether the committee is going to be monitoring the actual impact on the ground.

Annette Dale-Perera: Okay. I think it is beyond the remit of the committee to do monitoring. We would have to rely on other people to do that. We are a group of volunteers, but we have suggested that the situation is monitored, because we think that—

Alun Michael: By?

Annette Dale-Perera: We have requested that the Government look at how this is monitored, because we think that the potential disinvestment when there is a lack of ring fence on the drug treatment money is possibly the biggest risk to the recovery and treatment agenda in the drug strategy, and we have flagged this with Government through a letter.

Q364 Mark Reckless: On the drug treatment strategy, are you satisfied with the balance between harm reduction, including methadone maintenance treatment, and abstinence-focused treatment programmes?

Annette Dale-Perera: It is one of the things that we look at in detail. We have a very strong evidence base for drug treatment, particularly around some of the reducing harm aspects. The evidence base around recovery and how long people will take, who can recover, what are those characteristics—there is less of an evidence base there and one of the tasks of the recovery committee is to look at that. So our first output is a scoping exercise to look at what is the contribution of different factors to recovery agenda, and that includes things like housing, employment, communities, mutual aid and so on, so we will look at that.

In terms of the balance between harm reduction and abstinence, I think that the recovery ambitions and the ambition for everybody to be abstinent who has had a drug or alcohol problem is absolutely excellent. I think what we have to recognise is that when somebody is trying to overcome a dependency it is very difficult, and that if you force people to detoxify and they do not have the social and personal capital, they will relapse. An intermediate step in order to help them get there, if they have a heroin problem, could be a drug treatment like methadone substitution treatment and so on. It has had a big impact in terms of pulling people into treatment and reducing crime and helping people improve their lives, but the story should not stop there.

Q365 Mark Reckless: Do you see a role for faith-based organisations in drug treatment at all?

Annette Dale-Perera: I think it is almost a question of there is no one treatment that is effective for everybody, and there is a question of personal choice. We have an evidence base about what works, and a lot of what works are talking therapies in whatever format. Some of those, if the person requires, are faith-based or 12-step, so you cannot rule things out necessarily, and there is quite a strong evidence base for talking therapies.

Q366 Mark Reckless: Can I ask the other members of the panel, on the issue of legal highs, the evidence you gave is that these sought to imitate existing illegal drugs. Can the legal highs be more dangerous than the illegal highs because there is a lesser evidence base of their effect?

Professor Hill: Yes. I think there is good evidence for that already. I mentioned methoxetamine. Evidence is emerging that it is not just like ketamine, it has additional properties that may also be harmful. Of course, if something is introduced as a new medicine, it has to go through rigorous testing for its safety. These things are going straight from the chemist into the people who are taking them with no check on safety whatsoever.

Professor Iversen: I think methoxetamine, as a ketamine analogue, has special physical harm potential. It was recently recognised that ketamine itself can cause bladder damage and very severe bladder damage, to the extent of having to have your bladder removed and have a catheter for the rest of your life. This is quite different from the intoxicant effects, but there is no reason to think methoxetamine will not share this property, although it is being marketed as a bladder-friendly version of ketamine without any evidence whatsoever.

Q367 Nicola Blackwood: I wanted to go back to some of the points you were making about the recovery committee. Some of the problems that we have received evidence about are at points of transition, so the point between perhaps going on to a substitute drug and then going from that into maybe a residential rehab and then going from the residential rehab into a community-based programme, and perhaps problems with co-ordination between those different services. Are you taking evidence or doing research into those links and will you be able to give Government advice on those services, or is that not part of your remit?

Annette Dale-Perera: We will be looking at the contribution of various types of treatment systems to

recovery and what the evidence says about what is good outcomes and what is not working, so it is something that is likely to come up through that channel. We are aware that continuity of treatment is most important, because people can fall through gaps, for example coming out of prison services and then getting into the community, and that continuity of care is very important.

Q368 Nicola Blackwood: I would like to go back to a point that was raised right at the beginning and following on from the evidence that we have just received. As members of the ACMD, given the previous evidence, can you say if you have had experience of providing scientific advice to the Government that has not been accepted, and do you think that it is possible to balance the benefits of evidence-based policy with the wishes of public opinion?

Professor Iversen: The ACMD by its nature is advisory. We offer the advice and the Government does not have to take it. As you will be aware, when David Nutt was chair and I was a member of the council, we recommended downgrading ecstasy from its present status as a class A drug, and we did not recommend the upgrading of cannabis from C to B, and in both those cases the advice was overridden, so we are used to that.

Q369 Nicola Blackwood: You are used to that and you do not feel that that undermines your independence?

Professor Iversen: It is the nature of an advisory group to offer advice, not to execute the advice.

Q370 Lorraine Fullbrook: The ACMD have recommended, and I quote, "A credible message approach that uses all the agencies in a coherent drug prevention strategy rather than the ad hoc arrangements that we have currently as a preventative measure." Can you explain to the Committee what this would look like?

Annette Dale-Perera: The evidence base on drugs education and prevention is not as strong as we would like it to be.

Lorraine Fullbrook: In what way?

Annette Dale-Perera: Evidence on drug education is that it does not necessarily impact upon behaviour. What it does is it impacts on people's knowledge about substances, which is important, but I think there is an expectation sometimes that drugs education will prevent people using drugs and it does not work that way. There are some more promising methods called normative education approaches that involve interactive methods with young people, because that is important. Young people often overestimate how many drugs they use or how accepted it is by their peers, and if they realise that drug use is a minority activity and is not necessarily accepted, that can be used to modify behaviour. But the kind of messages and the data presented must be given by credible sources, otherwise the young people will not believe it. So these are slightly more promising approaches than other methods, but they have to be provided by people whom the young people respect, otherwise they do not take any notice of them at all. Then they have to be implemented with consistency and with competency and that has been a real problem in our schools, because we have not had that.

We also know that some messages do not work or have the opposite effect, so fear-based drugs education messages do not have any impact on behaviour and "Just say no" can send people in the other direction, so it can encourage use. So we have to be really careful about drugs education and prevention and we have to test things out with young people before they are implemented and then we have to evaluate them as they are rolled out and implemented, because we can get this wrong.

Q371 Lorraine Fullbrook: During this inquiry we have had many groups that we have met and some people that we have met who have asked for the decriminalisation or legalisation of recreational drugs, the ones we all know about, and nobody can explain to me what the world would look like if that happened. Can you explain to me what the world would look like if that happened?

Professor Iversen: In our evidence to the drug strategy document that the Government—during the consultation process and in our evidence to the Sentencing Council that recently reviewed what penalties should be available for drug offences—in both cases the Advisory Council recommended measures that would reduce the amount of criminalisation of recreational drug use. We will not go as far as David Nutt and we will not go as far as Portugal, which by the way has been described as a disastrous failure on one hand and as a resounding success on the other hand, so you pays your money and takes your choice there.

Lorraine Fullbrook: Well, they have more cocaine users than they have ever had before.

Professor Iversen: But what we would like to see is the discretion to divert from criminal penalties to civil penalties. Civil penalties might include obligatory education in a drugs education scheme, other penalties such as losing your driving licence for a while and so on, but to some extent this is what the police are already doing in terms of cannabis offences.

Q372 Lorraine Fullbrook: But that is assuming drugs are currently illegal. The people who are calling for decriminalisation or legalisation of recreational drugs, what does the world look like if that were to happen? If the Government decriminalised or legalised recreational drugs, what would the world look like tomorrow?

Annette Dale-Perera: I think it is impossible to say.

Chair: Excellent. That sounds like a very good end to that question.

Lorraine Fullbrook: But nobody has been able to answer.

Chair: Yes, but as the witness says, she finds it impossible. Dr Huppert has the final question. I am sorry, we have to move on.

Q373 Dr Huppert: Can I follow on from that? In your evidence you say, "Criminal justice interventions which involve young adult drug users gaining a

criminal record or a custodial sentence may not be the best use of public resources, given the life-limiting effect or negative impact this may have on a young adult's future employment and life prospects." Are you therefore advocating that we stop having criminal justice interventions for possession offences, in this case particularly for young adults? Is that how I should read that?

Professor Iversen: We are discussing discretionary diversion away from criminal offences. Discretion involves, for example, "Is this a first-time offence? Is this person likely to be a dealer? How many times has he been met by the police?", and so on. So you can judge the circumstances and then divert or not divert. I think it is discretion, really.

Dr Huppert: So part way to the Portuguese direction?

Professor Iversen: But we would like to see fewer young people given criminal records, because that has an impact on the rest of their lives in terms of getting a mortgage, a job, a college place and so on.

Q374 Dr Huppert: I was reading some work that has been done, I think in Mexico, about vaccines towards heroin and cocaine. Are these remotely realistic and what are the medical and ethical implications?

Professor Hill: Vaccines are obviously an attractive approach, because by one treatment you can potentially remove the craving for a drug, but vaccines are not easy to make, it takes a very long time and if you look at the current landscape, after about 25, 30 years' work there is a single nicotine vaccine in phase 3 clinical trials, which may or may not become a marketed product. There is a cocaine vaccine in early clinical testing, and as far as we can tell nothing at all going on for heroin or other drugs. It is an option; I suspect it will not be a panacea. It could be just something else that would help people who are trying to give up a drug habit.

Chair: Thank you very much. This has been very helpful and there are going to be aspects of the Committee's questions that you have not been able to answer because of time constraints, especially in response to Mrs Fullbrook's question. It would be very good to have a note from you on that. If you could send us a note, that would be very helpful. It is just we are running very short of time at the moment. Thank you very much for coming; we are most grateful.

Tuesday 3 July 2012

Members present:

Keith Vaz (Chair)

Nicola Blackwood	Alun Michael
Mr James Clappison	Bridget Phillipson
Michael Ellis	Mark Reckless
Lorraine Fullbrook	Mr David Winnick
Dr Julian Huppert	

Examination of Witnesses

Witnesses: **Richard Bradshaw**, Director of Offender Health, National Offender Management Service, and **Digby Griffith**, Director of National Operational Services, National Offender Management Service, gave evidence.

Q375 Chair: Mr Bradshaw and Mr Griffith, my apologies for keeping you waiting. As it comes to the end of the Session, we have all our witnesses in to try and clear up our inquiries. Perhaps I can start with this question: Committee members have visited both Pentonville and Brixton over the last few weeks and I was struck by the figure that one-fifth of prisoners, who have tried heroin for the first time, tried it in prison. People who go to prison, who have perhaps never had any dealings with drugs, then come out of prison having dealt in drugs. What do you say to that?
Digby Griffith: I think the 19% figure that you refer to came from a sample of people from 2005–06. I think the research was published in 2010. When you look behind those figures, it looks like those people who took heroin for the first time were heroin users in prison, so they were using heroin, but they became heroin users in prison. What is not clear is the extent to which they were using hard drugs before coming to prison.
We know from the figures that we have that 55% of people arrive in prison having used drugs to a significant degree; 64% arrive having used drugs within the last four weeks; 43% arrive having used cocaine or crack cocaine in the last four weeks—
Chair: Yes, we know that—
Digby Griffith: Sorry, I was just going to say it is unlikely that those people who started using heroin had never taken drugs before. It is a worrying figure, however.

Q376 Chair: We want to look at the broad principle here about people going into prison and then coming out having had drugs for the first time. That is what worries this Committee. Is it a worry to you?
Digby Griffith: It is a worry. The context of this is that a lot of people in prison are heavy drug users. The vast majority of people arriving in our custody have used drugs or some will have dealt in drugs. It is no surprise that there is a desire to maintain that habit in prison and to try to make some money from it. What we have is a twin-pronged approach: trying to reduce the supply of drugs while also reducing the demand for drugs, which is Richard's area of business.

Q377 Chair: Sure, we will come on to the other solutions to this in a moment. In January 2010, a report was published that claimed that the Prison Service had over 1,000 corrupt guards: that is the equivalent to seven per prison. In your evidence you say that you have in place a National Corruption Prevention Unit. How many corrupt guards have you found, for example, in the last 12 months? How many have come to your attention?
Digby Griffith: Can I deal with a slightly longer timescale because we put in place a new approach to tackling corruption in 2007?
Chair: Okay, how many since then?
Digby Griffith: Since then we have had convictions of 84 staff, we have dismissed 51 and we have excluded about 110. The big change before 2010 and then afterwards was that we have started pursuing convictions. We are talking about criminal offences here, not breaches of HR policy, so we have a very close relationship with the police now for them to investigate the material that we send them, to develop that material and to prosecute with the CPS.

Q378 Chair: But that is a very small figure, isn't it, 84 prosecutions, when the report claimed there were 1,000 corrupt officers?
Digby Griffith: Is this the Policy Exchange report that you are talking about?
Chair: Yes.
Digby Griffith: I think the evidence base for that report is not clear. When I talk to governors in prisons, they talk about a handful of people probably being responsible for some corrupt activity. It is very difficult to know precise figures simply because if you know the precise figure, we prosecute—we take action against people. Knowing with precision exactly how many corrupt staff we have is incredibly difficult. What is clear is that we are now prosecuting and taking action against people to an extent that we never did before.

Q379 Chair: Finally from me, on drug testing, we know that there is testing on arrival, we found it very odd that there isn't testing on departure. Why is there no mandatory testing of prisoners when they depart from prison?
Digby Griffith: I think it is an interesting approach. The mandatory drug-testing programme that we have was designed as, essentially, an enforcement tool to deter people from taking drugs. It was also designed

to give us an idea of the level of drug misuse inside prison and, thirdly, as a pointer towards treatment.

Q380 Chair: We understand why you do it but why don't you do it on exit?
Digby Griffith: We do not do it on exit for a number of reasons. One is that we take action against people who have taken drugs. If we took a test on exit we would be unable, in most circumstances, to take action against people, they would have left our custody. We also look at the rates of misuse in prison by using the mandatory drug-testing programme in a different way. We know that about 7% of tests are positive in the last year or so, so that gives us an indication that the level of drug misuse has probably fallen throughout the prison time, given that people are entering with a 64% chance of having taken drugs.

Q381 Chair: Yes. I think the purpose of testing when they go out is not necessarily to prosecute them for being involved in drug dealing in the prison, it is to help them be rehabilitated in the community so they are not one of the 63% who go back to prison in Brixton.
Digby Griffith: I understand that.
Chair: It's not to catch them or the system out, it is to make sure that they are assisted because we don't want them to come back in, do we?
Digby Griffith: I completely agree with that and we do it in a different way. In our drug-free wings, for example—
Chair: No, we know about that, we will come to that, but you don't mandatory test on the way out at the moment?
Digby Griffith: Not on the way out, no, we don't.

Q382 Dr Huppert: One of the figures that I heard at a seminar last week that really shocked me—I presume you are aware of it—was that, of the people who have ever taken heroin, when they are released from prison one in 200 of them are dead within two weeks. Are you aware of that figure and do you think that is acceptable? What could be done about that?
Digby Griffith: I hadn't come across that figure but the risk that that figure represents is the extent to which we have, I think, done some good things with people in prison, to try to get them off drugs, to try to treat them. What can sometimes happen is that when people leave prison they start using drugs again. The degree of purity that they are using may well be greater on the street and they end up in serious physical harm or dead because their tolerance levels have been reduced.
Our approach to that is that there are certainly many more maintenance programmes inside prison to aid the transition from being a drug misuser to a former drug misuser. But also the treatment programmes that we have, I think, are far more intensive and of greater quality now than they have been in the past, so there is a far greater chance of someone having better quality treatment. Can I just say one final thing about that? The drug treatment that we provide is only one part of a far larger package addressing accommodation needs, education and a large part—
Chair: Yes, we are coming on to that.

Q383 Dr Huppert: I am surprised you are not aware of that figure. It is quite well attested, there is a lot of literature on it. Singleton et al and various others have looked at excess mortality. I think what it really points to is a problem with the transition from prison back into the population, so what you do in prison is not the only issue. Are you aware, for example, of the Medical Research Council's trial at the moment into Naloxone on release? Is that something you are aware of or looking at?
Richard Bradshaw: Yes, we are aware of that and we are supportive of the idea of looking at the use of Naloxone to prevent deaths in circumstances whereby people have lost tolerance, as Digby has described. I think the point that you made before about continuity is crucial. I think we have been increasingly over the last few years making sure that, in a sense, the journey that started with a prisoner getting into a treatment regime in prison is just the first step on the way to where you really want to end up, in terms of the transition to ongoing treatment in the community.
The proposition you are making supports the idea that it is not enough just, in a sense, to get people off methadone in prison necessarily—that may not be the absolute goal if what we want to do is get them on to a recovery journey that continues; if they are doing a short sentence and they are going on and into the community. That is where drug recovery wings and all that that comes on, that wraps around them, are so crucial to—
Chair: We are coming on to that. Don't worry, we like your drug recovery wings, so we are coming on to it. Mr Reckless has a very quick supplementary.

Q384 Mark Reckless: Given what you said there, what would you say to a case that was raised with me yesterday of a prisoner released, come off drugs, wanted to continue drug treatment, went to an agency, the only drug treatment agency available in Kent was methadone maintenance, but they weren't able to treat him because he hadn't tested positive? It was basically suggested, I understand, to that individual that, in order to get on that programme, he would need to test positive for heroin and therefore he went back on the street to take a fix of heroin as the way of getting on that programme.
Richard Bradshaw: Clearly, that doesn't sound right in terms of how people would access the services, but clearly the clinician has to take a view in terms of, is the person using at the time in order to put them on a methadone regime? That is important because clearly methadone is a dangerous drug in itself and can cause harm in its own right if people haven't been taking it before.
I think the issue about the clinician making a decision, based on the clinical presentation of the person that they have been referred to, would be key and testing is a key way to establish what the status of somebody is before they enter treatment. It is what we do in prison. Before we commence treatment in prison, we

test to make sure that the story that somebody is telling us is backed up by the actual chemicals or factors in their—

Q385 Mark Reckless: But what is the point of putting all this effort into getting someone off drugs in prison if then, needing treatment on release, that is not available, unless they can, again, test positive for heroin?
Richard Bradshaw: In the future, what we propose to do under the new commissioning arrangements is make sure—after Lord Patel said that there should be "one pot, one purpose" in terms of dealing with issues of people who are either in prison or going to continue in the community—that commissioning those services will be much more joined up. It is joined up to an extent now, but there is more we need to do to make sure that that continuity continues and we do not face the situation that you have described.

Q386 Michael Ellis: Mr Griffith, the supplementary questions were referring to post-prison, but let us go back to in prison. Is the message getting through that supply reduction is a priority, because it is quite clear that there is still a degree of the supply of controlled drugs in prisons? A recent report by the Chief Inspector of Prisons was very critical, so is the message getting through?
Digby Griffith: I think the message is getting through very strongly indeed. It is very clear that drugs are harmful. It is very clear that substance misuse, substance addiction is part of the profile of many offenders. Given that we have—

Q387 Michael Ellis: Yes, well, we know that. We know that, Mr Griffith, but I am just asking you because I was a barrister in criminal practice for some years before I came to this place and I used to visit people in prison on a regular basis. People, including in category A prisons, would be subject to search on entry when going to visit, including lawyers going to see their clients and yet a quantity of controlled drugs are still getting into category A prisons. How are you addressing that, and it goes back to the point the Chairman raised about corruption?
Digby Griffith: Corruption is one angle on this but I think drugs enter prisons by a variety of means. There are sometimes corrupt staff, either directly employed or non-directly employed. For some prisons, throwing over the wall is the way that most drugs get in, especially for city centre prisons with very many people around. There is also smuggling in parcels in post. There are also prisoners who themselves will plug or crutch drugs in order to take them in via court. There are a variety of methodologies for getting drugs in and we are addressing each of those: netting to stop throwing over the wall; a far greater use of intelligence; we are using the Regulation of Investigatory Powers Act 2000 to use surveillance to a much greater extent, to use covert human intelligence sources to a much greater extent; we are searching staff where there is intelligence that would suggest there might be smuggling. We are using—

Q388 Michael Ellis: Sorry, can I just stop you there? Do you only search staff where there is an intelligent source? Might it not be a possible consideration to search staff routinely on entering prison, as visitors and lawyers are searched when they enter prisons?
Digby Griffith: It will depend on the type of prison. Obviously in the higher category prisons, you will find the searching of staff happening. Like most law enforcement agencies we have an issue of, do we simply blanket search or do we have targeted searching? Now, blanket searching can be extremely wasteful of money. We have an approach where we try to assess the risk, the level of threat and try to target resources based on those things. I think for most law enforcement agencies, that feels like a better way than simply wasting money targeting everybody.

Q389 Chair: Why don't you just have one of these special dogs that are trained to sniff out cannabis going round to see if someone has thrown some cannabis or drugs over the walls?
Digby Griffith: We have about 400 dogs in the organisation, 200 or so active dogs that go sniffing around cells and workshops, and about 200 passive dogs that sit in front of a visitor or a member of staff who smells of drugs.

Q390 Nicola Blackwood: Given the change of direction in the Government's new drug strategy, I wonder if you have adjusted the particular drugs treatment strategies that you have in prisons away from maintenance to abstinence-based programmes?
Richard Bradshaw: Well, the simple answer is no because we have NICE-approved guidelines around the treatment with methadone, which has been established since 2006. So the integrated drug treatment system, which combines clinical with psychosocial, is the same as we have been applying since 2006. It is evidence-based in terms of being able to treat the addictions, and also in reducing reoffending. We have not moved away from that, but, with the advent of the idea of drug recovery wings, we have really placed that on a journey towards recovery because I think—
Chair: I think we are coming to it.
Richard Bradshaw: We are coming to it, yes. We continue with the IDTS programme. There is a large amount of international evidence for its effectiveness, both in terms of clinical management and safety. A recent study demonstrated that we were saving lives of prisoners, particularly those who were dying in those first days and weeks that they come into prison, that methadone and the establishment of them on that was—
Chair: Thank you.

Q391 Dr Huppert: The National Treatment Agency has raised its own concerns that transferring funding from prison drug treatment to the NHS national board could cause the problems of integration, which we discussed earlier, between prison and community treatment to become even worse. What are you doing

to try to focus on that and how will you monitor what happens?
Richard Bradshaw: Yes, we believe that the advent of the NHS Commissioning Board taking responsibility for all health commissioning for people in prison and other prescribed places of accommodation will be a helpful step forward in making sure that all health services for people in prisons are integrated and thought through in terms of how they are delivered. But we have been very clear and we have been working closely with the NTA to make sure that the way that that is commissioned in the future is part of a journey between what happens in prison and what happens in the community.
We also have outcome measures that will incentivise providers to get people to complete treatment or to continue treatment into the community, so the outcomes are focused on making sure that that journey works. We have a well established partnership working, which has been existence for, as I said, five or six years for IDTS, and we think that is the rock on which we can build future work, which should prove more effective.

Q392 Dr Huppert: Just to follow on from my colleague, Nicola Blackwood's question. You would want to see any treatment system that was done by the National Commissioning Board to be evidenced-based and following all the best international guidelines?
Richard Bradshaw: Correct, yes.

Q393 Mr Winnick: The whole emphasis obviously of this session is drug recovery in prison and making sure—as far as is possible—that people get off drugs. Now, as I understand it, there is a report due this month, is that right, on an independent study?
Richard Bradshaw: It is the beginning of drug recovery wings[1]. It is an initial scoping to evaluate how we might evaluate drug recovery wings in the future. I think it is important to remember that the now 10—the five that started in the middle of last year and the additional five drug recovery wings that are being brought on-stream—have been locally owned and locally grown, and I think your experience of visiting both Brixton and Pentonville shows that they are developing in slightly different ways, but all to the good. All enhancing the skills of staff, using peer mentors. So we are developing a methodology whereby we can properly evaluate them as we go forward. We expect to have results from that in about a year from now. That will indicate what the essential features of the recovery wings are, and how we might replicate that across the state.

Q394 Mr Winnick: Is a report due this month?
Richard Bradshaw: It is in August.[2]

Q395 Chair: We were very impressed with what we saw in the drug-free wings. Why can't we make sure that all the wings in a prison are drug free?
Richard Bradshaw: Well, I think we have to work on that. We have to make sure that we know what works, and that, in orientating recovery in prisons, we pick the best features of community engagement, of mentors, and I think that could be a long-term vision, but I think we should sensibly wait for an evidence base to emerge about the best way forward.
Digby Griffith: May I just add a comment? I think that the success so far of drug recovery wings and drug-free wings is really based on the ethos with which they are run, and that depends on interviewing prisoners to make sure that they are committed and absolutely sure that they want to do this. I am afraid it will probably remain the case that many prisoners will want to try to continue to take drugs, as opposed to giving them up and being drug free.
Chair: We were very impressed with what we saw at Pentonville and at Brixton, so pass on our thanks to those involved.
Richard Bradshaw: Thank you.
Chair: Mr Griffith, Mr Bradshaw, thank you very much for giving evidence. We might write to you again as part of our inquiry.

[1] Note by witness: Drug recovery wings are aimed at those in the process of recovery and contain an integrated range of intensive support to meet the needs of drug misusing offenders who are motivated to work towards abstinence and who may be in receipt of substitution treatment. DFWs are aimed at prisoners abstinent from drugs and substitute prescribing. They include those in recovery but also prisoners who have never had a substance misuse problem and want to avoid the temptation to use.

[2] Note by witness: The report due in August is a NOMS Drug Recovery Wing Implementation Study

Examination of Witness

Witness: **Right Hon Kenneth Clarke QC MP**, Lord Chancellor and Secretary of State for Justice, gave evidence.

Q396 Chair: Could I call to the dais the Lord Chancellor?
Kenneth Clarke: Thank you for having me along to give evidence on the same subject as my senior officials.
Chair: We thought it was very important to have the boss sitting at the back.
Kenneth Clarke: I have only been sitting at the back for the last five minutes so the divergence between my answers and theirs will be particularly interesting. I was just looking up my briefing on one of the answers they gave, I will not give you a clue as to which one, but it was news to me.

Q397 Chair: Nicola Blackwood has already spotted one so we will leave that question to her.
May I start with one of your own quotes? It must be very nice to have your words quoted at you. On 19 October 2010 you said, "While more than half the people who are admitted to prison are believed to have

a serious drug problem when they arrive, some who enter drug free become addicted while they are there". Is this still a worry to you, after two years, that there are people who have never experienced drugs who enter the prison system and then discover drugs?

Kenneth Clarke: Yes, it most definitely is, although I think the Prison Service and NOMS are anxious to demonstrate they think they are getting all this problem down, to counter the anecdotal evidence that the Committee and I hear all the time about these things. There are figures about those who first take heroin in prison, and I think the latest figure I have seems to have dropped to 7%: those who have taken heroin and say they first had it in prison[3]. I haven't turned up the relevant page in my briefing. But it is a matter of great concern. It is of course the case that the majority of those who enter the prison will have had a history of drug abuse—over 60% appears to be the latest figure for that.

Chair: Yes, we have those figures.

Kenneth Clarke: Over 70% have at some time abused drugs. That last 10% is perhaps less surprising, but over 60% have, as it were, a drug abuse problem.

Q398 Chair: What do you see as the role of the Prison Service in this? Clearly, we have seen and we have been very impressed with the work that has been done, both in Pentonville and in Brixton.

Kenneth Clarke: You are ahead of me. I have not visited one of these wings yet.

Q399 Chair: We visited the wings. I know that Crispin Blunt has also visited one of the wings. But we are concerned that that does not go far enough, that in fact to make it truly effective, the whole prison should be drug-free rather than particular wings.

Kenneth Clarke: Firstly, what is the object of the prison? The prison is obviously to punish and then, as you know, the additional emphasis—we are putting much more emphasis on this—is to reform the prisoners so that fewer of them go out with the likelihood that they are going to commit more crimes with more victims. One of the things that is most important to that, crucial to that, is to do more about drug rehabilitation. If the majority of our prisoners have drug abuse problems, quite a lot of them probably are only committing crime as one effect of the fact they have become hopelessly addicted to drugs, and if you could deal with the drug abuse, you have some prospect of being able to tackle them in other ways that might induce them to get back to a more regular and straight way of life. Hence the emphasis we are putting on drug rehabilitation wings, drug-free wings, and so on. Ideally, every prison should be drug free, but I think as I walked in you were cross-examining my colleagues, who I think were explaining the difficulties of coping with this, with the vast traffic of people, and everything else, in and out of prison all the time. But nevertheless it is supposed to be a secure environment, and we are seeking to get on top of what is an unacceptable situation.

Q400 Chair: We are particularly concerned, Lord Chancellor, about the fact that when people left prison, there were not the support structures outside. Good work was being done inside, but as soon as they were out, the prisoners couldn't find homes, jobs, and so on, and the good work that is being done on these drug-free wings is just dissipated.

Kenneth Clarke: I don't know what other evidence you have had, but one of the things we are supposed to be placing greatest emphasis on—and I hope when I visit I will find this happening—is a link up with outside, and to get payment-by-results projects going, involving voluntary and charitable bodies and anybody with an expertise outside the Prison Service as well. The whole point is to begin tackling drug abuse by the individual inside the prison and try to get him or her abstinent, but it does need to be followed up afterwards otherwise, within a very short period of time, they will drift back. We are seeking to develop programmes of that kind.

Q401 Chair: We heard today from your officials that only 84 officials in the Prison Service have been prosecuted for drug-related offences. These are prison officers. But we also noted a report that suggested there were 1,000 corrupt officials in prisons.

Kenneth Clarke: Well, I constantly ask questions about what we are doing to make sure the staff themselves are not one of the sources of the illicit drugs. To be fair, the temptation they are open to is obviously enormous, because they can earn very considerable sums if they start providing a way of getting drugs into the prison. My belief is that we have emphasised that staff should be prosecuted. The procedures in the past were more reluctant to prosecute. It is a serious offence, a very serious offence, and I expect them to be prosecuted. I personally have no idea where your estimate of 1,000 corrupt staff comes from. Plainly, if we knew who the corrupt staff were, we would both prosecute and dismiss them. That sounds like somebody's estimate. But I have always suspected that one of the problems is that we are not totally on top of a few prison officers giving into the temptation to make themselves much wealthier prison officers by helping to take drugs into the prison.

Chair: It came from a Policy Exchange report. We will send you a copy.

Kenneth Clarke: Yes. I will get that looked into. But the security checks on staff, and particularly in these—well, the whole prison, are obviously a very important part of reducing the ability of people to get drugs.

[3] Note by witness: From a survey (Surveying Prisoner Crime Reduction—SPCR) of 1,435 adult prisoners sentenced to between one month and four years in England and Wales in 2005 and 2006, 7.5% of all the prisoners in the sample (drug users and non-drug users) reported that they had first tried heroin during a previous prison sentence. For those prisoners in the survey who reported having ever taken heroin 19% of those first tried it in prison. This question was asked only once; therefore there is no comparison figure for earlier or later time periods."

Q402 Chair: Finally from me, just on mandatory drug testing. We know it happens when prisoners enter the prison. Why doesn't it happen when prisoners leave?

Kenneth Clarke: I think because it would be just vastly expensive. We get the figures, and we have people telling us what their history of drug abuse is. Obviously, some testing goes on, but the idea you introduce a regime of mandatory drug testing all the time—it certainly is a way of getting statistics—would be pointless because we know we have a problem, so we just don't need to keep testing what it is. Obviously, once you get into a drug rehabilitation wing, and so on, I am sure they look out for any indication that someone is reverting. But testing does go on now. It is used as a control technique, and we usually produce figures prison by prison, so the Inspectorate discovers what the rates are.

Q403 Chair: Chair: Yes. We felt perhaps if you had it on departure from prison, there would be more ability to help people be rehabilitated into the community.

Kenneth Clarke: I will consider that.

Q404 Bridget Phillipson: As the Chair said, we visited Brixton drug recovery wing just last week, and saw the excellent work that they were doing there. But, given the number of prisoners with drug dependency, will it be possible to offer this kind of facility to every prisoner who wants it, even if it is rolled out, having been deemed to be a success following the pilot?

Kenneth Clarke: We are anxious to roll it out, and we are doing nothing whatever to discourage the schemes that are being run of their own volition by governors in prison by prison. We have our programme of drug recovery wings and variants of this are being established in various prisons by governors and staff, who are enthusiastic to contribute what they can. With our main programme, our intention is to roll it out, but we intend to evaluate it. The whole history of the struggle against drugs shows that an outbreak of enthusiasm occurs among politicians—everybody—for tackling it in a particular way, and it is pursued for a few years, and then you discover that it is producing rather disappointing results. So we will roll it out as resources permit, but that is not the main constraint, but we have to evaluate it carefully and get evidence to reinforce our optimism that we are going about it the right way.

Q405 Bridget Phillipson: We saw when we visited how prisoners were being supported in prison, towards the point of leaving prison and then would be supported in the community to remain drug free. But how can we sustain that? You potentially have someone in prison for six months or a year, they are drug free, but how can we ensure that when they are back in the community they don't simply lapse into the same reoffending and the same drug use?

Kenneth Clarke: Sadly, you can't guarantee that you are going to have a 100% success rate with anybody in this programme. However, as I have said, the key thing is to try to make sure that wherever possible there is, through the gate, follow up, a link up with those people outside who will help sustain the released prisoner in his drug free state. One difficulty of course is the short term prisoners, the ones with 12 months or less, who don't stay in prison long enough to make a dramatic improvement, though we do concentrate on them. We find people who are trying to get off drugs and can be helped get on the way. We don't at the moment usually give any support to them when they leave the prison, so you have to put in place the programmes that will give them support.

Q406 Bridget Phillipson: The staff at Brixton talked about the important use of mentoring or volunteers in supporting people to reintegrate back into the community and provide that direct contact one-to-one with someone. Is that something you think could be used effectively by prisons?

Kenneth Clarke: I get that advice frequently from people who have more expertise than myself in the practice of these things, and I think that is true. Actually, it is true of prisoners generally when you are trying to reform them—a very large number of successful programmes have to include an element of mentoring, alongside some positive steps that have been taken to get the man to settle down into a regular way of life and to avoid drifting back into whatever was the problem before that was helping get him into crime.

Q407 Nicola Blackwood: I was rather surprised by the response I received from Mr Bradshaw about the implementation of the Government's new drug strategy in prisons. Could you tell me if you think that the Prison Service should be fully implementing the Government's drug strategy?

Kenneth Clarke: Well, before we drive a wedge between Mr Bradshaw and myself, I have always found that clinicians disagree. Over the years, I have always thought that—not just in prisons—there is far too much use of methadone, and I always preferred abstinence-based approaches. I have always suspected that just sustaining people on methadone seems easier, but for years, whenever I have had any contact with this subject, I have always thought it was too easy to slip back into just doing that, and what really matters is trying to get change. The health service, the Department of Health has announced a shift in emphasis. Having said that, clinicians don't all agree. We are moving into this whole area, when it comes to treatment, of Department of Health commissioned services. It obviously makes sense for health professionals to be in charge of this, so it is not for me to start giving amateur views about the benefits. But I believe the Department of Health is going in the direction, and if I may read from my brief on the points suggested that I make on methadone prescribing, it says, "While substitute prescribing will continue to play a role in the treatment of heroin dependence, we are working with health services to move towards a drug treatment system based on

recovery, which does not maintain heroin users in prisons indefinitely on prescription alternatives, such as methadone, unless absolutely necessary". That, I believe, to be the policy.

Q408 Nicola Blackwood: What Mr Bradshaw seemed to imply was that there had been no change in policy since 2006, however, and—

Kenneth Clarke: He appeared to imply that to me, based on the advice of NICE as I understand it.

Nicola Blackwood: Yes.

Kenneth Clarke: I was not aware that NICE had not changed their advice. NICE is not an agency of my Department, and I think Andrew Lansley and myself, NICE and the Prison Service perhaps had better touch base afterwards, about whether we are or are not moving more towards a drug treatment system focused on recovery. I am sure everybody has argued that keeping people on heroin substitutes indefinitely is not something anybody should try to do, but I must admit that, in my present office, I have encountered schemes where it is quite obvious that is all that is being done.

Q409 Nicola Blackwood: Would you also agree that this drug strategy, as he seemed to imply, is not evidence-based but is instead based on—

Kenneth Clarke: I think everything we do has to be evidence-based and I think it is the health professionals who have to be in the lead of deciding what actually is effective. There are things that amateurs have done in the Prison Service in the past, like taking heroin addicts straight off heroin as soon as they come in with no substitute. That is positively dangerous and the service had to pay civil damages, civil compensation for that.

Q410 Mark Reckless: Secretary of State, I am concerned that what is happening in drug treatment on the ground may not be quite what Ministers want to be happening. Two issues have been brought to my attention. One is that the pressure to move from methadone maintenance to genuine recovery and abstinence-based treatment, is less than intended and it is not happening to a great degree. Secondly, you say you are very keen to involve the voluntary and charitable sectors through payment-by-results. However, the actual process of bidding for payment-by-results and the European Procurement Rules, and sometimes the need to have national networks for people to follow people up, is actually driving those voluntary and charitable organisations out of the sector. There are also these divisions between Justice and Home Office and Health, and I wonder if you could advise me on how I can bring these people into the process to try and show Ministers what their experience is on the ground.

Kenneth Clarke: On your first and third points, there has always been a history of slight inter-departmental rivalry—"rivalry" is not the right word; a sort of friction over the years, in my experience, and I think it is important to override that. Is it essentially a criminal matter with the Home Office in the lead? Is it a health matter with the Health Department in the lead? Where does the Prison Service fit in? If we are not careful, it all gets reduced to what is really a competition for resources, which does not get you to a policy. We are seeking to tackle that and, as far as I am aware, we are working principally with the Department of Health in prisons—very much with the Department of Health. It seems to me the relationships with the Department of Health are going remarkably smoothly, and that we are moving to commissioning all our clinical services in the prisons through the new Commissioning Board when it is set up, and on this we are we are working closely with the Health Service.

On things like sustaining people on methadone as opposed to going for full recovery treatments, I am never going to override the clinical advice, but the Department of Health and I must ensure we are all getting the same clinical advice, and that we have decided to establish it on a reasonable consensus.

Q411 Dr Huppert: I am encouraged to hear your focus on evidence, and listening to what the health professionals say. I do not know if you are aware of the work by Professor Strang that is in *The Lancet*, which looks at things like methadone maintenance versus other options, but I think we would all agree that it should be based on the clinical benefits and what we can do to help people and to reduce the crime that they later cause.

On the subject of evidence, I do not know if you are aware of the research that has been done by the Medical Research Council, looking at deaths of heroin users who are released from prison. But the figure I found quite shocking is that, of all the people who have ever used heroin, one in 200 of them die within two weeks of release from prison. You mentioned short sentences and the problems associated with that. First, presumably you would agree that that is an unacceptably high death rate. What should we be doing to try to reduce that and what steps are you taking?

Kenneth Clarke: First, no, I have not. It all sounds very interesting, very relevant and I do not mean to be difficult about the question, but obviously I have not been through all this medical research and medical opinion. I have always found in the past that medical opinion is not always unanimous on practically anything to do with drug abuse. So everybody tends to choose their particular learned article for their particular point of view, on the ground that these things are very difficult. I am not going to say it is not my Department, but it is not my Department; the Health Department has to be in the lead in deciding the most effective way forward, based on the best evidence they have. Yes, obviously the death rate of people leaving prison—how high it is compared with the ordinary death rate of those addicted to heroin, whether they are in prison or not I do not instantly know—but it is all evidence of failure, when you have someone addicted to heroin who goes on to a premature death.

Q412 Dr Huppert: The figures—and I can give you a reference, if you particularly want me to—are about 37 times higher within the first week. I don't have them over the fortnight, but I think the figures—
Kenneth Clarke: What do you suggest happens in the first week of leaving prison that causes this sudden mortality?
Dr Huppert: I believe that the suggestion is people taking heroin when they come out and the effects of that. I think the death rate is uncontroversial—I agree with you that there is a whole lot of evidence in different areas. Perhaps the most useful thing would be if you can find out what the Department is doing because clearly it is alarming if people are coming out of prison and dying immediately afterwards.
Kenneth Clarke: It may be that they are achieving more success in making the drug difficult to get in quite a lot of our prisons, so people who are addicted are finding heroin as soon as they can when they get out and not realising they can't take the same dose again straightaway.

Q413 Chair: You don't think it is a symptom of your success?
Kenneth Clarke: No, I wasn't putting it in that way but it may be slightly beyond our control. You are probably going to argue that means we should be maintaining them all on methadone when they are inside. You do create a thriving black market in methadone if you develop a love for it and that—
Chair: Dr Huppert, final question.

Q414 Dr Huppert: There are a number of studies looking at Naloxone and various other things. I would hope that we could agree that a death rate of one in 200 is too high for people leaving prison?
Kenneth Clarke: Of course I agree with that, yes. It is self-evident.

Q415 Mr Clappison: Secretary of State, could I ask you about the future of dedicated drug courts, what is going to happen?
Kenneth Clarke: Well, we are interested in them and obviously there are examples of people doing good work in dedicated drug courts with some enthusiasm. At the moment, we don't have any funding we can put into it to extend this approach. I always press for some evidence, both here or in examples abroad, where it is an American practice as well, of actual improved outcomes. I have attended—actually in America, not here—one of these styles of courts and I was impressed by the general atmosphere and the obvious rapport, as it were, and the close interest the judge was taking, a rather charismatic judge, in the progress of each client and so on. Sadly, it is quite difficult to demonstrate that this has any measurable effect on things like reoffending, but I am open to evidence that would justify putting more resources into it, but there are more enthusiasts than there are evidenced beneficiaries, is my slightly cautious—I hope not too cynical—comment.

Q416 Mr Clappison: I have another question, perhaps this is a convenient moment to ask it. If I could tempt you into painting on a broader canvas, because you have obviously rightly talked about the need to have an evidence-based approach, but once or twice in your evidence you have given us the benefits of your experience and you have, if I may say, huge and possibly unparalleled experience, certainly in this Government, of various Departments. On the basis of your experience, what wide conclusions have you drawn about the best way to tackle the drugs problem?
Kenneth Clarke: It is very tempting, Mr Clappison, but for me to sit here on behalf of the whole Government and start propounding the best way of tackling drugs would be unwise. I think I would have to try to reach a considered and collective view with my colleagues before doing that. You are very kind about my experience, but I have not reached the stage of that blinding insight about exactly how we are going to improve our record, is the honest truth. We have been engaged in a war against drugs for 30 years. We are plainly losing it. We have not achieved very much progress. The same problems come round and round, but I do not despair. We keep trying every method we can to get on top of one of the worst social problems in the country and the biggest single cause of crime.
Mr Clappison: In the very distant future, I hope that there will still be a House of Lords, that you will be a member of it, and that then you will in a position to give us the benefit of your experience.
Kenneth Clarke: Of course, in my future years on the benches in the House of Commons, I will try. But what has improved is the co-ordination between Departments. I was once given the thankless task of co-ordinating the Government's whole approach to drugs, and pulling together the work of the different Departments in the late 1980s. It was a complete waste of time. I did not have sufficient seniority in the Government to get anybody to take the faintest notice of me, and they merely thought it was a bid by my Department to muscle in on the territory of either the Home Office or the Health Department or whatever. That has not vanished but it is very, very much less than it used to be.

Q417 Mr Clappison: Without advocating or dismissing the argument, there are those who argue in favour of decriminalisation. Has your view changed at all on that or—
Kenneth Clarke: Speaking on behalf of the Government, the Government has no intention whatever of changing the criminal law on drugs. Now, you ask me my personal opinion. I have never been persuaded by the decriminalisation argument. I have frankly conceded that policy has not been working. We are all disappointed by the fact that, far from making progress, it could be argued we are going backwards at times. But my own purely personal view is that I would be worried about losing the deterrent effect of criminalisation on youngsters who start experimenting. The really key thing is to try to work out what can get fewer young people to start experimenting with drugs. One thing that does put them off is they will get into trouble with the police

if they do it. Once you tell them they will not get into trouble with the police, I have always had the fear that rather more people would experiment. But that is just my personal view as a citizen.

Q418 Michael Ellis: Lord Chancellor, community sentencing, I think you and I can agree, can often be more appropriate for drug users who have committed minor offences. But the drug rehabilitation requirement that is imposed by the courts on offenders in certain circumstances, is only placed on offenders where they consent to go on them, or there is a willingness at least for the offender to comply with the requirement of the drug rehabilitation order. Do you think that is a flaw in the system? Do you think there should be some avenue of recourse, whereby courts can say, "Well, you have failed to comply with a rehabilitation order, or you have failed to consent to it and, therefore, your sentence can be higher and non-community based?"
Kenneth Clarke: Again, in previous evidence we have referred to the advice you always get, that you only make progress on drug rehabilitation when the individual concerned is sufficiently motivated to respond and co-operate. If you have somebody who really is not prepared, in every sense of the word, to actually start trying to break dependency on drugs, you are almost certain to fail. I think that is why the drug rehabilitation requirement is usually linked with a willingness—

Q419 Michael Ellis: But is it too easy for people to say, "Well, I don't want to have the drug rehabilitation requirement"?
Kenneth Clarke: Well, if the person accepts themselves that they are not ready, not able, not capable, not motivated to try to abstain from drugs, the court may take some more severe step in some other aspect of the sentence. It is one of the things available to the courts. The courts do make use of it. I think obviously they get advice on the suitability of an individual case—alcohol dependence is the same—once someone is determined to have a go at breaking their dependency, it has a chance. If they are really not of a mind to do so you are wasting your time, frankly, in giving them treatment.

Q420 Mr Winnick: Recognising, Lord Chancellor, the need to try and ensure that people who go to prison don't constantly come in and out—and we had some examples of that when we visited Brixton last Thursday—the Probation Service undoubtedly has an important role to play. Why be so determined to drastically change it?
Kenneth Clarke: I think it needs reform. It hasn't been reformed for very many years. I think the Probation Service is absolutely crucial to the proper delivery of community sentences, and improving the delivery of individual elements in community sentences is equally important. Following the previous Government's policy on deciding that some market testing gives us greater diversity of suppliers, looking for some outsourcing is what is required. There is no need for the Government to legislate on the subject. It is the 2007 Act of the previous Government that they never quite got around to implementing that we will be implementing.

Q421 Mr Winnick: So your defence is that since the previous Government proposed it, it is okay?
Kenneth Clarke: No, I was just hoping to make it a little less controversial. Hopefully I was pushing at an open door, Mr Winnick.

Q422 Mr Winnick: When it comes to controversy, isn't it interesting that the former prison inspector, now in the Lords, supported by a former West Midlands Chief Constable, Geoffrey Dear, and the person who is the patron of the Probation Association—although it could be argued she has an interest, but I don't quite see why—are very much opposed and have said they will do their utmost in the House of Lords to oppose what you are doing?
Kenneth Clarke: Well, I am sorry Lord Ramsbotham is taking that view, and I have seen that he is but I don't, with the greatest respect, agree with it.

Q423 Mr Winnick: He usually knows his stuff, doesn't he?
Kenneth Clarke: Yes, he certainly does. I have every respect for Lord Ramsbotham, but there is quite a range of things on which I don't always agree with him. My right-wing critics always accuse me of being a terribly liberal sort of Justice Secretary, but I am not in the same league as Lord Ramsbotham, is my experience. I just think that the service has had this set pattern for a very long time, it has been contemplating moving to a purchaser/provider split in order to get a wider range of providers, in order to test the quality of what is provided and to do so more effectively. There are people in the Probation Service who are quite keen on that actually, but NAPO is not. The policy has been foreshadowed for some years and we are going into it, I hope, sensibly. The idea is to try to make a more effective delivery of more effective sentences.

Q424 Mr Winnick: You said you are not on the same liberal wing as the former Prison Inspector, you are not on the same wing as Lady Thatcher, but apparently much of the Probation Service is going to be privatised, which would have delighted her no doubt?
Kenneth Clarke: I find the old argument of whether we are privatising something or not, ever so slightly boring. It is an ideological debate of 30, 40 years ago and more. When it comes to the provision of public services, my own view is I am quite indifferent as to whether the management is categorised as private sector or public sector. I don't mind what trade union staff belong to, and I don't particularly mind whose payroll they are on. What matters is what the outcomes are of what they are delivering—whether you are getting good value for money and whether the quality of the service they are delivering is the best you can get. So I am generally somewhat blind as to the status of the provider. What I am more interested in is the quality and the cost of what that provider is going to give the Probation Service.

Chair: Thank you. Mark Reckless has a quick supplementary.

Q425 Mark Reckless: To make the Probation Services more locally responsive, would you see scope for giving powers to Police and Crime Commissioners in respect of probation after November?

Kenneth Clarke: Well, not immediately, no. Police and Crime Commissioners, I think we see where we go. I am keen on the Police and Crime Commissioners. We obviously are going to have democratic and local accountability for the police service. We are not quite sure how that is actually going to work, but I think we are crying out for change from the present police authority system, of which the public are quite oblivious and is not really accountable to the public at all. In another area of my Department, I am canvassing putting victim services fairly quickly—although we are keeping an open mind about the precise timing—into the hands of Police and Crime Commissioners, because I think the link between the police and the victims is one of the best ways of making sure we are getting the right victims and then there will be local accountability of the service. Starting to make them responsible for the delivery of sentences or anything of that kind I think is a bigger step. As of now, I think let's see how we get on as the Commissioners are set up, and let's see how the probation reform we are proposing gets on before moving to what would be a great leap for them to start commissioning services for the delivery of community sentences.

Q426 Alun Michael: You will be aware of a declaration of interest I made at the beginning of this process, in that I am a candidate for Police and Crime Commissioner in South Wales. Is your Department, and the justice system generally, keeping up with some rather fast developments? I refer to two things: one we have heard a lot during this inquiry about legal highs and things like the need for generic legislation to stop very clever games being played by unscrupulous chemists; and secondly, the sale of legal highs and other drugs via the internet. We have always found it difficult to cope with street corner sales. Perhaps the trackability of the internet might give some opportunities. Do you think the system is keeping up with these changes?

Kenneth Clarke: I hope so, but it is just ever so slightly outside my present sphere of responsibility, so you are probably more up-to-date than I am, Mr Michael. For as long as I can remember, enthusiastic chemists and pharmacists, and just amateurs who have particular skills in this area, have been inventing substances, trying to get themselves one step ahead of the law and producing what you call "legal highs", and it is a bit like the Inland Revenue dealing with tax abuse. There are experts on both sides, each all the time trying steadily to move ahead of each other, and you probably have to rely on the evidence you have taken, and your own opinion, as to who is winning at the moment.

On the second point, the Misuse of Drugs Act applies to the internet as much as to any other way of sale, and again I am not a prosecutor, or responsible for prosecutors, or responsible for the police service, but I trust that we are sophisticated as everybody else in making use of the fact that the technologies you can use to trace people who are dealing on the internet. But there is no different system of law, so far as I am aware, that applies to internet sales, which makes them different, in principle, from any other sale.

Q427 Alun Michael: I think the point being that perhaps the science can be exploited by the enforcement agencies being inventive and innovative. In view of your earlier answer, perhaps I could ask whether you are keen for Police and Crime Commissioners to be innovative in making connections and trying new ways of doing things?

Kenneth Clarke: Yes, I think anybody with that responsibility should try to be innovative, but we have to be quite clear about what powers they have and what powers they haven't got. I actually think the powers they will start with, as they replace the old police authorities, are quite substantial and there are plenty of parts of the country where a more innovative approach to the responsibilities of the police and how they account to the public is called for. But I wait to see, first, who is elected and, secondly, what they do when they have taken office.

Q428 Chair: Finally, Lord Chancellor, I am not sure whether as Health Secretary, you appointed the first drugs tsar, but somebody did in a previous Administration, and given what you have said to us today, you talked about the different Departments that are involved, is it now time to have a central figure, perhaps a Minister or someone outside ministerial office who can co-ordinate all the various parts of this very, very difficult subject? Because the Governor of Brixton made it very clear to us, for those who arrive at the prison, the problem starts much, much earlier on. Peer pressure, and the way it is dealt with at that level. You are not involved in prevention. You are involved in dealing, in the Ministry of Justice, with what happens at the end of the process. Should we have someone in charge of co-ordination?

Kenneth Clarke: I have no recollection of appointing or being a drugs tsar. The phrase wasn't fashionable I think at that time. It came in later. I am sure somebody eventually appointed a drugs tsar. We have had a tsar for most things at various stages. I do think the co-ordination is quite important because I am conscious of the fact that, in the Prison Service or in the criminal justice system, we are merely one part of the picture, a very serious part of the picture: schools, education, policing, the effectiveness of policing, and the health care system that provides cures. When I said my appointment in the late 1980s proved to be pretty ineffective, I was not questioning the wisdom of making such an appointment. I was merely saying in those days there was a mountain, which one of the more junior Members of the Cabinet found quite unable to climb. The powers of Whitehall were not going to have anything of this kind. Things have now changed, and I think there is better co-ordination.

Q429 Chair: So you would say favour better co-ordination?

Kenneth Clarke: I can't speak for the Prime Minister, but I think the Prime Minister would rather that we worked as a Government, not as different Departments on this subject and that we do co-ordinate what we are doing. My Department is having no problem at all working closely with the Department of Health, and they are taking over the commissioning of all health services in prisons. We are talking about diverting people sometimes to more suitable places to be treated, and they are in the lead on the health care system and they work with our people who are responsible for the custody, the security and fitting in with all the other rehabilitative work that has to do with prisons.

Chair: Lord Chancellor, thank you very much for coming today.

Tuesday 11 July 2012

Members present:

Keith Vaz (Chair)

Mr James Clappison	Alun Michael
Michael Ellis	Bridget Phillipson
Lorraine Fullbrook	Mark Reckless
Dr Julian Huppert	Mr David Winnick

Examination of Witnesses

Witnesses: **Danny Kushlick**, Transform Drug Policy Foundation, and **Niamh Eastwood**, Release, gave evidence.

Chair: Order, can I call the Committee to order? This first session of the Committee's deliberations this morning relate to our inquiry into drugs. Could I welcome Mr Kushlick and Ms Eastwood; thank you very much for coming to give evidence. Are there any interests that need declaring in respect of this inquiry?
Alun Michael: Simply in relation to the police elements. I am a candidate for the Police Commissioner role in South Wales.

Q430 Chair: Thank you, Mr Michael. All the other interests of members are declared in the Register of Members' Interests. Could I start with this question? Both of you are in favour of either relaxing or decriminalising our drug laws. Ms Eastwood, why is that?
Niamh Eastwood: Firstly, thank you to the Committee for the invite today. Release has just published a new report, "A Quiet Revolution: Drug Decriminalisation Practices Across the Globe", and we looked at over 25 to 35 jurisdictions across the world that have adopted decriminalisation, and overwhelmingly we find that drug use did not increase in any statistically significant way. Our definition of decriminalisation is the application of known criminal sanctions to drug possession offences and in some cases to cultivation of cannabis for personal use.
The question then arises: why pursue a harsh criminal justice approach and the harms of criminalisation that impact on an individual? For example, it has a negative impact on employment, on educational aspirations and, furthermore, it stigmatises individuals and we would argue that this is a barrier both to treatment for those who use drugs problematically and a barrier to full integration into society for those who use drugs problematically and those who use drugs non-problematically.
So we believe the evidence is there for decriminalisation. We believe it reduces the harms of the current system and it should be properly considered as a response to drug use.
Danny Kushlick: Thank you to the inquiry for inviting me too. I gave evidence back in 2001 to the drugs inquiry that HASC ran then and our evidence is going to be similar but worse in terms of what has happened in the intervening period. Our view is that the global war on drugs and the domestic war on drugs should be ended and that we need to put in place an overarching system of regulation and control. The reason is that prohibition does not work. What it does not do is stop people using drugs: 270 million people use drugs worldwide, a billion have lifetime use, and that stimulates a trade valued by the United Nations at $320 billion a year. It creates an incredible amount of crime. It basically operates a wrong-headed approach towards dealing with, as Niamh said, use and misuse. People who are using, who are not causing a problem to themselves or to other people, do not need the intervention of the criminal justice system and people who have problems need health intervention. On the supply side the Government ought to be in control of the trade, not international organised crime.

Q431 Chair: We will come on to that later. Ken Clarke, the Lord Chancellor and Justice Secretary, when we had him before us to talk about this issue, specifically what was happening in prisons—we were very alarmed at the amount of drugs in prisons—made a statement to the effect that the war on drugs had been lost. Do you agree with him?
Danny Kushlick: Absolutely, the war on drugs was never winnable, on the basis that the numbers of people who use have risen year on year on year to such extraordinarily high levels; it was never going to be a war that was going to be winnable; in the same way that the war on alcohol, in terms of prohibition in the 1920s and 1930s, was never going to be winnable, unless the numbers could be kept down to a level low enough to keep organised crime and criminality out of the supply side.
Niamh Eastwood: I completely agree, we have not won the war. In fact what we have done is we have created greater harms with the policies that we pursue at the moment. I have mentioned decriminalisation but we see the damage around the world that is done in the global illicit trade of drugs where we have handed it over to organised crime and people who are essentially driven by huge profits because of the illicit nature of this market.

Q432 Lorraine Fullbrook: When the Home Affairs Select Committee visited the United States and Colombia we met with six organisations who were in favour of either decriminalisation or legalisation of drugs and none of them could articulate what the vision was after decriminalisation or legalisation. What does the world look like? Can you articulate what the world would look like after decriminalisation or legalisation?

Danny Kushlick: In 2009 in this House we launched a publication called "After the War on Drugs: Blueprint for Regulation", which shows the technical detail of how drugs could be controlled and regulated in a post-prohibition world, and that shows how they can be controlled through pharmacies, through licensed outlets and through doctors. On the supply side we already have half of the world's opium grown for the legal market: 8,500 hectares of UK arable land are under cultivation for opium poppy for supply to the licit opium industry. None of it is taxed by the Taliban. None of it contributes to the profits of organised crime so we know how to do that.

We know how to control drugs in terms of production and supply for pharmacies and we know how to do it for licensed retailers. What we also know is if you prohibit a demand-led trade all you do is you gift it to organised crime and unregulated dealers, so the regulatory frameworks are all currently in place. This is not a step into the unknown. In fact, prohibition was a step into the unknown.

Niamh Eastwood: In terms of decriminalisation, which is what we advocate for as a first step because we believe the evidence is there for it, I think we can look around the world, at the countries that have already adopted it and see how it has impacted on those countries. Overwhelmingly, as I said, drug use does not go up. But we have some examples from Australia, for example, where they have decriminalised cannabis possession and cultivation and they have had very positive results.

There was a study that compared two states—one that had criminalised use and one that had not—and it found that individuals who were criminalised had greater negative outcomes in terms of employment, education, accommodation, relationships and were more likely to re-enter the criminal justice system. So I think in terms of decriminalisation then, yes, we can see what it looks like.

With regards to regulation it is more complicated. Release argues for an evidence-based approach to this. I would support a lot of what Danny has said but what we would say is, for example, with cannabis it is probably easier for us to move forward regulating that drug and it is very much dependent on the drugs. This is not a homogenous group of drugs. They are very different in the way that they are used and their impact and we have to have different policies for them.

Q433 Bridget Phillipson: Mr Kushlick, you were talking just a moment ago about the comparisons or analogy that can be drawn with alcohol and how prohibition of alcohol did not work, and I accept that. But equally with alcohol have we not seen because of the growing availability and cost a growing problem with social harm associated with alcohol? What do you think on that point but also would you extend that analogy further because obviously you are advocating decriminalisation?

Danny Kushlick: We are advocating control and regulation. That is the key here. In our submission we have a graphic that demonstrates how at one end of the spectrum the over-commercialisation and lack of control of multi-national companies who produce and sell alcohol, tobacco and pharmaceuticals effectively have deregulated the market and, at the other end, we have prohibition, which effectively deregulates the market but in a different way and gifts it to organised criminals. In the middle there are significant opportunities for Government to intervene in terms of price, outlets, production, supply and that is where we are heading. What we are trying to do is close that gap, so yes, we fully recognise that an overly commercialised market can drive up levels of use to horrendous levels, but this is because of a lack of control of those multi-national companies who effectively run the trade themselves. What we are calling on is for Government to restrain and regulate far more powerfully current illicit drugs and at the same time take control of the prohibited trade and put in place best practice in terms of control and regulation.

Q434 Mr Winnick: Do you think there is some sort of contradiction between the Justice Secretary saying, as he did last week, that the war on drugs has not succeeded, it has failed, and immediately afterwards telling us that he is very much in favour of continuing with the policy? Do you see that as a contradiction?

Danny Kushlick: Far be it from me to call into question Ken Clarke's evidence, but what disturbed me about what he said was that he had not had any blinding revelations about what to do about it. So for me the concern was that having recognised that there is a significant problem here and that we are indeed losing the war on drugs and, as Niamh was saying, it was totally counter-productive. Look at Mexico where 55,000 people have killed each other over the last four years. It has destabilised the entire Latin American region, West Africa, Afghanistan—this is a global problem that is causing genocide.

There are not that many options that we need to look at. One is intensifying the war on drugs, which seems to me to be patently stupid given the evidence that we have had over the last 50 years. We can carry on as normal, which we clearly cannot, because it is not working. We can move to a public health approach and decriminalise drugs or we can look at full legal regulation, ending the war on drugs and bringing it under the control of the Government. Those are the only options that we have, and I think that in the absence of Mr Clarke's definitive solution to what is going on, we need a review that looks at all those options and explores cost benefit analysis, conducts value for money studies and begins to put an evidence base on all those options.

Q435 Mr Winnick: I am not unsympathetic, as you may or may not know, to the view that you have just expressed, but what do you say to the argument that, in fact, on the use of drugs, all the statistics show the use of drugs is such that it is falling. For example, it fell significantly from 11% in 1996 to 8.8% in 2010–11. Cannabis fell from around 9.5% in 1996 to 6.5% in 2010–11, so the argument is it is falling. With all the failures, the Justice Secretary said; if you are going to do what you have advocated for so many years, it will reverse the trend.

Danny Kushlick: Some use is going up and some use is going down. Overall, global use remains steady:

270 million used in the last year, a billion lifetime use. The problem is that at those levels of use you stimulate insecurity, destabilisation of developing countries and transit routes. You just spawn opportunities for organised crime and create criminality and a whole host of other problems: health problems, stigma and discrimination, human rights issues, and a waste of money of gargantuan proportions. Currently it costs $100 billion a year to run prohibition, and if we continue doing it for another 10, it is going to cost us $1 trillion. The value for money is poor, to say the least. It is counter-productive. What we need to do is get back and look at the evidence of what the policy is causing.

Use is only one indicator. Levels of security of developing countries that are involved in production and supply, the value for money, all this evidence, which Transform has been calling on Government to produce for the last nearly 20 years now, which it still will not because it cannot show that it is producing value for money across that host of indicators, across those departments. Until we have it we should—

Q436 Mr Winnick: And the drug barons, not just the street corner characters who do certainly much harm, but the drug barons who usually operate on an international scale, are they happy, do you think, with the existing law?

Danny Kushlick: They will be delighted to the extent that any country, Government, continues to support the status quo, the prohibition; that is manna for them. That is what they want. The last thing that they want, and the big losers in terms of a move away from prohibition towards Government-control and regulation, as was the case for alcohol prohibition, is international organised crime and unregulated dealers; businessmen who do not pay tax.

Q437 Mr Winnick: You would agree with that, Ms Eastwood?

Niamh Eastwood: I certainly agree with much of what Danny says. I think that we have to take an incremental approach to change. I think in terms of the steps that you mentioned around drug misuse, first, statistics on drug misuse are not always reliable, people are not likely to disclose their use because of the illicit nature of it, and we do not have the message around this right. For example, the policy does not impact on use. We have seen that with reclassification of cannabis and various other illicit substances.

Q438 Dr Huppert: You have talked quite a bit about evidence and I come back on some of that. Public opinion is also quite important in this area. Have you seen the article recently in *The Sun*, not noted as a bastion of liberalism, I have to confess, which says, "Legalise drug use, say Brits in poll". Six out of 10 said they would back trials where users escape prosecution to get medical treatment—so, the Portuguese model. They interestingly also say that more people think that crime levels would fall if cannabis is made legal. Although I am sure my colleagues would not be interested in this, they also find that people in all ages, all genders, and all voting intentions would be more likely to support a political party that supported a move that way. Do you think there is a trend in what is happening? Do you accept those figures and do you think it is becoming more and more acceptable both in the UK and around the world?

Niamh Eastwood: Absolutely. I think the public is moving on this issue. I think that is both driven by a recognition that the policy is failing and a recognition of the cost involved. I also believe that the growing call from very high-level individuals around the world has impacted on people's views so we had the Global Commission on Drugs Policy come out in June 2011 calling for a review, calling for decriminalisation and for Governments to experiment with cannabis regulation. That commission is made up of a range of individuals. There are several ex-Presidents on it, Kofi Annan is a member, Richard Branson—these are intelligent—

Chair: We have taken evidence from them already. We know the score.

Niamh Eastwood: Sorry. I think that has had an impact on it. I also think that in terms of policing that people see, especially in the UK, high levels of proactive policing around drug possession, and that undermines their belief that this is necessary. What communities care about are crimes against the person, crimes against property. If we looked at a London Communities Poll back in 2009 drug possession was 22nd of concerns of Londoners, so we need to be questioning, why follow this?

Danny Kushlick: Could I come in on that one? For many years now the public has been ahead of senior politicians' opinion and rhetoric on this issue. It has been a taboo and the mantra has been it would be political suicide to make moves on this issue. This evidence from *The Sun* and the YouGov poll shows that the public is now a majority in terms of support for change and that cover now of saying that the *Mail* will take us apart, *The Sun* will take us apart, the public will not come with us, is wrong. It is just wrong. The evidence shows that we have now moved to the point where politicians need to put this on the agenda. It was actually slightly higher; it was 58%. It is reported wrongly in *The Sun*, as 58% of the public support a review of all options including legal regulation, but the other interesting thing is only 22% oppose.

Q439 Dr Huppert: That is very helpful. Can I just briefly return to the assessment of what has happened in other countries, the real evidence? Two questions: one is, how do we know that what happens in those other counties will be replicable here? You have presented quite detailed evidence, I think, that there was no statistical increase in drug use. How can we be sure that would happen here? Also I notice that quite a number of those countries, while some have decriminalised all drugs, some have just done cannabis. What are the distinctions and the options here in the UK?

Niamh Eastwood: I think in terms of policy transference that is a legitimate question. As I have said, the report looked at over 20 countries that have adopted some form of decriminalisation. None of the countries that are states that we looked at were

particularly similar or hegemonic. There were several Latin American countries, Western European countries, Australian states and US states that have decriminalised either all drugs or just cannabis. Different types of system as well, so we have systems where it was a de jure system, it was incorporated into statute law. We had de facto where it was a policing and prosecution-led policy. So it is absolutely right to say that there are different systems around the world and then the question, how do we know it would work here?

I would argue that several of the countries we looked at, and particularly Western Europe, Portugal, Belgium, Germany where drugs are decriminalised on a state level, all drugs, not just cannabis, and the US states and Australia, are very similar to our kind of cultural and social situation.

Danny Kushlick: Could I make a brief comment? One of the things about the blanket prohibition on non-medical use of drugs is that that is not country specific at all. It does not allow countries to experiment according to their own needs; so that lifting the blanket prohibition would enable countries to plan their own policies according to need. For some, that will mean hanging on to their prohibition. Saudi Arabians are not itching to decriminalise or legalise drugs but the Netherlands may well wish to go further, the Spanish, the Swiss and others.

Chair: We have quick supplementaries from Bridget Phillipson and Lorraine Fullbrook.

Q440 Bridget Phillipson: Ms Eastwood, just returning to your point around possession and how people view that as being lower down the list of their priorities. Of course if they are mugged or burgled because of someone's drug use that is obviously when people understandably feel very strongly about drug use. In terms of Mrs Fullbrook's point, what I am unclear about is in a decriminalised world where we have regulation how would that stop? What would that look like? I am still not entirely clear about how deregulation would inevitably mean that people are not stealing from others in order to buy drugs regardless of who that is from.

Niamh Eastwood: In terms of decriminalisation, which I said is the application of non-criminal sanctions, it would not impact on acquisitive crime linked to drug use and I am sure Danny will have points to make about the reason why acquisitive crime is driven by the current system. Essentially in the UK we criminalise 80,000 people every year for drug possession. Those are primarily young people. They are disproportionately from ethnic backgrounds and a reasonably large section will be problematic drug users. So Release delivers services in the community. We see every week people who are affected by problematic drug use. Many of those have not committed acquisitive crime and their barrier, once they are in recovery to getting back into employment is very much this criminal record. So it does not deal with all the problems of decriminalisation but, as I said, we see this as an evidence-based first step that can be done in the very short to medium term and that will impact positively on all those people who are criminalised currently.

Q441 Lorraine Fullbrook: Can I ask Ms Eastwood and Mr Kushlick, could you be specific about which drugs you would decriminalise and which drugs you would regulate?

Danny Kushlick: The question for us is across a series—

Lorraine Fullbrook: Just a list of which drugs you want to regulate.

Danny Kushlick: The question would be—

Chair: Mrs Fullbrook would like a list rather than going through her question.

Danny Kushlick: No, I am going to put this in context because it needs to be, which is which drugs would we want to leave in the hands of organised criminals and unregulated dealers? That is the first question. So the next one then is how could we best control drugs alternatively according to the best available evidence and we have basically four options other than prohibition.

Chair: We understand the context.

Lorraine Fullbrook: Give us a list of drugs you wish to do that to.

Danny Kushlick: We would like to see all the drugs that have heavy levels of demand so that—

Chair: So which are they?

Danny Kushlick: That would be heroin, cocaine, ecstasy, cannabis, stimulants, speed; all the ones that have heavy levels of demand, so it is back to the question of falling use. Unless you can keep the levels of use down you have to control supply.

Q442 Lorraine Fullbrook: Can I ask Ms Eastwood what you would do?

Niamh Eastwood: Very simple. We would decriminalise all drugs. Under that model it is still illegal but it is not a criminal offence, so it is a civil offence.

Lorraine Fullbrook: For all drugs?

Niamh Eastwood: Absolutely.

Q443 Lorraine Fullbrook: How do you square the circle with the illegal trade in prescription drugs?

Niamh Eastwood: That is a good question. Currently with prescription drugs we would argue—in decriminalisation people who use prescription drugs problematically are not being criminalised for that use, so it would not impact on what we are—

Q444 Lorraine Fullbrook: It is a huge issue in the United States and here.

Niamh Eastwood: Absolutely.

Danny Kushlick: It is. The fact is, it is increasingly difficult to control people's use and to control those markets. But what we can do under a controlled regime is push the criminal market and the illegal use to the margins. At the moment the entirety of the heroin market, the cocaine market, the ecstasy market and the cannabis market are controlled by organised crime. Currently the case is with the legal ones that the illegal market is a much smaller proportion, so that the vast majority is under Government control and legally used. A small proportion of it—it can still be big—is illegally controlled.

Chair: Order, Mrs Fullbrook.

Lorraine Fullbrook: I would like to ask about legal highs.

Q445 Chair: We will come back at the end because there are other people asking questions. Just to be clear, in respect of your answer to Lorraine Fullbrook, you would only decriminalise or regulate those drugs where there is high demand, Mr Kushlick. You, Ms Eastwood, and your organisation are calling for regulation and decriminalisation of all.
Niamh Eastwood: No, we are just calling for decriminalisation. Regulation is different from decriminalisation.
Chair: Very clear, thank you very much. We will come back to you, Mrs Fullbrook.

Q446 Michael Ellis: Have either of you ever seen the effect of crime caused by people on drugs? Have you spoken to or taken any time to consider the effect on people who are subjected to burglaries, robberies or assaults due to people who are on drugs or seeking access to more drugs?
Danny Kushlick: I hope it was made clear in my biography. I used to be a drugs counsellor.
Chair: We have not read your biography so you need to give us a potted version.
Danny Kushlick: I will. I was asked for one beforehand and I presumed that the members of the Committee had read it, my apologies.
I used to be a drugs counsellor in the criminal justice system working with heavy-end heroin and crack users and it was very much my experience of working with that group of people that led me to believe that it was the prohibition, the criminalisation of their drugs, that was leading them to steal and become involved—can you just let me finish—in prostitution.

Q447 Michael Ellis: No, Mr Kushlick, you are here to answer questions, with respect.
Danny Kushlick: Absolutely.

Q448 Michael Ellis: So answer my questions if you would. The effect of crime is not necessarily visible from the people who are taking it but the victims of those people who are taking it, so have you taken the trouble to speak to victims of crime? Have you done that?
Danny Kushlick: I have indeed. The issue here—this is important and it relates to Ms Phillipson's question—is why do people steal to support a habit? And the fact is that if you make a drug illegal and fail to control and regulate it then the price—there is a kind of alchemy of prohibition that turns vegetables at the point of production into products worth more than their weight in gold at the point of use. Someone who becomes dependent on that very expensive product will steal.
In the case of Switzerland where they prescribe heroin—this is going to explain to you, Mr Ellis, why there is—
Michael Ellis: Mr Kushlick, I do not need to know about Switzerland.
Chair: Order. This is a very interesting set of questions but what the rest of us need to know is the question and then the answer rather than—
Danny Kushlick: I am going to be able to complete—
Chair: If I can say, Mr Kushlick, that, time wise, we have a lot of other witnesses so the more succinctly you can put your point the more effective it would be.

Q449 Michael Ellis: I am going to make it clear to you, Mr Kushlick, for the absence of any ambiguity that I think your position is grossly irresponsible. I think there must be a proper regard to the effect of crime on the people who are victims of it, so I am concerned with the victims that I have seen, having been a barrister in criminal practice for 17 years before I came to this place, that people who are the victims of burglaries and robberies and assault would not think that the people who are on drugs when they committed those offences were in the right place.
Danny Kushlick: They are absolutely not, and the reason they are not in the right place is because their drugs are too expensive and that is because they are not controlled by the Government. Let me tell you about—can I please finish this, Mr Chairman?
Michael Ellis: No, I just want you to answer that point. On the other hand—
Danny Kushlick: Mr Chairman, please can I finish.
Chair: Order, if we could just let Mr Kushlick give his answer and then, Mr Ellis, please come back.
Danny Kushlick: So people who were dependent on heroin who are now prescribed, not just in Switzerland but in the UK, the rates of offending reduced significantly, sometimes down to almost zero because their drugs were free. If we made alcohol and tobacco vastly more expensive people would start stealing to support a habit and we could do that by prohibiting them. We do not because it would be a nightmare.

Q450 Michael Ellis: You have said it is because you consider that drugs are too expensive. You have argued about alcohol and prohibition. I suggest to you that the fact that alcohol is allegedly too inexpensive now has given a reason for campaigners on the other side to argue for alcohol to be made more expensive, so that is counter to your own argument.
Danny Kushlick: It is not a counter to it.

Q451 Michael Ellis: So if drugs were made dirt cheap, as you would like them to be, more offences would be committed, if alcohol is anything to go by.
Danny Kushlick: No, the point is to get the price right to a point where you reduce the crime but maintain a deterrent effect in terms of those people who misuse. So Transform and many other organisations who support legalisation and regulation, support minimum alcohol pricing. We would like to see—one of the things here is that tobacco is currently sold in sweet shops, which is wrong. It is sold without a licence, without an ingredients list. Alcohol is currently sold without a health warning and also sold in sweet shops and it is too cheap. We would like to see those prices increase but certainly not to a level where people are offending to support a habit.

Q452 Dr Huppert: I understand Mr Ellis' concerns, although I think we come from slightly different perspectives. What is the evidence from all the other countries that have tried decriminalisation? Has it in

fact led to an increase in crime or a decrease in crime because I think we do share an aim of reducing crime?
Niamh Eastwood: In terms of the impact on acquisitive crime, as I said, we were looking at prevalence rates. A lot of the countries have not analysed the impact on acquisitive crime, so, for example, probably the best researched area is Portugal. Portugal find that during a period of decriminalisation certain types of acquisitive crime went up and certain types of acquisitive crime went down. The type of crime that went up was crime that was less violent, so things like muggings, home burglaries, so there is an increase on business burglaries and that kind of thing.
In terms of decriminalisation I am not sure it impacts on acquisitive crime. I would not advocate that is necessarily the reason for introducing the policy. The reason for introducing the policy is because criminalisation does not achieve the effects that we want. It does not deter use and it does not impact on those who use problematically.

Q453 Alun Michael: You have both suggested that a Royal Commission should be established to look at this. A Royal Commission can be expensive and can take a lot of time. Why do you think it would be worth that investment?
Niamh Eastwood: We advocated for a Royal Commission because—I respect the Committee for taking on this difficult task and it is not an easy policy area, and in terms of one of the barriers to reform, the politicisation of the debate has been a major problem so that politicians—I am not suggestion the members of the Committee, but other politicians and certainly Governments—do not necessarily feel comfortable with addressing this issue, and I think we can see that when we have people like Bob Ainsworth who, after leaving office, came out and said, "There needs to be a review in this area. We should be prescribing medical heroin to people who use problematically." So a Royal Commission, we feel, would depoliticise it. I accept that it is expensive but when we spend £1.5 billion a year on law enforcement and the costs of the—

Q454 Alun Michael: It is also the fact that very often a Royal Commission comes out with a report, which then stays on the shelf because it does not deal with the political issues, with the views of the public, and the sort of counter-suggestions to the type of approach that you might think it might come out with; of course it might not.
Niamh Eastwood: Absolutely, but, as I said, we are led by the evidence so that is what we want to see. I agree with that point but I think, as I have said, this area is so difficult for Parliament. I mean this has not been looked at in 10 years, not since this Committee looked at it before. Having a debate on the Floor of the House around this area is almost impossible. Bob Ainsworth, when he talks about the timing that he got for it, I mean he was kind of put into the bleachers at 4 pm or something like that when nobody would be there. So I think there is a difficulty around this and that a Commission allows the evidence to be put forward. It may give politicians the cover they need to move forward, but I think the fact that we have change around public opinion is also something that we would hope would influence policy.
Danny Kushlick: There are a number of ways that we can approach this and a Royal Commission is something that Transform would also support. To be honest with you, we will take anything at this point because it is so taboo and it is so difficult. But a Joint Committee is another one. We could look at independent value-for-money studies.
What we use as a touchstone here is President Santos of Colombia's call for a review at which he said all options need to go on the table and they are doing that through the Organization of American States. I think we need to look at anything we possibly can: value-for-money studies, scenario plans, cost-benefit analyses. We need them to be as independent as possible but definitely evidence-based and be led by the evidence.

Q455 Alun Michael: We met President Santos and of course he was not recommending a specific approach.
Danny Kushlick: We don't need to.
Alun Michael: I am not quite clear now what you are suggesting; you are suggesting that, rather than a Royal Commission, a sort of series of studies be done, are you?
Danny Kushlick: The thing is, like I say, and I absolutely agree with Niamh, and we can all look at it—it has demonstrably been shown that this is so difficult to talk about historically by politicians and certainly senior ones. David Cameron sat in on the 2001–02 report, supported a debate and now has gone silent on it again.
Chair: He is not here today and you are the witness.
Danny Kushlick: No, but it demonstrates the difficulty as people move towards high office that it gets very difficult, so any opportunity to raise the debate to follow the evidence and look at all policy options will be welcomed.
Chair: We have other witnesses today so very quickly, Lorraine Fullbrook.

Q456 Lorraine Fullbrook: Thank you. I do not think you have answered my question about the illegal trade in prescription drugs in your list of drugs you would either decriminalise or regulate, and you have not included legal highs in your report or your findings, which change week by week and are as harmful if not more harmful than misuse of the usual drugs. What is your position on prescription and on legal highs?
Chair: These are very big areas. We are very happy to have a note from you on them. What I would like is 30-second answers because we have other witnesses.
Niamh Eastwood: Very briefly, we would consider the issue of legal highs as probably overstated in terms of use. If you look at the studies that say what are the most popular drugs it tends to be those that have been illicit for a long time. Methadrone has taken hold, there is no doubt about that. If we look at the classification of methadrone, methadrone use has gone up double since we controlled it and that is a common experience that we see. Ketamine in 2006—use has doubled again since that was controlled. Criminalisation does not work and it causes a huge amount of harm.

Chair: Mr Kushlick, again, 30 seconds please.
Danny Kushlick: With regard to the emergence of legal highs, that has been a product of prohibition. The diminution in the quality of both cocaine and ecstasy has led to people looking for new pills and powders that will produce similar effects. You end up chasing your tail. It is called substance displacement. To the extent that you win a war against one drug, another one will pop up to replace it. What we cannot use is the criminal justice system to defeat this.

Q457 Bridget Phillipson: Whatever the rights and wrongs of decriminalisation it does not deal with the underlying causes of why people might become problematic drug users. For example when heroin use was a particular issue in my community it was predominantly young people from troubled backgrounds who did not have a job and faced big challenges in their life. How would you respond to that?
Niamh Eastwood: I think that is absolutely right; it is a much more complicated area. Problematic drug use is a symptom of a much deeper issue. We see 1,700 clients every year at legal outreach programmes. Most of them have suffered trauma, whether it be abuse, sexual abuse, physical abuse, and again criminalising them is not going to help the situation.
Danny Kushlick: I absolutely concur with what Niamh has just said, and in terms of looking at underlying issues, certainly the evidence that I have seen shows that there is a clear correlation between the level of welfare and the level of misuse. So if we are looking at underlying issues we need to look at things like that, about benefit provision, and about reducing the gap between rich and poor. Those are the kind of things that will fundamentally influence the conveyor belt that leads people into misuse.

Q458 Chair: Thank you. Thank you both. Obviously what you have had to say is of great interest to the Committee eliciting a number of very interesting questions and answers. There may be other issues that you want to bring before us; please do. We are holding a seminar on 10 September in the House, and we would very much like you to come along and participate as well. If there is more information to put before us please do write to us.
Danny Kushlick: Thank you.
Chair: Could we have Tim Hollis from ACPO and Tom Lloyd please?

Examination of Witnesses

Witnesses: **Chief Constable Tim Hollis CBE QPM**, Association of Chief Police Officers, and **Tom Lloyd**, former Chief Constable of Cambridgeshire, gave evidence.

Q459 Chair: Mr Hollis and Mr Lloyd, former Chief Constable, I do not need to tell you all to be succinct and brief in your answers and to the point because you have done this many times before. I start with you, Mr Hollis; you have now been the lead on ACPO for six years. It must have been a huge embarrassment for you when you heard that the Secretary of State for Justice, in effect the head of the legal system as far as the Government is concerned, has said that the war on drugs had failed since you have been the lead on ACPO, and very distinguished Chief Constables have given evidence in the past to this Committee and to other Committees in this House that things are getting better. They are not, are they?
Chief Constable Hollis: First, I never find it embarrassing when a person states an honest opinion, Chair. As a former professional soldier I am familiar with the concept "war on drugs". I find it an unhelpful expression for two reasons. Firstly, because I think it is the wrong approach to what is a deep-seated and complex social problem. If, as Kenneth Clarke suggests, and of course 20 years ago he was Home Secretary so he is knows the business, that the war has been lost then I think he probably is referring to successive Governments' overarching drug strategy as to how successful that has been. Obviously I am here today to talk about one element of that, which is the enforcement element.
As a cop, two things. Firstly, I am into year 35 of my service. We have been dealing with burglary for 35 years; no one has told me we have lost the war on burglary. Secondly, a very personal view; the majority of people who experiment and use drugs are young people. I joined the police—
Chair: We will come on to that.
Chief Constable Hollis: It is relevant to the war on drugs concept, please. I came into police service to serve and protect the public. I did not come into the service to go to war with young people, so I challenge the concept.
Has policing solved the problem? No.

Q460 Chair: Let us concentrate on what you do know about in terms of policing. Drugs are still coming into this country. The use is only happening because drugs still come in. What is going wrong with the system that we have at the moment that drugs still pour into this country?
Chief Constable Hollis: One of the people following me, I understand, is Trevor Pearce from the Serious and Organised Crime Agency—
Chair: We will ask him his questions, I am asking you.
Chief Constable Hollis: I am explaining, my responsibility is domestic drug issues within the UK. I am not well sighted professionally to give you a detailed analysis on what is going on with the international—

Q461 Chair: Do you know what happens when they arrive in then, Mr Hollis?
Chief Constable Hollis: Yes, we do, in areas. I police a major port and we know full well that in Humberside, a lot of drugs coming through and other illicit material coming through our ports, so we

endeavour jointly with other law enforcement agencies—SOCA, UK Border Agency—to try to reduce the flow, predominantly using intelligence-led policing. We focus our efforts and our priorities—we have to, our resources are scant and diminishing—on organised crime because that is the crucial issue. That is where the great harms are coming through.

Q462 Chair: In terms of seizures and in terms of prosecutions and drug dealers, do you have some figures to give to this Committee about the increase in the number of dealers we have taken to court and sent to jail?
Chief Constable Hollis: No, if you want figures and statistics I can obtain them. The Home Office have ample supply of statistics.

Q463 Chair: What does ACPO do in this respect then? What is the point of having a lead on drugs?
Chief Constable Hollis: ACPO itself is an association. It draws together all the agencies. I chair a meeting; we meet three times a year. It has no executive role so I cannot direct a police force or another agency to do something. It is good-will support. We have Home Office, UK Border Agency, Scotland and Northern Ireland sitting with us because Scotland and Northern Ireland have similar problems. It is to share good practice, identifying emerging problems. We did a critical bit of work over an 18-month period on understanding the commercial cannabis; the cannabis factories.

Q464 Chair: So you cannot tell this Committee anything about whether or not there have been more prosecutions. I mean you must have looked at the figures, you are appearing before the Home Affairs Select Committee talking about drugs.
Chief Constable Hollis: Correct.
Chair: You must have looked at the figures about prosecutions. You must know have they gone up, has the amount of seizures gone up, you must know something to tell us, apart from the fact that good practice is being disseminated throughout the land.
Chief Constable Hollis: ACPO drugs does not study the statistics in relation to drugs. They are dealt with at force level and by SOCA—

Q465 Chair: But as the ACPO lead you have not looked at them?
Chief Constable Hollis: It is not something routinely we study, as I explained.

Q466 Chair: Mr Lloyd, you are a former Chief Constable.
Tom Lloyd: Correct, yes.

Q467 Chair: And you publicly call for the decriminalisation of drugs. Is that all drugs?
Tom Lloyd: Yes.

Q468 Chair: Every single one of them?
Tom Lloyd: Yes.

Q469 Chair: Why?
Tom Lloyd: If you take somebody who is indulging in youthful experimentation with a drug that other witnesses have said is less powerful, for example, or harmful than alcohol, it seems to me that they should be afforded the same sort of forgiveness and understanding that is afforded to Shadow and Cabinet Ministers in this and other Governments who have admitted to youthful experimentation. It seems hypocritical to saddle a young person with a criminal conviction that could blight their lives rather than some support or guidance and proper education.
Secondly, those who are suffering from the disease of addiction, many have experienced extreme trauma in their lives. It seems to me the last thing the police should be doing is arresting them. You have two consequences. They will get a conviction. The second consequence is it encourages risky behaviour in drug users. If you just scored your heroin for £20, which you may well have got by stealing, to feed your addiction then what you will do in fear of being arrested is go to the nearest place possible, whether it is a public lavatory, some inappropriate place, borrow a needle to get that drug into your system as much as possible. We encourage that. Those are two powerful reasons just based on humanity for not using the criminal law for drug users.

Q470 Chair: Putting humanity to one side, just for a moment.
Tom Lloyd: Chairman, I will keep it in mind, if I may.
Chair: And looking at the harmful effects of drugs, which will affect a person's humanity, bringing it back into play, surely it is not humane to allow people to carry on taking drugs, which will have a harmful effect on them.
Tom Lloyd: We have a situation at the moment where, to put it crudely, the drug dealers all over the world are laughing at law enforcement. They love this situation because it elevates the price. That gives them the motivation to probably succeed in getting 80% plus of their products through border controls in whatever country you are talking about. So if even 20% gets caught, that is not a bad tax rate.
People are called drug pushers because they actively push drugs to people. If you are talking about people who are susceptible, shall I say, to drug use, we have a situation—

Q471 Chair: Mr Lloyd, I am not talking about drug use, I am talking about the harmful effects. It cannot be not harmful to take cocaine. I understand what you are saying about—
Tom Lloyd: Okay, Chairman, I understand. I will get to your point.
Chair: I am not talking about the drug dealers. I am talking about the effect it has on people taking drugs.
Tom Lloyd: It is much more harmful for those drugs to be produced and supplied by criminals who care only for profit and we have tragic examples of people injecting heroin, which has been contaminated, say, with anthrax even in recent history. So all drugs are more harmful than they would otherwise be.

Q472 Chair: Because of the illegality?
Tom Lloyd: Because of the illegality. In essence, the point I want to get across is that there is a massive amount of work done by law enforcement, by health, by treatment, by a whole range of workers, all of which is pushing against this massive influence of the criminal drugs market, driven by profit, so we are very much on the back foot, if not being pushed back, as I think Ken Clarke said, and I must say on his point it is encouraging to hear a politician speak out openly and honestly about what he thinks about that.

Q473 Chair: I am glad you said that because my final point is about Mr Clarke's statement about the war on drugs. You heard what Mr Hollis has said—he does not like the use of the term—whereas our previous witnesses acknowledged the term was used and felt that it had been lost. Do you think we have lost the war on drugs?
Tom Lloyd: Yes. We have been losing it; it is unwinnable. But we have President Richard Nixon to blame for this and his 1970–71 campaign where he coined the term "war on drugs" and that has sadly been used by drug warriors as a reason for increasing spend on law enforcement, not on health and support. It is not a war on drugs. Drugs are inanimate objects. They could not care less. You cannot have illegal drugs. What you have is prohibition towards people's behaviour, which is more about society deciding on particular norms and outlawing them, such as, say, religious practice or homosexuality as opposed to something like burglary, which in a technical term is a malum in se, as opposed to a malum prohibitum.
Chair: That is very helpful. We have a number of questions. We have other witnesses. The context is very important but I would be grateful if you could answer the questions as succinctly as possible.

Q474 Mr Winnick: Mr Lloyd, you are a former Chief Constable, Mr Hollis is a former Assistant Chief Constable, both distinguished—
Tom Lloyd: He is the current Chief Constable.
Mr Winnick: You are both certainly senior and distinguished former police officers.
Chief Constable Hollis: Do you know something I don't? I know John Prescott's lighted on my Police and Crime Commission; it is a bit worrying.
Chair: You are still in your job.
Mr Winnick: Mr Lloyd, you have set out a list of things that you wish to see done. As the Chair said, among other things, declare an immediate amnesty by means of de facto criminalisation. How far do you believe the views that you have personally put forward, and I recognise they are your own views, are similar to other senior police officers, including Chief Constables and Assistant Chief Constables?
Tom Lloyd: It is very difficult to estimate but I do know that there are more people than you would think who would accord with my views. But I think it is fair to say, and Tim perhaps will have view on this, maybe I am being more optimistic for obvious reasons, but certainly I have come across a lot of people who think that. Interestingly enough I have come across a lot of senior politicians who privately think the same and increasingly in my work of advocating drug policy reform it is very encouraging, as are *The Sun* YouGov poll statistics, in saying there are a lot of people who think about this.
What I will say though is that I suspect almost every police officer you ask would say, "Well the system is not working very well. We arrest a dealer and another one turns up." Arresting users does not seem to deter them from their use. What we are doing maybe is not the right way of approaching things. That would be a minimum position taken by a large number of people. Perhaps fewer, but still a substantial number would go as far as me.
Chairman, I need to also just clarify my position. Decriminalisation I think is absolutely necessary for the reasons I have stated but also for the reasons that the criminals are in charge of the market; they are running a very successful business. We need to tackle that business. We can either do it by increasing the risk to the business, which is effectively arrest and prosecution—it has not worked—or we do it by reducing the profits and you reduce the profits by taking over the supply. So control and regulation are actually harmful.

Q475 Mr Winnick: I think it is generally recognised that certainly the drug dealers, particularly the barons, as the last witness stated, would like the status quo to remain, as we would if we were involved in the same terrible business. Mr Hollis, what Mr Lloyd said, is that your view as well?
Chief Constable Hollis: More up to date, with great respect, because Tom retired a wee while ago. I am also one of the vice-presidents of ACPO, so I do know the Chiefs very well.
I represent a very broad church. The former Chief Constable of North Wales, Richard Brunstrom, came out formally and wrote formally to the Home Secretary advocating decriminalisation. He does not represent the majority view, I have to say. Within that there are other colleagues who have a much more hard line, I know some of your witnesses have had quite a strong view. The police find themselves in a difficult position because they do absolutely get the point made by Mr Ellis. We see the damage done by drugs within our communities and of course we get both from future Police and Crime Commissioners potentially and our public about what they want us to do and another group saying they want us to do it differently. So we do occupy a rather different space, which is why I welcome a well-informed open debate on the evidence.

Q476 Lorraine Fullbrook: Could I ask Mr Lloyd the same question I asked the previous witnesses? Which drugs would you decriminalise?
Tom Lloyd: All of them
Lorraine Fullbrook: All of them?
Tom Lloyd: Yes.

Q477 Lorraine Fullbrook: Including—
Tom Lloyd: Heroin, cocaine.
Lorraine Fullbrook:—prescription drugs?
Tom Lloyd: I must say I am not very well informed on prescription drugs. Certainly what that shows is that some people are, as it were, evading controls that

have been put in place and perhaps need to be firmed up in order to satisfy probably an addiction, and I think some of this comes around either from people who might possibly be using heroin or cocaine choosing to get supplies, as it were, illegally or circumventing the prescription route, or it is people who have fallen into addiction as a result of being prescribed the drugs in any case and maybe find that they are forced into that position in order to satisfy their addiction.

Q478 Lorraine Fullbrook: That is certainly not what the Home Affairs Select Committee found in the United States. It was that people who use the illegal trade and prescription drugs use only prescription drugs and a mixture of prescription drugs.
Tom Lloyd: That may well be the case. As I said, I am not particularly informed on that but what I would say is whatever we do let us not use the criminal law to prosecute people who clearly have a problem with addiction as is evidenced by the efforts they will go to in circumventing the rules about obtaining prescription drugs. That is my basic point on that. In other words, there is a consistency across my position. As far as legal highs are concerned, I think we heard earlier, and I would agree with that, you do get this so-called balloon effect: if you are seeking to stamp out production of cocaine in Colombia, which has dropped slightly, you will see it go up in Peru to compensate for the market. Similarly with heroin and similarly with drugs themselves. You might have, I would not really call it success, but an impact on the supply of a particular drug. So for example, there may be drugs like ecstasy. I know I am not a medical opinion but people die because they do not regulate the water they take in from ecstasy. Ecstasy itself—
Chair: Sorry, could we speed up. Thank you very much.
Tom Lloyd: So on the point of those drugs, legal highs—
Chair: Speed up meaning conclude.
Tom Lloyd: Don't criminalise them.

Q479 Lorraine Fullbrook: Can I ask you both, do you believe if drugs were decriminalised that you would see no new entrants to the market?
Tom Lloyd: I think you would see a shift in the use of drugs. At the moment, when you think about drug use you have to include alcohol, so we have a large number of people taking psychoactive substances, most of which is alcohol, some of which are heroin, cocaine and the like, that are under the criminal market. I think it would be odd not to see some sort of shift in the drugs that are used but, as the evidence that has already been put forward by a witness, it would not go up.
Chair: Mr Hollis, in 30 seconds please.
Chief Constable Hollis: Just to be clear I am not here to argue for decriminalisation, but I do feel outnumbered. I am here to articulate honestly and openly the pragmatic problems for the police service.

Q480 Lorraine Fullbrook: As a police officer if drugs were decriminalised would you think you would see new entrants to the market?
Chief Constable Hollis: Personally there would be, invariably so; unavoidably so.

Q481 Chair: Mr Lloyd, we would be astonished if the ACPO lead on drugs had come before the Home Affairs Select Committee to suggest decriminalisation.
Tom Lloyd: I do realise that, thank you.

Q482 Mark Reckless: Mr Hollis, what does ACPO perceive to be the purpose of the war on drugs?
Chief Constable Hollis: Again, I just register the term "war on drugs", which I find unhelpful. We are there to enforce the law and to protect our communities from harm. We understand fully, and Trevor Pearce will describe, the high-level threat from organised criminality to this country. A point well made I think is that regulation is not the solution because organised crime is into tobacco, prescription drugs and alcohol smuggling because there is money there. It will solve one set of problems; it does not resolve another one.
I witness within my police force area the harm that is done to my communities, both by organised criminality but also the tragedies. It was two young worthy lads in Scunthorpe who originally were thought to have died from suspected methadrone; interestingly, they died as a result of mephedrone, already an illegal drug, and alcohol. So we deal with, and my family liaison officers deal with, the families and victims of people who die from that. We are there to protect our communities. It is against the law. The Misuse of Drugs Act makes certain drugs illegal and that is our responsibility.
Where I think there are some interesting issues and some challenges for the service, for the Home Office, and for politicians is the new generation of legal highs being rapidly developed and promulgated through social networking. We are not designed—

Q483 Mark Reckless: That was my question. In terms of interception, does that interception activity, in your experience, increase the price of drugs?
Chief Constable Hollis: Anecdotally, yes, but it varies because it is replaced very quickly. A lot of our organised crime, in my force area—

Q484 Mark Reckless: What is the point of that, then?
Chief Constable Hollis: Exactly the point made by the decriminalisation lobby that if by arresting drug dealers they are within a few weeks replaced, why do it? We do it because there are some very specific harms hurting our communities. At the lower level, I make no apology for lower-level enforcement. If you are a single mum on an estate in Hull living next door to people who are selling drugs the quality of your life is absolutely appalling, and I make no apology for our neighbourhood officers working jointly with local authority and other agencies to tackle that particular problem. Will it move somewhere else? Of course it will. We are not stupid. We know it will move somewhere else because there is big money behind it, but if it relieves that particular problem that is a legitimate police enforcement activity to be done. That is part of the dynamic.

Where I am interested, and there is some good work being done, is about how can you reduce reoffending so the work of police jointly with other agencies to try to deal with damages done by drugs and addiction and the treatment issues is an integral part of trying to reduce the harms to our communities. It is not enforcement. It is better joint work across different agencies into the different areas of the drug strategy.

Q485 Mark Reckless: I have a question for Mr Lloyd. To the extent that interception is effective in raising prices, potentially perhaps at least in the short term, does that in your experience increase or decrease the value of drugs in the illegal market; that is, is the demand elastic or inelastic for drugs? By raising the price does volume fall by more than the increase in price, in your experience?
Tom Lloyd: My understanding of this is that it is pretty inelastic. If you are addicted you want your drug. If there is a temporary shortfall then you will go to other places to get some form of relief. What we are talking about here is what I mentioned at the start of my evidence which is that all of this is in the context of the fact that the criminals are laughing at us with this wonderful system we have created where they make so much profit and there is very little risk to them that they will create the sort of problems that you are quite properly talking about with that woman, as you said, on a council estate perhaps, or wherever, suffering these problems. But that is what prohibition creates. It creates an illegal dealing market.
Chair: You have said that.
Tom Lloyd: That is why I argue for the end of prohibition and the start of control and regulation so that you will not have dealers on the street.
Chair: Indeed. We are going to have some quick supplementaries from Dr Huppert and Mr Ellis. Mr Reckless, you are done?
Mark Reckless: Yes, thank you.

Q486 Dr Huppert: Thank you, Chair. Firstly, one of my previous witnesses Professor Nutt, whom you probably know of, in his opinion from a public safety perspective, police officers would rather be dealing with someone who is stoned rather than drunk. Do you think that is accurate? Do you think that somebody who has taken cannabis is going to cause less harm in the community than somebody who has taken alcohol?
Chief Constable Hollis: Depends to whom you speak. As a former street cop in London, if I had the choice between walking down the street at 11 o'clock at night and finding three lads who were tanked with extra strong lager or three on cannabis, back in the 1970s in the last century, then I would have opted for the latter. You talk to the parents, as I have, of someone who has had severe behavioural problems as a result of cannabis, then that is a very hard argument to sustain. There are elements of truth in what you describe, in terms of impact within my policing areas. The other thing is poly-drug use. It is very rarely now, in our experience, just alcohol, just drugs. Young people are frequently mixing different drugs. As we heard, the two lads died tragically, methadone and alcohol. It is rarely binary, one or the other. It is a combination of the two.
Tom Lloyd: There is very little evidence that while you have the drug in your system that you are going to be a problematic individual. This refers back I think to Mr Ellis' question to the other witnesses that there is some evidence that if you have a lot of cocaine in your system you might have a psychotic episode and be very difficult to deal with. By and large heroin users, cocaine users, ecstasy users, cannabis users are all relatively harmless in terms of what might be termed aggressive behaviour. The problem arises, of course, with alcohol which does produce a massive amount of aggression and so the answer to your question I think is yes, Mr Huppert.

Q487 Dr Huppert: Very briefly, both of you as experienced Chief Constables will be used to resource allocation problems. How much resource, from a policing perspective, is best spent at the local level dealing with possession, at the sort of higher level in your areas or even internationally? How would you change that allocation for resources to best control the harms.
Chief Constable Hollis: Speaking in Humberside, firstly the joint work with other agencies is absolutely critical. Frankly, simple enforcement—putting a person with cannabis or drug before the magistrates—is not the long-term solution.

Q488 Dr Huppert: Would you transfer more powers to SOCA, though?
Chief Constable Hollis: Not to SOCA because SOCA does not deliver locally. SOCA is dealing with national and international matters.

Q489 Bridget Phillipson: We have had evidence on the education provided to young people in schools around drugs and alcohol and that young people frequently now no longer believe the evidence that they are receiving; it has to be balanced. We should give young people information—not necessarily scaremongering, but providing the information for young people to be fully informed. What do you think about the education that is provided to young people on drugs education? Do they routinely think that adults, teachers, the police or whoever are simply not being accurate about the risks associated with drug use?
Chief Constable Hollis: Tom will have his own view. From my perspective I have a real concern, as do my colleagues across the service and whom I do represent on drugs, about the impact of all the changes currently taking place. We are happy with our young children's team who link in to look at the education prevention which is a crucial part of the strategy. I understand that PSHE is due to be reviewed, which will be integral to the drug element to that and that review keeps being delayed. From our perspective, the education information to young people—the counter-balance to what they can get on social networking—is crucial. Our concern is clearly where that is being progressed. The other end is the potential impact on the treatment and prevention side; National Treatment

Agency going, money from drugs going down from drug intervention programmes—
Tom Lloyd: Can I just answer?
Chair: Yes, Mr Lloyd.
Tom Lloyd: Thank you, Chairman. I do not think the police should be involved in drugs education. It should not be a criminal issue. It should be a health and social issue. The evidence from the United States on a programme around DARE, which is drug abuse resistance education, is that it does not work and can even be counter-productive. It is pretty much like a lot of the education which we give youngsters which is a variation of Nancy Reagan's "Just say no" which does not work. When we had people like Gordon Brown a few years ago calling skunk "lethal" which it simply is not, then we had a real problem engaging with young people. This is very serious. They need to be treated in a way which does not focus narrowly on drugs. There is some evidence that something called Lifetime Skills training, which involves a range of issues about growing up into being a responsible human being, you have introduced drugs as a part of that process so they feel good about themselves in many ways and that, the early studies are showing, seems to have some impact. You need to do things differently without police.

Q490 Bridget Phillipson: Alcohol education? If you want to provide education to young people?
Tom Lloyd: It will be all part of it. Not with a criminal threat, because the evidence shows it is fewer than 20% of kids who were asked about why they do not take drugs say it is because they might get caught by the police. It is a relatively small number. They thought, "I do not want to take drugs. I want to be healthy." We have got some opportunities here to tap into that but what we must not fall into the trap of is saying it is the criminalisation of drugs that deters youth. That is a myth. The Government will say, "We are firmly of the opinion that criminalising and putting things into a higher classification A, B, or C has this deterrent impact." It may be a firm opinion, but the evidence says otherwise.

Q491 Bridget Phillipson: Of course alcohol will be the first or potentially the only drug that young people may be exposed to?
Tom Lloyd: When you have a system that we have at the moment with drug pushers, sadly you will get cannabis and other drugs being pushed to youngsters, because that is in the nature of the market. That, as I said, is why I go beyond decriminalisation, which is a necessary step, to the idea that if we do not have a situation where the profits are so great that people will become criminals under current law and push drugs, then drug availability will go down in my view. I appreciate that is why we need a review to explore this. In the decriminalised countries, remember, you still have the pushers, so it is not like a fair playing field. If you take away the pushing and you have mature, as it were, adult education of the children, if you see what I mean, and you attend to some of the underlying social issues which is a far bigger indicator in fact of drug abuse, this is shown. In fact the US is incredibly enforcement focused, and yet it has a very, very high incidence of drug abuse. You can go to other countries where they are much more relaxed and it is very different. It is a myth, Chairman, that I think needs to be dispelled.
Chair: Very, very grateful that you have dispersed that myth. Michael Ellis?

Q492 Michael Ellis: Is it not rather like living in a cloud cuckoo land, Mr Lloyd, to make a comparison with alcohol in the way that I think you seem to be seeking to do, and others before you? Because what I perceive that you would like to happen is to reduce what are now illegally controlled drugs to the level of alcohol. If I am right in that and that is what you would like to see happen, we have a situation today where alcohol is not illegal and it is still responsible, I am sure you would agree, for huge criminal justice problems; a huge impact on the public purse, both in law and order and in the national health service. Would we not simply be creating a two-tier disaster? Rather than lower the price of controlled drugs to exacerbate an already dangerous situation as far as alcohol is concerned, this is the effect of what would happen under your idea.
Tom Lloyd: No, and you mis-state my position which echoes what Danny Kushlick was saying: alcohol is not probably sufficiently regulated at the moment and its price has gone down relative to people's ability to pay over a very long time and so I think we need more regulation of alcohol. The difference, and there is a difference between alcohol and many of the other drugs, which I have already explained, is that they are psychoactive in the sense that they tend to depress and calm.
Michael Ellis: Mr Lloyd, forgive me—
Tom Lloyd: No, this is very important because alcohol—
Michael Ellis: It is not really—
Tom Lloyd: It is. Alcohol is the thing that causes the problems and that alcohol needs more regulation because it does lead to violence and it does lead to problems.
Chair: Thank you, that is very helpful.

Q493 Michael Ellis: You have said that you would increase the regulations around alcohol but my point to you was that you would decrease the regulations that surround drugs.
Tom Lloyd: There is no control of drugs at the moment. We do not have control of the drugs market. The criminals do. I am seeking to gain control of that, so that the quality, the purity, so that the dangers inherent in taking the drugs as currently supplied are reduced, the criminality and the stigma are reduced, and treatment opportunities are increased; that is where the money goes.
Chair: You have made that clear. Mr Ellis.

Q494 Michael Ellis: We have, arguably by the same calculation, lost the war, and I do not like the term "war on drugs" because I think that is an absurd misnomer, but burglaries have being going on for decades and centuries, other crimes have been going on for as long. We do not hear anybody saying that we should decriminalise burglary because we have

lost the war on burglary. You are taking a defeatist attitude, are you not, to a serious problem?
Tom Lloyd: No, I am simply seeking to reduce the pain caused by banging one's head against a brick wall which is our approach to prohibition. What we have, and I have said it before, in—
Chair: We do not want a long explanation.
Tom Lloyd: I understand. I am sorry. I am probably more used to chairing meetings. I do apologise.
Chair: I have to tell you, Mr Lloyd, if you chaired meetings like that they would last a very long time. Mr Lloyd, order. We would like a brief answer. This is a serious session.
Tom Lloyd: I understand.
Chair: I would be grateful for a brief answer and not a repetition of what you have said before.
Tom Lloyd: You will get one.
There is a difference between laws passed to protect people's property and their person from assault and crime, malum in se, and the types of law that are passed to govern societal norms such as, for example, homosexuality and religion. That was repealed in the same way that we need to do in this legislation.
Chair: I do not think that we need to go down the homosexuality route.
Tom Lloyd: There is a difference between the two.
Chair: Mr Ellis, final question.

Q495 Michael Ellis: Can I just point out, I do not agree with your analysis on that? What society sees as a norm varies over time and I do not agree with you that burglary is different in that respect. That is the first point. The second point is that the opinion poll that has been regularly quoted from *The Sun* newspaper, I understand indicated the same poll, 78% said that possession of killer drugs should still be a crime. I would like your views on that.
Tom Lloyd: I think that the population at large is relatively ill-educated and has been misled by a lot of the media coverage of the so-called war on drugs. If we have a review, as has been suggested and I would urge, I think that a lot of very important information about the reality of the situation would become available and I think opinions would change quite substantially.

Q496 Alun Michael: One supplementary to Mr Lloyd, I am very clear about your critique of the criminal approach to drugs, but I am not clear whether you want an immediate decriminalisation when by your own words your alternative is regulation. In terms of how regulation should operate you say that we should conduct a comprehensive inquiry to UK drug policy to consider implementing proper control and regulation of drugs by the Government. That is a very long-term option, is it not? Were you talking about immediate decriminalisation? What time scale for introducing regulation? What happens in between?
Tom Lloyd: I think we should go for decriminalisation straight away
Alun Michael: Without having done the work that you yourself say is necessary to identify a system of regulation?
Tom Lloyd: Control and regulation is different from decriminalisation. Decriminalisation is focused on the users and I just think there is overwhelming evidence that using the criminal law against users is problematic and damaging.

Q497 Alun Michael: Sorry, please; I am asking a very specific question. We have already identified the fact that there are problems with those that are legal, including alcohol. If you immediately decriminalise there is a vacuum before you can have what you describe as a long-term project of introducing regulation. Are you saying that we should simply trust to luck in the meantime?
Tom Lloyd: It is not a vacuum. You heard from Niamh Eastwood; there are at least 20 countries she had looked at that had some form of decriminalisation without the great fear of increased drug use. I am saying that, I think we should try—

Q498 Alun Michael: You are saying that even though it would be impossible to introduce a system of regulation immediately, we should decriminalise immediately?
Tom Lloyd: Because they are separate issues, as other witnesses have said.

Q499 Alun Michael: Okay. As far as the ACPO position is concerned, there has been a highlighting of the growth in commercial cannabis farms. I have certainly seen evidence of that at a local level as well. You say they are not a high priority for most police forces who concentrate on class-A drugs?
Chief Constable Hollis: Correction, I did not say that. That is some work my committee undertook because there was a gap. The individuals—

Q500 Alun Michael: Are you saying the committee is wrong then?
Chief Constable Hollis: No, no we got it right. We spotted there was a gap across the 43 forces of England and Wales. We linked in to international forces as well on commercial cannabis. We did a lot of risk analysis about what is happening out there now and we gained a much greater understanding as a result, of the scale of the problem, and it is linked into organised crime and we do prioritise organised crime.

Q501 Alun Michael: Yes, but in terms of the identification of the growth in commercial cannabis farms, certainly there seem to be more of them. Certainly we see more of them being closed down, so there is a lot of activity both by those who are undertaking them and by the police. Can you just tell us where that is getting us?
Chief Constable Hollis: Working closely with SOCA to identify who is involved in it, there was evidence of Vietnamese people in there, which is international organised crime and Trevor Pearce may have a view. There is increasing indication that it is local serious organised criminals. It is resolving the immediate problem locally. I accept someone will then open it up somewhere else, but that is not a reason for not tackling the local problem.

Q502 Alun Michael: Is this something that ought to be more of a priority for SOCA or for the National Crime Agency?
Chief Constable Hollis: It is a joint one. SOCA have the national and international; we have the UK.
Alun Michael: I understand that.
Chief Constable Hollis: We work jointly with SOCA as an enterprise because we both have an interest in trying to tackle those problems.

Q503 Alun Michael: Sorry, I am trying to get it clear who ought to be doing what. Should local forces be doing more across England and Wales, are you saying? Should SOCA be taking a greater interest?
Chief Constable Hollis: SOCA have an interest, they deal with the international element of it. The local forces working collectively and collaboratively with our support are tackling the problem within their force areas.

Q504 Alun Michael: But you are implying, as I understand it, that there is a gap that not enough is being done. Who is it that is not doing enough?
Chief Constable Hollis: There is always more to be done, simple as that. We have spotted a gap, we are putting—

Q505 Chair: We know that. Mr Michael is asking you a specific question as the ACPO lead. Who should do more? Not everyone should do more. Who?
Chief Constable Hollis: We will never be able to tackle it in its entirety, we have to prioritise. That would be done by individual Chief Constables assisted by their Police and Crime Commissioners in November. What emphasis they put on what priorities will be very interesting. We know not at this moment in time.
Alun Michael: I look forward to considering the suggestions.
Chief Constable Hollis: I am sure you do.
Chair: You have given the responsibility to Mr Michael, clearly?
Chief Constable Hollis: And the Chief Constable of South Wales.
Chair: Indeed.
Chief Constable Hollis: Thank you.

Q506 Chair: Mr Lloyd, Mr Hollis, thank you very much for giving evidence.
***Chief Constable Hollis*:** Chair, can I just say one thing I have been expecting, very quick, because you asked me about whether we were succeeding or failing. I did expect to be asked about my views about the overarching strategy.
Chair Maybe what you could do is write to us about your views. That would be very helpful. Thank you very much, Mr Hollis. Could I call Mr Pearce from SOCA?

Examination of Witness

Witness: **Trevor Pearce**, Director General of the Serious Organised Crime Agency, gave evidence.

Trevor Pearce: There is obviously a vast amount of interest. People seem to be leaving as I arrive.

Q507 Chair: Do not take it personally. We are still here, that is very important. Can I start, Mr Pearce? Thank you for giving evidence to us again.
I ask you whether you agree with the Lord Chancellor that the war on drugs has been lost?
Trevor Pearce: Subject to the discussions we already had about the nature of the phrase, which I think is pejorative, and also to a comment, and you would have seen this in South America, that there are law enforcement officers and officials who on a daily basis are facing the threat of—
Chair: Yes. We know all that. If you would just answer the question. We know all that and we are coming to all this and we are very grateful for that. But the question is do you agree with the Lord Chancellor that the war on drugs has been lost. We know about all the good work and we are coming on to that.
Trevor Pearce: No, I do not, sir. I think it is a constant battle and we have to fight that, if we use that metaphor, but I do not think we have lost.

Q508 Chair: Excellent. In terms of seizures by SOCA, 12% of the heroin market was seized and 9% of the market share was seized before SOCA took office, so to speak. Has it improved?
Trevor Pearce: Yes it has and working on a basis in 2010 we were also able to look at what we thought the UK consumption was using a new methodology which I am happy to share with the Committee but it is somewhat detailed for a presentation like this. We would suggest that probably in the region of 30% of the cocaine market and somewhere in the region of 10% to 13% of the heroin market are being covered by our interdictions and seizures.

Q509 Chair: Interdictions meaning what?
Trevor Pearce: Seizure of the commodity.

Q510 Chair: Right, so 30% of the cocaine market is being seized by SOCA?
Trevor Pearce: That is right, yes.

Q511 Chair: Before it comes to the country or after it has arrived?
Trevor Pearce: In principle, probably about 95% before it comes to the country.

Q512 Chair: One particular issue, and Mrs Fullbrook is going to talk to you about our visit Colombia and ask specific questions in a moment, can I ask about the amount of money that is being laundered? One of

the issues that was raised with us in Colombia is that the actual profits that are held by Colombians in Colombia are miniscule compared with the amount of money that ends up in the European Union laundered through the banks. Is that your understanding as well? Are those statistics correct?

Trevor Pearce: I would have to go into those in detail. Certainly we have just worked with the Colombians and together we have been able to, I think, restrain about £165 million in assets in Colombia recently. The issue, I think, which the Colombians are concerned about is that it brings them to their shared responsibility agenda; of course, they are in many ways victims.

Q513 Chair: I know all that, but I am talking about the percentage of money that is laundered through our banks. Do you recognise these figures?

Trevor Pearce: I do not recognise those figures but I am happy to go away and do some research and come back to you, yes.

Q514 Chair: Would you look at them? Because we were concerned that—we understood that the profits of the cocaine trade, a very small amount was being kept in Colombia, the vast majority ending up in the European Union and being laundered in the European Union.

Trevor Pearce: I think the profit is spread across the supply chain, where and how the laundering takes place is probably slightly more detailed. We are happy to do a piece of research and give that to you.

Chair: We do not need research, we have done the research. We will write to you and ask for your validation.

Q515 Lorraine Fullbrook: Thank you, Chairman. When the committee were in the United States and Colombia, particularly Colombia, we were looking at the drug routes out of Colombia into the European Union and the UK and cocaine particularly from Colombia, and indeed Peru and Bolivia, went out to West Africa into Portugal, because it is a decriminalised country, and then across the European Union and into the UK. In your evidence you make reference to capacity building in West Africa, where several of the countries you have acknowledged to be in danger of becoming narco-states. How effective is your work in these countries? What are you doing about this? What are your biggest challenges now?

Trevor Pearce: I think the biggest challenge in working in some of those states where there is a notion of a failing state and a level of the corruption is how do you engage with law enforcement. That is the fundamental challenge and one we face with the different communities as well. In terms of how we are dealing with this operationally, we in Ghana and the French in Senegal have liaison units where we bring together the European, American and Canadian liaison officers and the intelligence that they have to understand the problem and to enable activity and operational activity to take place.

The capacity building is about how we can bring the experience we have from working with other jurisdictions, but also in terms of our approach to those countries, recognising that their resource levels are woefully small in this. Being able to surge activity from the UK to support them, we have done that in Sierra Leone, following a 600 kg seizure of cocaine; we have done it in The Gambia where we were able to identify the facility where another 2.1 tonnes of cocaine were being stored. Through that, through taking our forensic experts and taking investigators, we were able to build the experience and importantly build experience in how they operate in the criminal justice system.

Q516 Lorraine Fullbrook: I have to say, when we were in Colombia SOCA were doing a fantastic job within the country and also in Turkey when we were looking at the jobs coming in from Afghanistan, Iran, China and so on and they were doing a fantastic job in the drug seizures there. Do you hope when SOCA comes into the National Crime Agency that will continue?

Trevor Pearce: I think it must continue, I think the National Crime Agency will have a broader remit so the international footprint needs to be extended and make sure it has coverage. I think we have taken the lead, the UK, in how we operate in third-party countries and with them and help them develop their regional approaches. Everything I see in terms of the National Security Strategy, the Organised Crime Strategy and the Drug Strategy, and indeed the NCA plan, encourages us to continue the international working.

Q517 Alun Michael: We saw some of the impact of the way the drugs have been tackled at source in Colombia and although the balloon effect has been referred to earlier, we, I think, saw the impact of being able to take some of the criminal activity out of a state in restoring administration and justice.

From your perspective, what do you think would make the greatest impact in trying to deal with this extremely problematic trade and the trade routes? Because the Colombians, very reasonably, said to us, I think the President specifically, if there was not a high price for drugs in the UK there would not be the growth in the market. What do you think we could do that could make a difference?

Trevor Pearce: I think the whole of our drug control policy has to recognise that there is an enforcement element, there is prevention, and there are education and treatment elements. I think absolutely we need to build on the models that we have developed with Colombia and we see Colombia take that into the regional approach and that bears down on one commodity and particularly the balloon effect, which you have described.

I am very taken with the Colombian position about shared responsibility and there is a need for us to get forward the messaging in the UK that the impact of the use of cocaine has a significant impact on not the streets of Colombia, but within the rainforest, within the indigenous communities. In fact, interestingly the Colombian national police would say that they lose more rainforest to drug production and cultivation than they do to deforestation through farming. You can see why President Santos is so engaged because

his country is, I think, the victim in this. I think we have to play our part of the shared responsibility agenda into the game.

Q518 Mr Winnick: The organisations, Mr Pearce, which are involved in combating drugs being smuggled in the UK, there is obviously yours of which you are the director general, the military, the border force and so on. Is there sufficient co-ordination in your view or should it be one organisation in effect?
Trevor Pearce: I think one organisation is quite difficult to conceive of. I think the point about co-ordination is absolutely right. Through the Threat Reduction Board we chair through SOCA, a Threat Reduction Board for international drugs which has been set up under the Organised Crime Strategy, it does enable us to bring together the appropriate leads from key agencies to make sure we have a single understanding of the threat and how we can each individually bring our expertise to bear on the problem. For example, we will ensure that the Border Force can take their experts to Colombia, as an example, or other countries, to assist in the training of officers around profiling containers, because that is a big threat. Bringing together all of the expertise if we do it effectively I think gives us a good opportunity for success.

Q519 Mr Winnick: Touching on what the Chair asked you in the beginning, it is not your view that this is a sort of unwinnable war, that one way or another it will be resolved in the end.
Trevor Pearce: I think we have to approach it from a number of different directions. It would be very sad for me as a law enforcement officer for some 37 years if we walked away from the challenge. I think that is our responsibility to our public.

Q520 Dr Huppert: Firstly looking at the comments from other members of the Committee on how well SOCA is received around the rest of the world. It was very striking I think, both in the US and when we were in Colombia, just how positive people were about the role that SOCA plays on frankly very small staff. I think many of us think that we hope that the SOCA brands can continue with a change into the NCA and I think we have come up with various ways of coming up with phrases like the Serious Overseas Crime Arm that might allow something to continue being called SOCA in the new world. SOCA clearly does a very impressive job in terms of interdiction. As long as that is an aim, it does it very well and it does far more with much fewer people than happens domestically with much more effort and many more people. Do you think that SOCA could benefit from a transfer of resources so that domestic police were freed up from spending their time to ineffectually do some of these interdictions and allowing you more resource to do it overseas?
Trevor Pearce: Certainly we spend about 8% of our budget on our overseas activity for which we lever up I think a great deal of resource from other law enforcement agencies. The challenge is, I think, this is about the nature of the end-to-end, the source, the street, which is you should still seek to attack some kind of UK action against what you are doing back in the source, in those countries. There will always need to be the ability to carry out criminal justice investigations and in terms of its development investigations against those who are seeking to import and then distribute. Getting the balance, I think, is a fine and tricky one. We review our overseas posts every year to see where we need to be best placed and whether we are getting most effect out of them. I think it is like everything, we would always like to do more. It may be an opportunity of the NCA when we review the footprint against the broader set of requirements that we can do that but I think as long as we have got the ability to co-ordinate the activity and to make sure that if there is an opportunity to do something on the streets of Hull, while at the same time dealing with the origin in Cartagena, then that is our responsibility across the whole of the supply chain.

Q521 Dr Huppert: SOCA have said—I do not know if it was you yourself—that one of the main problems of capturing key players in the drugs trade is that those based in the UK are simply easily replaced. It is much more effective to do that in the source countries. Does the same question apply then? You are saying that domestically we should be targeting those who are importing and trafficking within the UK, so the high-level dealers. How much resource should be on that versus targeting key players overseas?
Trevor Pearce: I think it is the balance. I suppose the concept of the multiplier effect is that one well placed liaison officer can mobilise that country's resources to carry out a criminal justice investigation because that is their jurisdiction; we cannot go in and carry out the investigation for them, unless asked for some kind of support. It is getting the balance about what we can lever up from a very small resource to have the best effect for the UK, as well as the host country.

Q522 Dr Huppert: The resources spent picking up cannabis users on a street or heroin users, how does that fit in to your global picture?
Trevor Pearce: In terms of the end-to-end and the police service taking that responsibility clearly anyone who is arrested provides an intelligence source to understand what the greater drug picture is and therefore from that you can aggregate who is the pusher, who is the supplier, who is the distributer. It seems a bit simple. On occasions you can get to key importers through that. To understand the whole of the problem is important. That way we can decide where do we best put the resource? Where do we best focus?

Q523 Dr Huppert: The value is the intelligence that you gather from those arrests rather than—
Trevor Pearce: Yes.
Dr Huppert: Okay; thank you.

Q524 Mark Reckless: The SOCA website states that organised criminals involved in the supply of cannabis perceive it, and I quote, "To be a high profit, low risk activity which allows them to fund further criminal activity". What impact would decriminalisation have on that?

Trevor Pearce: I think there will always be organised criminals who will trade in cannabis whether we have a legitimate market or illegitimate market. The whole notion of tobacco which is completely licit, we see counterfeit tobacco, we see tobacco which is imported or brought in without tax so there will always be a two-tier market. There will always be, I think, the rationale for organised crime to see this as an opportunity particularly if the risk is diminished slightly. What we also know is that organised criminals use cannabis loads to either conceal multi-drug loads, or to even test out conduits or routes into the UK. Would I think they would ever walk away from trading in cannabis if it was legal? They would not.

Q525 Mark Reckless: Whatever its price or tax?
Trevor Pearce: Whatever price, yes. Absolutely, because—

Q526 Mark Reckless: Even if it was taxed at a very low level?
Trevor Pearce: Even if it was. It could be taxed at a very low level. You have revenue tax at the moment. But of course no-one has yet today put forward the point of who is going to provide these drugs? I take it the state is not. Do you therefore get the capitalisation through the drug companies of this commodity? If you do, where does the pricing go to? Pricing can be undercut by illegal activity; therefore the market continues.

Q527 Mark Reckless: Mr Pearce, I take it you are opposed to decriminalisation?
Trevor Pearce: Yes.

Q528 Lorraine Fullbrook: About cigarettes, I do not believe our previous witnesses have taken into account the regulations that are currently in place for cigarettes and of course the price has gone up and as you say there is an illegal trade in cigarettes. What will the situation be when the price of cigarettes goes up higher? Will we be in the same situation as say cannabis?
Trevor Pearce: It is very true. You are—
Lorraine Fullbrook: I am a nicotine addict, by the way.
Trevor Pearce: Okay. All I would say is that, and maybe your Clerks can find it, but an interesting piece of work was done by the tobacco industry back in the early part of this century whereby they picked up tobacco packets abandoned at football matches to see which were duty paid and which were not duty paid and I think the figure was somewhere close to 40% not duty paid. It just illustrates for me if you have a legal market people will seek to undercut the legal market.

Q529 Mark Reckless: Yes, but does that not depend on the level of taxation?
Trevor Pearce: Of course it does. There are some figures in this, but none the less the principle that organised crime will look for opportunities wherever still remains and we should tackle this as well as an organised crime problem.

Q530 Mark Reckless: Would your organisation be able to provide us of estimates as to the elasticity of demand for various illicit drugs?
Trevor Pearce: We will have a go at that but the UNODC report of only last month is very good on this and we will perhaps identify some appropriate parts in that which may be relevant for the Committee to see.

Q531 Chair: The worry of the Committee is that the good work that is being done internationally by SOCA might be affected by the new landscape. How many employees do you have left with SOCA? How many have left in the last year?
Trevor Pearce: We probably have just about 150; 180 left in the last year and we have been recruiting to 250 to keep us to what our intended number is through the CSR period.

Q532 Chair: None have joined the National Crime Agency because they are not in existence yet.
Trevor Pearce: No. No the NCA is not. We have brought elements of the National Police Improvement Agency into SOCA for transition into the NCA. My expectation is—it is there in the draft legislation—that all SOCA officers have the right of transfer into the NCA. What my staff are telling me is that they intend to come in, they look forward to the opportunities and want to carry on the excellent work that they are delivering.

Q533 Chair: But the Public Accounts Committee has uncovered a lot of redundancy payments to SOCA officers. What is the total amount of money that has now been paid to those who have taken redundancy?
Trevor Pearce: For those who took voluntary early severance it is just short of £7 million over two processes I think, which was about 90 staff all together.

Q534 Chair: £7 million for 90 staff?
Trevor Pearce: Yes.

Q535 Chair: Have any been re-engaged by the new organisation?
Trevor Pearce: No.

Q536 Chair: Is it a condition that once they take redundancy payments they will not be re-engaged?
Trevor Pearce: I will need to check that fact but I believe it is so, sir, yes.

Q537 Chair: Thank you. Mr Pearce, we might write to you with further information. You promised us further facts. If you would send them to us, that would be great.
Trevor Pearce: Will do, thank you.
Chair: Thank you very much.

Tuesday 30 October 2012

Members present:

Keith Vaz (Chair)

Nicola Blackwood	Bridget Phillipson
Dr Julian Huppert	Mark Reckless
Steve McCabe	Mr David Winnick

Examination of Witnesses

Witnesses: **Lord Turner**, Chairman, Enforcement and Financial Crime Division, Financial Services Authority, and **Tracey McDermott**, Enforcement and Financial Crime Division, Financial Services Authority, gave evidence.

Q538 Chair: Lord Turner, Ms McDermott, thank you very much. Can I apologise for keeping you waiting? There was a Division right in the middle of the session. Ms Phillipson has declared her interest. I will declare my interest as having known you personally for 30 years. Welcome to the Home Affairs Committee.

Do you think, having done this job for four years, that there is an increase or a decrease in the amount of money laundering by those involved in drugs within our financial institutions?

Lord Turner: I would have to say that I do not know the answer to that, and I do not think there is anything about the way in which we operate and the role that we particularly play, the FSA, which would enable us to answer that question. We have, under the Money Laundering Regulations 2007, a responsibility to make sure that firms have systems and controls to deal in general with money laundering, but money laundering there is not specifically to do with drugs. It could cover money laundering that relates to the receipt of money from what are called politically exposed people—people who have political offices and who, therefore, could have received money in a corrupt fashion. It might include drugs money. It might include terrorist money, or it could include any other category of financial crime. Because our focus is on making sure that banks or other financial institutions have adequate systems and controls in place, it would be very difficult for us to have a specific point of view on the drugs subset of that, in that we are not typically involved right down in the detail.

The other thing to say is, of course, that once one actually gets to the detail of what is going on, the core mechanism is that firms are required to produce suspicious activity reports, which go to SOCA which then follows up on those.

Q539 Chair: We will come to that. You saw the outcome of the HSBC case.

Lord Turner: Yes.

Q540 Chair: And the money, the $7 billion that was transferred from Mexico to the United States—the majority coming from Casa de Cambios. The Senate talked about a "pervasively polluted" culture of British banks, in particular this British bank. Didn't that set off alarm bells in the FSA? Here was the Senate in the United States talking about the pervasively polluted culture of a British bank. Didn't you worry that this was much bigger than you suspected?

Lord Turner: Well, it is certainly something that we are concerned about. I have read the Senate report. We are obviously close with the American authorities in the discussions on the HSBC situation and you are quite right: reading the Senate report on HSBC, the assertions being made are very prima facie and very concerning. Whether that carries implications for other UK-based banks, we do not know. It will certainly be a spur for us to look in more detail at what we are doing in the area of anti-money laundering. It is true to say that it is important to understand that there is a difference in the legal status of HSBC from the other major UK banks in this respect. HSBC is organised as a holding company. We regulate the UK and European bank and we do not, because of that organisation as a holding company, have any regulatory oversight over the subsidiaries and branches overseas. That is somewhat different from the situation that applies, for instance, with other international banks such as Barclays, RBS or SCB.

Q541 Chair: I accept that there is a different structure, but it must concern you, as chairman of the body that is supposed to regulate banks, when you hear Martin Woods, the whistleblower in the Wachovia case, saying, "The FSA were involved in what was a catastrophic failure of banking regulation. They gave the bank a clean bill of health for five years despite an ever-growing mountain of evidence against it". If you look at the particular cases of money laundering, Coutts were fined £8.7 million and Lloyds were fined £350 million. At HSBC, as I said, $7 billion was laundered. At the Barclays private bank, the UK Government froze £54 million, which was held in a private bank, at the request of the United States. But there were no prosecutions of anybody as a result of all those cases. Does it not worry you that here we have these vast amounts of money, figures that indicate that 85% of the profits of the drug dealers of South America end up in either the United States or in the European Union? Surely somebody must be looking for this money.

Lord Turner: We have a responsibility to make sure that there are reasonable anti-money laundering controls in place. I think you are quite right that what has occurred in relation to HSBC is something that is going to mean we focus even more on it; for instance,

at a board meeting later this week we will be debating the issue as to whether this indicates that we need a greater focus on these issues than we have had in the past. I would say that for the last two or three years, we have been steadily ramping up our focus on these issues. For instance, the report we produced last year on banks' management of high money-laundering risk situations, which followed the launch of a more intensified, thematic review of those issues in 2010, very clearly set out a set of concerns that we had about the controls that they had in place. It is quite interesting that the key area of concern that comes out of that report, which you have probably seen, was more on the politically exposed persons area. There were some concerns on the correspondent banks area but not as many and, broadly speaking, we did not find problems in that review on things to do with wire transfers and the identification of the origin of money in a wire transfer. We did not, in that, find the exact equivalent of some of the issues which existed or appear to have existed in relation to Mexican Casa de Cambios and receipt of cash money.

Q542 Chair: Hand on heart, can you say to this Committee, that in the FSA, in all the meetings you have had and all the regulation you have done, you have no worries about the amount of dodgy money?
Lord Turner: I certainly am worried. We will take the HSBC case.

Q543 Chair: Yes but prior to HSBC, it is clear—
Lord Turner: We have been steadily increasing our focus but again, we are not a law enforcement agency directly in this respect. We are focused, as we should be, on adequate systems and controls to make sure that they are appropriately putting in their suspicious activity reports, and that they have the controls in place. We do not have a huge amount of resources devoted to this area. Our specialist resource devoted to this area is about 20 people. It is not more than that.

Q544 Chair: In the whole of the FSA?
Lord Turner: Yes, the specialist resource. There are other people who are supervisors of banks on a set of issues who will be able to call on that specialist resource. There are people involved in the policy debates with FATF at international level. But the number of people operationally devoted specifically to anti-money laundering, which includes things to do with PEPs as well as drugs or terrorism, is only 20.

Q545 Chair: Do you need more?
Lord Turner: The issue is should we have more. Yes, I think that is a legitimate issue.

Q546 Chair: Obviously the FSA is going, and you are odds-on to become the next Governor of the Bank of England—11–4 this morning, I understand. Leaving that aside, what is going to happen to these very crucial areas that you obviously have some expertise in? How is it going to be divided between the two new organisations?
Lord Turner: They will fundamentally stay in the Financial Conduct Authority because we think of issues to do with anti-money laundering and politically exposed people as things to do with conduct activity—correct conduct—rather than things that directly relate to the financial soundness of a bank in the sense of its capital and liquidity. So they will stay in the FCA. They will stay under the division that Tracey is in charge of. Tracey McDermott is in charge of the whole enforcement and financial crime area. That is staying under Tracey.

Q547 Chair: As one unit, just transferring over, not separating?
Lord Turner: Yes. Essentially it will stay where it is. Fundamentally, the FSA has already divided itself under me, as Executive Chairman, into two separate groups, one headed by Martin Wheatley to whom Tracey reports, to be the Financial Conduct Agency, and the other headed by Andrew Bailey to be the Prudential Regulatory Authority. We are now at the stage where all that really happens next April is that we legally separate them and put them in different buildings.

Q548 Chair: But the work will continue?
Lord Turner: The work will continue, yes, absolutely.

Q549 Steve McCabe: Are you familiar with the remarks of Antonio Maria Costa, the former Executive Director of the UN Office on Drugs and Crime. In a series of interviews, he is reported as saying that drug money laundering kept the banking system afloat at the height of the crisis in 2008, to the tune of $352 billion. In another report, he is quoted as saying that in many instances, drug money is the only liquid investment capital available. Is the scale of the problem he is describing credible to you?
Lord Turner: I did see that report but I do not think it is a credible description of the survival of the global banking system at the end of 2008. I find it difficult to make sense of those comments in that it could only have been the thing that kept the banking system afloat if new money came into the banking system, and new money only comes into the banking system through two routes. One is when people take cash—physical paper currency—and put it into the banking system, and there is no sign that that occurred in late 2008; indeed, in most banking systems in the world, there was a slight flow the other way. The other thing that can go into the banking system is central bank money—provided by the Bank of England, the Federal Reserve, the Bank of Japan, the ECB—and that is essentially what kept the banking system afloat in autumn 2008. You can see that simply from the expansion of central bank balance sheets, which were much bigger than that $300 billion figure. If that $300 billion figure in any way—and I have no reason to know—reflects the money from crime that is in the global banking system, it would have been there before; it did not flow in during that period, and it is, of course, less than 1% of the total assets and liabilities of the total global banking system. This is a very big problem—the issue of how we stop the financial system being used by criminals—but I did not personally think that the problem was well described by suggesting that the role of criminality

was essential to the survival of the banking system in autumn 2008.

Q550 Steve McCabe: When something like that does surface, would it be automatic for the FSA to carry out its own inquiry or would you assume, as you said to us, that it is 1% and it did not make that big an impact?
Lord Turner: Well, we would not necessarily look at every statement that comes from everybody. At any one time, people are, for all sorts of reasons, making—

Q551 Steve McCabe: I am asking because I presume this gentleman has a fair amount of credibility, given the organisation he ran, and I am surprised that he is making these claims.
Lord Turner: My understanding is that there is a fair amount of credibility on the specific issues of drugs and money laundering, but even people who have good credibility in relation to that can sometimes make statements relating to financial stability issues that the experts in that area would not recognise as adding much to our understanding of what the problems are. That is what I would have to say in relation to that comment.
Tracey McDermott: I think that is right. I would also say, picking up on one of the earlier questions, that the question of how criminals are using the financial system to launder money is not something the FSA takes the lead in identifying. That is very much something where law enforcement and SOCA in particular—who I know you have already had evidence from—take the lead in identifying how criminals are using money, what new techniques are being used and so on. In our part of that overall picture, we take the role of ensuring that financial institutions have robust systems and controls to minimise the risk of those being used for financial crime. We do work with other agencies, including SOCA, in identifying new risk. So if there is an emerging risk, an emerging way of transmitting money, that is something that we would feed into our own assessment of where we focus our resources.

Q552 Steve McCabe: Are you satisfied that the financial institutions for which you are responsible do have robust systems at the moment to deal with that?
Tracey McDermott: In the report we published in 2011 that Adair has already referred to, we stated very clearly that we were disappointed by our findings in a number of areas; we found that the banks we had visited as part of that review had, in some areas, good controls but had many more weaknesses than we would have expected to see and than we would think were appropriate. We have taken a series of enforcement cases off the back of findings from that thematic review, and we have made it very clear that we expected to see improvement. As Lord Turner mentioned, a lot of those issues were around politically exposed persons, who from a private wealth banking perspective are potentially lucrative clients, and that was an area where we had particular concerns. We did look at correspondent banking, which was part of the area that caused the issues with HSBC in Mexico and the US. We found that there were some weaknesses there and at one of the banks we have taken action against recently, a Turkish bank, it was in relation to correspondent banking controls. But actually we found controls were generally better there. Would I say that we think they are perfect? No. Would I say that we have given a very clear signal as to what we expect? Yes. Do we think they are improving? Yes.

Q553 Steve McCabe: In terms of the problem of tackling economic crime, would a decision by this country to opt out of European Justice and Home Affairs measures have any bearing on the work that you do?
Tracey McDermott: At the moment, the primary thing that we have done is to use the European arrest warrant. We used the European arrest warrant to arrest a suspected insider dealer who was then convicted and sent to jail, which is obviously part of the framework. We also participate in and co-operate with Eurojust and Europol. It would very much depend on exactly what frameworks were in place to ensure that we could have continued co-operation.

Q554 Chair: Are there aspects that you would like to opt into, but others that you do not have a view on?
Tracey McDermott: There are aspects that we have used that are useful to us.

Q555 Chair: Presumably you will be consulted at some stage by the Government on this? Or you will tell them what you think rather than being told?
Tracey McDermott: We will tell them.

Q556 Nicola Blackwood: I wanted to follow up on exactly that point. In the light of the potential for the need for transitional measures, and then for the need to opt in, perhaps with renegotiation on future measures, have you been consulting with your partners and preparing for what you might like and need given the international nature of money laundering and the crimes that you are seeing?
Tracey McDermott: In relation to money laundering in particular, the issue is less relevant, because we are not the prosecuting authority. It is actually more relevant to our role as a prosecutor, which is primarily around insider dealing and market-facing crime. In relation to the generality of the point, we are in regular contact with law enforcement colleagues, both here and overseas, and we would liaise to the extent we needed to in terms of whether there are changes needed, but we would not be taking the lead in those discussions because, frankly, we are a minor player in the law enforcement community compared to others.

Q557 Nicola Blackwood: Can I ask you how your systematic anti-money laundering programme is going?
Tracey McDermott: We piloted the programme last year and are now rolling it out. The intention of the systematic anti-money laundering programme was to focus on some of the larger players and do a very in-depth review of their anti-money laundering controls. This is very resource intensive for us. We estimate it

takes four to five people about five months to do this, and the one we did in the pilot involved around 30 to 40 interviews of people at all levels—from senior management through to people on the ground to people who are business facing—as well as reviewing 250 actual files, customer files and so on. We found it extremely useful. We think it gave us a much better understanding of particular banks' systems and controls, and particular areas of strength and particular areas of weakness. We have decided that we will roll it out now and it will be part of the Financial Conduct Authority approach to anti-money laundering. There will be 14 institutions subject to this systematic anti-money laundering programme, which means that on rotation they will have this deep dive. In addition, we also do thematic work, which is targeted across a range of banks and what we call reactive work—when specific issues come up, we visit a particular institution.

Q558 Nicola Blackwood: My briefing says, and you can tell me if it is right or not, that the programme examines how well the various parts of the institution communicate with each other. Are some risks falling between the gaps and are the banks' highest risk customers being given the right level of due diligence and monitoring? Is that right?
Tracey McDermott: That would be some of it. It is actually a fairly extensive programme.

Q559 Nicola Blackwood: It is extensive. Where the pilot has run, what were your findings?
Tracey McDermott: I cannot talk about the individual findings in relation to the individual firms, but we found some areas where we thought there was good practice, and we found some areas where we thought that there was work that needed to be done. That is a fairly typical result for in-depth supervisory work. You do not necessarily expect everything to be absolutely perfect when you go in.

Q560 Nicola Blackwood: Do you think that the outcome of running the systematic anti-money laundering programme, which is quite hard to say—
Tracey McDermott: It is very hard to say.
Lord Turner: Yes, it is not exactly a catch phrase.
Nicola Blackwood: Do you think the programme is going to act as a deterrent? Do you think that it is going to improve performance because it is going to be spot-checked? What is the intent of the programme?
Tracey McDermott: There is a range of intents. One is that it is a deterrent because if you know that we are going to be periodically coming around—

Q561 Nicola Blackwood: Do you notify people in advance?
Tracey McDermott: Yes, we do notify.

Q562 Nicola Blackwood: How much notice do they get?
Tracey McDermott: I do not know exactly, but it would not be something that is done as a surprise visit particularly. We occasionally do visits where we do not give people notice, but this would not be that sort of programme.
Nicola Blackwood: This is not that sort of programme, okay.
Tracey McDermott: This is very intensive. This is the sort of thing where you cannot actually manufacture something overnight to make it look as though you are compliant.
Part of it is also about making sure that we have a clear view of how standards are evolving on the ground and helping inform our assessment of risks. To the question your colleague asked about what we see as the risks that are coming in, actually the banks and people on the front line often see new ways of moving money, so that is another source of information for us in assessing the risks and so on. Part of it is around deterrence, part of it is around spotting actual problems, and part of it is around making sure we are close to what is actually happening on the ground.

Q563 Nicola Blackwood: What data will be available publicly in order to improve accountability and boost public confidence? With the allegations flying around, which you have heard today, and with the cases that have been reported, there is obviously this feeling that a lot of banks are hiding away criminals within their walls. A programme like this is designed to try to weed that out and boost public confidence. How much of this will be available in the public domain, and how much will people be able to see as a public assurance exercise as well?
Tracey McDermott: So far, in relation to what is in the public domain, the typical approach of the FSA has been to publish thematic reports. In the one we did in 2011, which is published on an anonymised basis, we talk about examples we have seen at various banks. We do not routinely publish individual supervisory assessments of individual firms, partly because of confidentiality restrictions in the Act and partly because of commercial and sensible reasons.
One of the things that the FCA is doing though, and one of the things we will do before the FCA comes into existence, is to publish in the first quarter of next year a discussion paper on transparency, which goes precisely to your point. It will not be limited to money laundering, but asking if there is more we could do in terms of providing transparency about what we do, whether on an aggregate basis or an anonymised basis, to enable people to see what we are doing, and to hold us more accountable. It is tricky because there are an awful lot of confidentiality restrictions, particularly when you are talking about banking, of course—people's private accounts.
Lord Turner: Obviously, there are two things that go into the public domain. There are what we call thematic reviews; there was one in 2011 on how banks are doing on their management of high money-laundering risk situations, and we will be doing a subsequent one on the way in which trade finance could or could not be used to deal with anti-money laundering. When we bring specific enforcement cases against specific firms, like the Coutts and Co case earlier this year, we then issue what is called a final notice, which describes what has occurred. Typically, what we would not do is describe an individual firm

where we have not discovered something that is subject to enforcement. That is the balance of the way that we deal with transparency at present.

Q564 Mr Winnick: Lord Turner, this is in fact, as you know, an inquiry into drugs rather than money laundering as such, but money laundering obviously comes into it, hence the reason the two of you are giving evidence today at the request of the Chair. On the points that were made by the Chair about the criticism by the United States authorities of various financial institutions in the United Kingdom, do I take it, Lord Turner, that you have given evidence to other Committees, be it of the Commons or the Lords, on these matters?
Lord Turner: No, we regularly appear in front of the Treasury Committee, as you would expect, on issues.

Q565 Mr Winnick: Yes. When was the last time you did that?
Lord Turner: I had three separate sessions, or at least two, during the course of July, which covered the issues relating to LIBOR. They also covered issues relating to the Bank of England Financial Policy Committee on which I sit, which is to do with macro prudential issues. We have meetings with the Treasury Committee once every two or three months because they are the Committee directly responsible for the performance of the FSA.

Q566 Mr Winnick: Presumably you will be asked questions by the Treasury Committee on the points made by the Chair, which I have already quoted from?
Lord Turner: That is possible. I am not aware yet that there is in the diary a meeting with the Treasury Committee specifically on this issue. We do have a session shortly in the diary with the Banking Standards Commission, the joint Commons/Lords commission being chaired by Andrew Tyrie, which although chaired by Mr Tyrie is separate. I am sure they could touch on these issues then because it is about banking standards in general. But at the moment the Treasury Committee has not in the past, nor I think in the immediate future, selected anti-money laundering or financial crime as specific issues on which it has chosen to focus.

Q567 Chair: Thank you. Ms McDermott, in the report you published last year, which Lord Turner referred to, you said, "Again and again we saw the desire to win and keep the business, trump the obligation to honour anti-money laundering rules fully and in good faith". Basically, banks putting profits above compliance. Since you made those comments and since the report last year, have you seen a difference on the part of the banks?
Tracey McDermott: What we have not done yet is a follow-up piece of work where we go back and test to see whether in practice it has happened. When we do this sort of review, we will have some firms referred to enforcement where there is specific action taken. There will also, typically, be supervisory work undertaken with a number of other institutions; for instance, we might require them to have a third party review and so on. I can say with confidence that this has gone significantly further up the senior management agenda, that there is absolute clarity about what our expectations are and that we believe that firms are actually taking steps to try and address these issues. As I said, we have not yet gone back and done further testing.

Q568 Chair: As Mr Winnick reminded us, Lord Turner, this is an inquiry into drugs. I have a quote from you on this: on 5 November 2003—you probably know what I am going to put to you—at the Global Economy Memorial Lecture, "As tonight's deliberately provocative thought, if we want to help sustainable economic development in the drug states, such as Colombia and Afghanistan"—the Committee has visited Colombia and seen this for itself—"we should almost certainly liberalise drugs use in our societies, combating abuse by education not prohibition rather than launching unwinnable wars on drugs, which simply criminalise whole societies".
Lord Turner: Clearly those points of view were expressed as a personal point of view and are nothing to do with my role at the FSA.
Chair: Of course.
Lord Turner: It is also important to say that as long as society has decided, in its rules, to prohibit drugs or prohibit particular drugs, that is a criminal activity and banks must not allow the transmission of criminal money. A point of view as to whether or not the overall approach is a sensible one does not change in any sense the moral responsibility and the legal responsibility of banks to stick to the rules as they are at the moment. Also, let us be clear, there are other aspects of anti-money laundering that are not to do with drugs but are also very important, like terrorist finance. I think that is a separate point of view; it is a point of view that I happen to hold and, as you know, it is a point of view that several commissions on drugs have, over the years, arrived at. But it does not in any way imply either that any bank is, therefore, entitled to say, "Well, if they think that that is what the rule should be they don't have to apply this," nor does it in any way imply that the FSA will be other than as rigorous as we should be in making sure that money laundering is—

Q569 Chair: Can you give this Committee an assurance that despite the changes that are going to take place, which are quite important changes in the way in which the financial structure and landscape of this country are concerned, this will remain the focus of the new organisation? What worries us in terms of what the drugs barons are doing is that SOCA is changing, the NCA has been created and the FSA is going; there is a lot of change taking place over the next year and a half. We would not want to see the focus change as to where this money comes from and how it is going to be stopped. Having been to Colombia and been given the figure that 85% of the profits end up in Europe and the United States of America, it does worry the people in the Committee who have been on that visit that this not being taken seriously enough.
Lord Turner: I can give you an absolute assurance that the division of the FSA into the FCA and the

PRA will make no negative impact on this. Indeed, I would say, on the whole, it will be positive. In general, I think one of the benefits that we will get from dividing the FSA between the PRA and the Financial Conduct Authority is that we will make sure that we have a group of people in the PRA who are worrying about financial stability and the safety and soundness of banks and the capital and liquidity of banks, even when the rest of the world thinks that the single most important thing is anti-money laundering or defending people against mis-selling. We will have, in the Financial Conduct Authority, people who are focusing on that, even if we were back in 2008 and 2009 and the world financial system was collapsing.

Bluntly, I think in the past that the FSA was doing too much; putting all of those activities into one organisation made it very difficult for the top management to be focused on all those issues. If you were to honestly ask me how much attention did I pay to anti-money laundering in autumn 2008, the answer is not much because the financial system was collapsing and it felt that the single most important thing for myself and Hector Sants and the other most senior people to be focusing on was how we were going to rescue the banking system.

I think the focus that we have in future, of the PRA within the Bank of England and the conduct authority just focused on conduct, makes it more likely that we will get that focus. It is also the case that we have taken the revelations of what appears to have been going on in HSBC in Mexico as a stimulus to make sure that we are doing a drains-up on what are we doing and are we doing enough and should we be putting more resources into it.

Chair: Lord Turner, Ms McDermott, thank you very much for coming.

Lord Turner: Thank you very much.

Tracey McDermott: Thank you.

Written evidence

Written evidence submitted by Dr Leslie King (DP003)

Further to the call for written evidence, as set out in the notice of 29 November 2011 on the Parliament website, I attach a memorandum addressing the topic "The availability of 'legal highs' and the challenges associated with adapting the legal framework to deal with new substances".

None of this material is confidential.

1. Executive Summary

- Almost 200 new psychoactive substances ("legal highs") have been notified to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) since 1997. Their rate of appearance is increasing; 41 were notified in 2010, and 2011 is expected to be another record year. The UK has notified more substances than any other Member State.
- New substances are widely available, yet official statistics (eg British Crime Survey, law enforcement seizures, number of offenders and mortality data) provide only limited information.
- The harmful properties of new substances are largely unknown, yet conventional drug control requires that harm to individuals or society should be demonstrated before scheduling.
- In the absence of basic research on the pharmacology and toxicology of new substances, "Temporary Class Drug Orders" may only provide a temporary solution.
- The impact of import bans is unknown.
- Analogue legislation suffers from many weaknesses.
- It is unclear what priority law enforcement agencies give to new substances, particularly at a time of decreasing budgets, and with a trade that often relies on retail internet sites.
- Many countries are exploring and enacting distinct legislation to deal with new substances. A common theme is to use or modify consumer protection legislation or medicines legislation such that the focus is on producers and suppliers, but not on individual users.
- A number of recommendations are listed.

2. Introduction

I am now retired. My working life was concerned with drugs analysis, pharmacology, toxicology, epidemiology and policy. I spent eight years in the pharmaceutical industry and almost 30 years in the Forensic Science Service, the last 10 of which were as Head of Drugs Intelligence. I was a co-opted member of the Advisory Council on the Misuse of Drugs (ACMD) from 1994 to 2007. From early 2008 until late 2009, I was the chemist member of ACMD. From 1997 to mid-2011, I was an advisor to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and responsible to the UK Focal Point on Drugs (since 2003 in the Department of Health) for co-ordinating a United Kingdom network that collected and analysed information on new substances. I have published over 100 articles as author and co-author in the scientific literature, many book chapters and two books.[1]

Recent publications include:

King, L A (2012). Legal classification of novel psychoactive substances: an international comparison, In: *Novel Psychoactive Substances: Classification, Pharmacology and Toxicology,* (Eds Dargan, P and Wood, D), Elsevier, in press.

King, L A and Kicman, A T (2011). A brief history of "new psychoactive substances", *Drug Testing and Analysis,* 3(7–8), 401–403.

Sainsbury, P D, Kicman, A T, Archer, R P, King, L A and Braithwaite, R (2011). Aminoindanes—the next wave of "legal highs"? *Drug Testing and Analysis,* 3(7–8), 479–482.

Nutt, D J, King, L A and Phillips, L D (2010). Drug harms in the UK: a multicriteria decision analysis, *Lancet,* 376, 1558–65.

King, L A and Corkery, J M (2010). An index of fatal toxicity for drugs of misuse, *Hum Psychopharmacol Clin Exptl,* 25, 162–166.

King, L A (2009). Forensic Chemistry of Substance Misuse: A Guide to Drug Control, Royal Society of Chemistry, London.

King, L A and Elliott, S (2009). Review of the pharmacotoxicological data on 1-benzylpiperazine (BZP), In: *Report on the risk assessment of BZP in the framework of the Council Decision on new psychoactive substances,* EMCDDA.[2]

[1] A full list of published work is at: www.zen140250.zen.co.uk/

[2] www.emcdda.europa.eu/publications/risk-assessments/bzp

King, L A, McDermott, S D, Jickells, S and Negrusz, A (2008). Drugs of Abuse, In: *Clarke's Analytical Toxicology, First Edition*, (Eds S Jickells and A Negrusz), Pharmaceutical Press, London.

King, L A and Sedefov, R (2007). Early-Warning System on New Psychoactive Substances: Operating Guidelines, EMCDDA, Lisbon.[3]

3. "Legal Highs"

3.1 *European Union (EU)—Early Warning System*

An Early Warning System on new psychoactive substances ("legal highs") has operated in the EU since 1997 (1, 2). New substances are appearing at an increasing rate; almost 200 have been reported to the EMCDDA since 1997. In 2010, there were 41 substances (3), a figure which is likely to be exceeded in 2011. The UK has notified more substances than any other Member State.

3.2 *Availability in the UK*

Most new substances can be purchased from retail internet sites. However, apart from occasional *ad hoc* surveys, there is only limited official data on prevalence. The most recent issue of the British Crime Survey: Drug Misuse Declared (4) did include usage of a few of the better-known substances (eg mephedrone, BZP), but law enforcement seizures of new substances were not itemised in the most recent Home Office bulletin (5). Mortality data published by the Office for National Statistics (6) included data on mephedrone, GBL and BZP/TFMPP, but no other new substances. I am unaware of any recent publications detailing the number of persons prosecuted for offences involving "legal highs".

3.3 *Unknown harms*

Many "legal highs" were originally investigated as potential therapeutic agents by academic laboratories and the pharmaceutical industry, but never succeeded to market authorisation. Alongside these "failed pharmaceuticals" are true designer drugs, namely the products of clandestine laboratories (7). Whatever their origin, it is a common feature of new substances that almost nothing has been published on their pharmacology; and their harmful properties and potential for abuse are unknown.

3.4 *Scheduling of substances*

It is a general principle of drugs legislation, be that the United Nations (UN) Drug Conventions or national laws, that substances should only be scheduled when their harmful properties can be demonstrated. In the UK, the Misuse of Drugs Act 1971 provides some flexibility in that it is sufficient to demonstrate potential if not actual harm. But in the absence of published scientific information, risk-assessments can have only limited value. Recourse to the precautionary principle in drug control is not an ideal solution (8, 9).

3.5 *Temporary Class Drug Orders*

The recently-introduced Temporary Class Drug Orders (TCDOs) (10) are welcomed as a means of avoiding a repeat of the unfortunate circumstances that occurred in early 2010 when the hasty decision to control mephedrone and related compounds was widely criticised (eg 11). However, TCDOs will only achieve their full potential provided that, during the period of temporary control, information is collected on the harmful properties of the substance in question. It is likely that such information could only be obtained by conducting original research, at an uncertain cost, on the pharmacology and toxicology of that substance.

3.6 *Importation control*

In 2010, the substance desoxypipradrol was subject to an importation ban (12) by variation of the "Open General Import License". In 2011, the Advisory Council on the Misuse of Drugs (ACMD) recommended that there should be a similar ban for phenazepam (13), diphenylprolinol and diphenylmethylpyrrolidine (14). While this may provide a means of restricting the supply of new substances, many of which are manufactured in the Far East, no evidence has been published to show the effectiveness of such bans.

3.7 *Analogue control*

Analogue legislation was introduced into the United States (US) by the Controlled Substances Analogue Enforcement Act 1986. A recent report from the ACMD (15) recommended that this approach should be considered as a means of controlling new substances. The ACMD suggested that a statutory agency could decide which new substances were "substantially similar" to existing controlled drugs as a means of avoiding some of the recognised problems with this legislation. However, experience in the US shows that the concept of "substantially similar" relies essentially on individual opinions and is not strictly amenable to scientific evaluation. If the decisions of such an agency were to be challenged in a criminal trial then nothing would be gained, and the defendant could face the prospect of being convicted on what might be seen as law that is either retrospective or uncertain.

[3] www.emcdda.europa.eu/html.cfm/index52448EN.html

3.8 *UK law enforcement*

It is not clear what priority is given by Police and the UK Border Agency to seizing new substances, particularly at a time of reduced budgets (16). Nor is it obvious that those agencies could disrupt a trade that is largely conducted via retail internet sites, some of which are based beyond the jurisdiction.

3.9 *International initiatives*

Despite the early lead taken in drug control by the World Health Organisation (WHO) and UN agencies, the current world-wide concern with new substances has not been reflected by these international bodies. The last, and 34, meeting of the WHO Expert Committee on Drug Dependence took place in 2006. Meanwhile, a number of countries have taken unilateral action to review their arrangements for restricting the availability of new substances, and some have enacted specific legislation for this purpose. Some examples are set out below:

3.9.1 Ireland

The Criminal Justice (Psychoactive Substances) Act 2010 was designed specifically to deal with the problem caused by novel substances (17), and stands as a piece of legislation quite separate from the existing Misuse of Drugs Act 1977. It makes it a criminal offence, to advertise, sell or supply, for human consumption, psychoactive substances not specifically controlled under existing legislation. The Act excludes medicinal and food products, animal remedies, alcohol and tobacco. There is no personal possession offence.

3.9.2 New Zealand—current

Until 2008, BZP was listed as a "Restricted Substance" within the Misuse of Drugs Act 1975. Substances in this category, informally known as Class D (18), attracted no penalty for possession, but were regulated through control of manufacture, advertising and sale, rather than prohibition.

3.9.3 New Zealand—proposed

In 2011, the New Zealand Law Commission (19) concluded that a new way was required for regulating new drugs. It proposed a form of consumer protection with elements of the "Restricted Substances" regime. There should be restrictions on the sale of novel substances to persons under the age of 18, restrictions on advertising and where they could be sold. An independent regulator would determine applications from suppliers.

3.9.4 Poland

In 2010, the Polish Government adapted the Act on Counteracting Drug Addiction to eliminate the open sale of psychoactive substances not controlled under existing drug laws (20). The new law prohibits the manufacture, advertising and introduction of "substitute drugs" into circulation, but does not penalise users.

3.9.5 Japan

Japan has also experienced a wide availability of new substances. Because of their unknown harms, it has likewise been unable to incorporate them into the Narcotics and Psychotropics Control Law. These novelties are referred to as "non-authorised pharmaceuticals" (21). In June 2006, the Pharmaceuticals Affairs Law was modified to introduce the category of "designated substances", where there is a general prohibition on importation, manufacture and distribution.

3.9.6 Sweden

In Sweden, the Ordinance on Prohibition of Certain Goods Dangerous to Health (22) lists drugs that are not otherwise classified as narcotics. As part of general health and safety legislation, it includes a number of new substances.

3.9.7 Austria

In January 2009, the Austrian Government used a decree under the Pharmaceutical Law to declare that "smoking mixes" containing synthetic cannabinoid agonists are prohibited from being manufactured or imported (23).

3.9.8 European Union

The European Commission has begun a process to deal with the deficiencies of the existing Council Decision (2005/387/JHA) on new psychoactive substances (24).

4. Recommendations

4.1 The Government should consider new legislation, separate from the Misuse of Drugs Act, to control the supply and manufacture of "legal highs", but not penalise possession. The experience in other countries of restricting novel substances may provide a way forward.

4.2 Analogue legislation is not considered to be an appropriate method of controlling new substances. The concept of a substance being "substantially similar" to a controlled drug relies essentially on individual opinions and is not strictly amenable to scientific evaluation.

4.3 Current official statistics (eg household surveys, seizures, offenders, mortality) are insufficiently comprehensive to assess the prevalence of new substances.

4.4 The impact of import bans, if not drug legislation in general, should be measured to determine "what works".

4.5 The Government should consider funding basic research into the pharmacology and toxicology of selected new substances. This would support Temporary Class Drug Orders, and might form an extension of the Government's existing "Forensic Early Warning System".

5. REFERENCES:

1. European Commission (2005). Council Decision 2005/387/JHA on the information exchange, risk-assessment and control of new psychoactive substances. *Official Journal of the European Union*, L 127/32.[4]

2. King, L A and Sedefov, R (2007). Early-Warning System on New Psychoactive Substances: Operating Guidelines, EMCDDA, Lisbon.[5]

3. EMCDDA (2011). *EMCDDA-Europol 2010 Annual Report on the implementation of Council Decision 2005/387/JHA*.[6]

4. Smith, K and Flatley, J (2011). Drug Misuse Declared: Findings from the 2010–11 British Crime Survey, England and Wales. Home Office.[7]

5. Coleman, K (2011). Seizures of drugs in England and Wales, *Home Office Statistical Bulletin*, (HOSB 17/11).[8]

6. Office for National Statistics (2011). Deaths related to drug poisoning in England and Wales, 2010.[9]

7. King, L A and Kicman, A T (2011). A brief history of "new psychoactive substances". *Drug Testing and Analysis*, 3(7–8), 401–403.

8. Nutt, D (2010). Precaution or perversion: eight harms of the precautionary principle.[10]

9. European Commission (2000). Communication from the Commission of 2 February 2000 on the precautionary principle.[11]

10. United Kingdom Government (2011). The Police Reform and Social Responsibility Act 2011 (Commencement No 1) Order 2011.[12]

11. Editorial, (2010). A collapse in integrity of scientific advice in the UK. *Lancet*, 375, 1319.

12. United Kingdom Government (2010). Import ban of Ivory Wave drug 2-DPMP introduced.[13]

13. United Kingdom Government (2011). Phenazepam.[14]

14. Advisory Council on the Misuse of Drugs (2011). Further advice on Diphenylprolinol (D2PM) and Diphenylmethylpyrrolidine.[15]

15. Advisory Council on the Misuse of Drugs (2011). Consideration of the Novel Psychoactive Substances ("Legal Highs").[16]

16. Beck, H (2011). Drug enforcement in an age of austerity: Key findings from a survey of police forces in England. UK Drug Policy Commission, London.[17]

17. Government of Ireland (2010). Criminal Justice (Psychoactive Substances) Act.[18]

18. Bassindale, T (2011). Benzylpiperazine: The New Zealand legal perspective. *Drug Testing and Analysis 3* (7–8), 428.

[4] www.emcdda.europa.eu/html.cfm/index5173EN.html?pluginMethod=eldd.showlegaltextdetail&id=3301&lang=en&T=2
[5] www.emcdda.europa.eu/html.cfm/index52448EN.html
[6] www.emcdda.europa.eu/publications/searchresults?action=list&type=PUBLICATIONS&SERIES_PUB=a104
[7] www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1211/hosb1211?view=Binary
[8] www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/police-research/hosb1711/hosb1711?view=Binary
[9] www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2010/stb-deaths-related-to-drug-poisoning-2010.html
[10] http://profdavidnutt.wordpress.com/2010/06/
[11] http://europa.eu/legislation_summaries/consumers/consumer_safety/l32042_en.htm
[12] www.legislation.gov.uk/uksi/2011/2515/contents/made
[13] www.homeoffice.gov.uk/media-centre/press-releases/ivory-wave
[14] www.homeoffice.gov.uk/drugs/drug-law/phenazepam/
[15] www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/acmd-d2pm?view=Binary
[16] www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/acmdnps2011?view=Binary
[17] www.ukdpc.org.uk/resources/Drug_related_enforcement.pdf
[18] www.irishstatutebook.ie/2010/en/act/pub/0022/index.html

19. New Zealand Law Commission (2011). *Controlling and regulating drugs: A review of the Misuse of Drugs Act 1975, Report 122.* Wellington, New Zealand.[19]

20. Hughes, B, and Malczewski, A (2011). Poland passes new law to control "head shops" and "legal highs". Drugnet Europe online 73, EMCDDA.[20]

21. Kikura-Hanajiri, R (2011). Drug Control in Japan—Designated Substances—Update. Presented at the First International Multidisciplinary Forum on New Drugs, EMCDDA, Lisbon, May 2011.

22. Reitox National Focal Point, Sweden (2010). National report (2009 data) to the EMCDDA; New Development, Trends and in-depth information on selected issues.[21]

23. Hughes, B (2011). Legal Responses to New Psychoactive Substances in EU: Theory and practice—typologies, characteristics and speed. Presented at the First International Multidisciplinary Forum on New Drugs, EMCDDA, Lisbon, May 2011.

24. European Commission (2011). European Commission seeks stronger EU response to fight dangerous new synthetic drugs. Press release, 25 October.[22]

December 2011

Supplementary written evidence submitted by Dr Leslie A King (DP003a)

I provided a memorandum of written evidence to the Home Affairs Select Committee on 19 December 2011. Further to the oral evidence presented to the Committee on 19 June 2012 (Ref HC 184-i), the Chairman asked for a further submission concerning areas where official data on new substances could be improved (part of Q330).

RE: OFFICIAL STATISTICS ON PREVALENCE OF NEW SUBSTANCES

1. Introduction

Over the past few years, the Government has sought to control many "new psychoactive substances" under the Misuse of Drugs Act 1971, but the impact of those controls is uncertain.

The Forensic Early Warning System now provides information on the availability of "legal highs" in the UK by conducting test purchases from internet suppliers and elsewhere. Some data on prevalence have been published [1]. However, these are ad hoc and often confined to existing drug users; there is a lack of official information. The purpose of this note is to highlight some of those deficiencies.

2. The British Crime Survey: Drug Misuse Declared

The most recent issue of the British Crime Survey: Drug Misuse Declared [2] was published in August 2011 and covered the period 2010–11. It included usage of a few of the better-known "legal highs" (eg mephedrone, BZP). Given that over 100 new substances have been reported in Europe in the past three years [3,4], and that some users will not always know what they are consuming, it would be helpful if future Surveys could ask an additional general question about use of any "legal high".

3. Seizures by Law Enforcement Agencies

In the most recent Home Office Bulletin of law enforcement seizures [5], new substances were not itemised, but included among others in Class B and Class C. However, detailed information was available at the time as I discovered from a request made to the Home Office under the Freedom of Information Act 2000 (Ref FOI 20820, 23 November 2011).

4. Prosecutions

At the time of my original written submission to the Home Affairs Select Committee (December 2011), no published data were available on the number of persons prosecuted for offences involving "legal highs" in 2010. The Ministry of Justice subsequently provided this information following a request (Ref FOI 73726/708–11, 25 November 2011).

5. Mortality

Mortality data published by the Office for National Statistics (ONS) for England and Wales in August 2011 [6] included data on mephedrone, GBL and BZP/TFMPP. Although I have no reason to believe that data for other new substances had been omitted, the number of deaths associated with mephedrone in 2010 (six cases

[19] www.lawcom.govt.nz/sites/default/files/publications/2011/05/part_1_report_-_controlling_and_regulating_drugs.pdf
[20] www.emcdda.europa.eu/publications/drugnet/online/2011/73/article12
[21] www.emcdda.europa.eu/attachements.cfm/att_142550_EN_SE-NR2010.pdf
[22] http://europa.eu/rapid/pressReleasesAction.do?reference=IP/11/1236&type=HTML

where mephedrone was mentioned on the death certificate) may be compared with those reported by Corkery *et al*, [7] for the whole of the United Kingdom in 2010 (46 fatalities with confirmed mephedrone intake). This inconsistency may arise from different definitions of what constitutes a drug-related death, but could also suggest that the ONS data represent an underestimate.

6. References

1. Guardian/Mixmag drug survey reveals a generation happy to chance it. (2012).
http://www.guardian.co.uk/society/2012/mar/15/respondents-guardian-mixmag-drug-survey

2. Smith, K and Flatley, J (2011). Drug Misuse Declared: Findings from the 2010/11 British Crime Survey, England and Wales, Home Office.
http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1211/hosb1211?view=Binary

3. European Commission (2011). Commission staff working paper on the assessment of the functioning of Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances, SEC(2011) 912 final.
http://ec.europa.eu/justice/policies/drugs/docs/sec_2011_912_en.pdf

4. EMCDDA–Europol (2012). 2001 Annual report on the implementation of Council Decision 2005/387/JHA.
http://www.emcdda.europa.eu/attachements.cfm/att_155113_EN_EMCDDA-Europol%20Annual%20Report%202011_2012_final.pdf

5. Coleman, K (2011). Seizures of drugs in England and Wales, Home Office Statistical Bulletin, (HOSB 17/11).
http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/police-research/hosb1711/hosb1711?view=Binary

6. Office for National Statistics (2011). Deaths related to drug poisoning in England and Wales, 2010.
http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2010/stb-deaths-related-to-drug-poisoning-2010.html

7. Corkery J, Schifano F and Ghodse H (2012). Mephedrone-related fatalities in the United Kingdom: contextual, clinical and practical issues. In: Pharmacology (Chapter 17, pp. 355–380) Ed. Gallelli, L, InTech—Open Access Publisher, Rijeka, Croatia.
http://www.intechopen.com/books/pharmacology

July 2012

Written evidence submitted by Mary Brett (DP021)

Mary Brett, Former biology teacher (30 years—grammar school for boys), Trustee of CanSS (Cannabis Skunk Sense), Member of PandA (Centre for Policy Studies) and former Vice President of Eurad.

The Independence and quality of expert advice which is being given to the government.

Executive Summary

Prevention is the policy of this Government but harm-reduction organisations are being consulted for information and evidence—the Advisory Council on Misuse of Drugs (ACMD), Drugscope and the John Moores University Liverpool.

Information on cannabis from these sources is out-of-date, misleading, inaccurate, has huge omissions and is sometimes wrong. It does not stand comparison with current scientific evidence.

Children do not want to take drugs. They want reliable information to be able to refuse them.

Tips on safer usage and "informed choice" have no place in the classroom.

Prevention works.

1. Current information about drugs being given to this government comes mainly, if not entirely, from harm-reduction organisations. I find this astonishing. The policy of this Coalition Government is prevention.

2. I had long suspected, and had it confirmed by BBC's Mark Easton's blog 20 January 2011, that "Existing members of the council (ACMD) are avowed "harm-reductionists". Drugscope, a drugs information charity paid for entirely by the taxpayer, has always had a harm reduction policy. We find statements like, "prevention strategies are not able to prevent experimental use" and "harm minimisation reflects the reality that many young people use both legal and illegal substances". And the John Moores University in Liverpool has been at the forefront of the harm reduction movement since the eighties. Pat O'Hare, President of the International Harm Reduction Association (IHRA), said: "As founder of the first IHRA conference, which took place in

Liverpool in 1990, it gives me a great sense of pride to see it coming "home" after being held all over the world in the intervening 20 years".

3. FRANK is the official government website providing information to the public, especially children 11–15. I have learned that the information for the recently re-launched FRANK website came from The John Moores University. A member of the FRANK team, Dr Mark Prunty was involved in a commissioned report, "Summary of Health Harms of Drugs" published in August 2011.

4. Harm reduction has its place in the treatment of addiction, eg reducing the dose till abstinence is attained. But no place in the classroom where well over 90% of children have no intention of ever taking drugs. Harm reduction can and does sometimes act as a green light.

5. This government says it wants to stop young people from ever starting to use drugs, but that's not the aim of harm reductionists. They assume children will take drugs anyway, so give them "tips" on taking them more safely, and offer them "informed choice". And for some reason I have never understood, they always downplay the harmful effects of cannabis—information is vague, inadequate, misleading, out-of-date and sometimes completely wrong.

6. Brains are not fully developed till the 20s, the risk-taking part developing before the inhibitory area. Children from seven upwards are simply incapable of making the right decision. They need to be protected, not abandoned to make critical life choices. Only 30–40% will ever try drugs—a world away from regular use. What other illegal activities do we invite them to choose—pilfering, graffiti-spraying? Harm reduction advocates are so wrong. Children don't actually want to take drugs. They want sound, reliable and full information to help them refuse drugs from peer group users who are pressuring them. I know—they've told me. Harm reduction policies are tantamount to condoning drug use.

7. Prevention works. The prevention campaign in USA 1979–1991 saw illicit drug users drop from 23 to 14 million. Cannabis and cocaine use halved. Over 70% abstained from cannabis use because of concern over physical and/or psychological harm (P.R.I.D.E. survey USA 1983). In Sweden, 2010 "last month use" of cannabis was 0.5% (ages15 to 64), European average—3.7%.

8. Overall, drug use may have fallen in the last 10 years but the last BCS reported that there had been a 1% increase in the "last year" use of cannabis among 16 to 24 year olds in the UK. This amounts to around 55,000 people—no room for complacency.

9. At a meeting of the FRANK team, Dr Mark Prunty, asked me to send my large scientific report on cannabis ("Cannabis—A general view of its harmful effects", written for The Social Justice Policy Group, in 2006, fully endorsed by eminent scientists, and regularly updated), and all new research papers that I received. He also had the two books I have written ("Drug Prevention Education" and "Drugs—it's just not worth it"[23]). I wasted my time. Why is there no scientific researcher on the FRANK team or at least temporarily co-opted?

10. One of the John Moore's staff members, Dr Russell Newcombe helped to pioneer the harm-reduction movement in Merseyside from the mid-1980s and was Senior Researcher for Lifeline Publications & Research (Manchester, 2005–10). Lifeline literature on drugs, used in some schools, is hugely harm reduction based. Several leaflets and DVDs on "How to inject" are freely advertised on the Internet and can be easily accessed, as are needles, by children. Children are scared of injecting—now they needn't worry!

11. The last paragraph in Lifeline's Big Blue Book of Cannabis says, "If we look at our crystal ball at the world of tomorrow what can we expect to see? More medical uses for cannabis; stronger types of weed appearing on the streets; more laws; more fiendish ways of catching users and the same old hysterical reactions to people smoking a plant"—That says it all!

12. My analysis of the cannabis information in the "Summary of Health Harms of Drugs" pages 31–33 follows:

13. "No cases of fatal overdose have been reported". Isn't it the same with tobacco? "No confirmed cases of human death". "Stoned" drivers kill themselves/others. Cancers recorded, especially head and neck at young age (Donald 1993, Zang 1999). Serotonin, "happiness" neurotransmitter depleted (Gobbi 2009) causing depression—can lead to suicides (Fugelstad (Sweden) 1995). Violence from psychosis or during withdrawal, murders documented in the press and coroners' reports. Teenagers have had strokes and died after bingeing (Geller 2004).

14. Strength: No figures are given for Tetrahydrocannabinol (THC) content. Skunk now averages 16.2% but can range up to 46% THC, old herbal 1–2%, Hash 5.9% (*Home Office Report 2008*). No warning that skunk occupies 80% of the UK market, hash 20%. FRANK says that skunk is 2–4 times stronger than old herbal cannabis—wrong! They mislead the public by comparing it with hash. The enlightened Dutch, who know about drugs, have now banned any skunk with a THC content over 15%, equating it with cocaine and heroin. The vast bulk of our young users are smoking what amounts to a class "A" drug!

15. 50% of THC will remain in cells for a week, 10% for a month. The John Moores report makes no mention of its persistence. Numerous studies show the adverse effects of this on academic results (Grade D student four times more likely to use cannabis than one with A grades, USA 2002) and personality. Users

[23] All available on www.cannabisskunksense.co.uk

become inflexible, can't plan their days, can't find words or solve problems, development stalls, they remain childish. At the same time they feel lonely, miserable and misunderstood (Lundqvist 1995).

16. Psychosis: Not reported is that anyone (with/without family history) taking cannabis can develop psychosis if they take enough THC (Morrison, Robin Murray team 2009). D'Souza (2007) had also shown this. Cannabis increases dopamine (pleasure neurotransmitter) in the brain. Excess dopamine is found in brains of schizophrenics. The first paper linking psychosis and cannabis was published in 1845! The report says: "Health effects of increases in the potency of cannabis products are not clear". Skunk users have been found to be seven times more likely to develop psychosis than hash users (Di Forte, Murray's team 2009).

17. No mention of absence of Cannabidiol (CBD) (anti-psychotic) in skunk, so psychotic THC is not counteracted! Old herbal cannabis had equal amounts CBD and THC. (McGuire 2008 and 2009, Morgan (2010), Demirakca (2011) etc. Dependence risks and psychotic symptoms are blamed on bingeing—regular use is enough! It is suggested that psychotic or schizophrenic patients may be self-medicating negative symptoms—disproved in several papers (Degenhardt 2007, Van Os 2005).

18. They say that likelihood of progressing to other drugs is more to do with personality, lifestyle and accessibility than a gateway effect. Swedish research (Hurd 2006, Ellgren 2007) on animals finds THC primes the brain for use of others, and Fergusson (2006 and 2008) in a 25 year NZ study from birth found cannabis to be the single most significant factor for progressing.

19. It is claimed that there is "no conclusive evidence that cannabis causes lung cancer" We don't have conclusive proof for cigarettes and lung cancer! "Evidence for the effects on the immune system is limited"—over 60 references in my report! No warning that people should not drive within 24 hours of consumption (Leirer 1991).

20. Children born to cannabis-using mothers may have "mild developmental problems". Fried has followed child development since 1987. He has found cognitive impairment, behaviour and attention problems, babies twice as likely to use the drug at adolescence. Goldschmidt (2002) found delinquent behaviour, Bluhm (2006) warned of an increased risk of neuroblastoma, a childhood cancer.

21. Now several recent papers demonstrate structural brain damage eg Welch (September 2011) loss of volume in thalamus, Solowij 2011 smaller cerebellum white matter volume, Ashtari (2011) loss in hippocampus volume, (Yucel 2008, Rais 2008).

22. I have cited only a few references, there are well over 600 in my report.

23. At least one piece of information in FRANK's magic mushroom (Psilocybe—Liberty Caps) section is not in the Moore's report, so where did it come from? The extremely poisonous familiar red/white spotted fungus, the Fly Agaric, is included. This is serious—it should not be there. Its inclusion is even more alarming as the amount used (1–5g) and the fact that it should not be eaten raw are given—blatant harm reduction advice! A child could die!

24. New posters from FRANK:

www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/frank/coke-poster

www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/frank/meow-poster

www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/frank/skunk-poster

My pupils would have used words like: pathetic, patronising, trite, useless and positively encouraging drug use—and so would I.

25. I repeat—children don't want to take drugs. They want a sound education and good grades, free from hassle and the pressure to take drugs.

26. Drugscope's cannabis information updated 2011 is even less reliable than FRANK's. They continue to deny that cannabis can cause physical addiction, say "There are suggestions that the drug can in rare cases trigger psychosis, a factor that led to the government in 2009 to reclassify cannabis" (Drugscope disagreed with the reclassification), state that the strength of skunk is 12–14% THC when in 2008 it averaged 16.2%, and completely ignore all the Swedish and New Zealand evidence for the "Gateway Theory". Professor Murray's 2009 papers are not mentioned, and in a reply to me, the writer of Drugscope's literature, seemed to think it was the THC that caused cancers, not the smoke.

27. In 2006, Professor David Nutt said that LSD and Ecstasy probably shouldn't be class A. In May 2008 I attended an open meeting of the ACMD at which a presentation (by Pentag) on ecstasy was given—a meta-analysis commissioned by the ACMD. I was concerned about their conclusions so contacted the foremost ecstasy researcher in Britain, Professor Andrew Parrott of Swansea University.

28. Incredibly Professor Parrott knew nothing about the proposed down-grading of ecstasy by the ACMD until I alerted him. He was leaving for Australia to Chair an International Conference on Ecstasy and sent me his numerous publications. I passed them to the ACMD. When he returned, having missed the evidence—gathering meeting in September, I alerted him to the open meeting in November. He had to send three e-mails before they answered and allowed his presentation to go ahead. He was given a mere 20 minutes.

In an open letter to the ACMD on November 13 he wrote:

29. *I cannot believe that I have spent the past 14 years undertaking numerous scientific studies into Ecstasy/MDMA in humans, then for the ACMD to propose downgrading MDMA without a full and very detailed consideration of the extensive scientific evidence on its damaging effects. My research has been published in numerous top quality journals, and can be accessed via my Swansea University web-page.*

30. Professor Nutt, who was Chairing the ACMD meeting on November 25 2008 for the first time was severely criticized by Professor Parrott. He said that Nutt made numerous factual errors, eg that there were zero dangers from injection of MDMA. Parrott said it was probably safer to inject heroin. Nutt said that ecstasy was not addictive, involved no interpersonal violence, was not responsible for road deaths, did not cause liver cirrhosis or damage the heart. Scientific work demonstrates that users show compulsive and escalating use, midweek aggression, that driving under its influence is extremely dangerous, that it is hepatotoxic—liver transplants have been needed in young people under 30, and profound cardiovascular effects. Professor Nutt did not defend himself in our presence. Nor to my knowledge has he since!

31. Answers from Anne Milton, Minister for Public Health given to Parliamentary Questions from Charles Walker MP, October 2011 include:

32. The Medical Research Council (MRC), funded by The Department of Business, Innovation and Skills, is supporting Professor Glyn Lewis in his research on adolescence and psychosis and Professor Val Curran's research into the vulnerability of people to the harmful effects of cannabis.

33. Professor Lewis, widely quoted on the Web by Peter Reynolds (CLEAR—Cannabis Law Reform) said that, "there is no certainty of a causal relationship between cannabis use and psychosis", and announced that the risk of psychosis from cannabis use is at worst 0.013% and perhaps as little as 0.0030%. Professor Curran is a member of Professor Nutt's Independent Scientific Committee on Drugs (ISCD).

34. I find it incredible that there is essential sound accurate up-to-date scientific information about the effects of cannabis available in scientific journals and publicised in the press and the public is not being made aware of it by FRANK, the official Government website. Why has FRANK not been taken to task?

35. While the harm reduction lobby are being consulted, persisting with their own agendas, and the preventionists supporting the Government's New Strategy not listened to, nothing will change.

36. Prevention is better than cure. Prevention is what every parent wants for their children. Prevention is common sense and it works.

37. Meanwhile, while we wait for common sense to prevail, some children will become psychotic, addicted, move on to other drugs, drop out of education or even die. And the parents I work with will be left picking up the pieces.

January 2012

Supplementary written evidence submitted by Mary Brett [DP021a]

ADDITIONAL MATERIAL FOR SUBMISSION TO THE DRUG POLICY INQUIRY FOLLOWING THE EVIDENCE SESSION AT 12PM ON 24TH APRIL 2012

Mary Brett, Former biology teacher (30 years—grammar school, boys), Trustee of CanSS (Cannabis Skunk Sense), Member of PandA (Centre for Policy Studies) and former Vice President of Eurad.

Already in my written evidence I have drawn attention to the fact that Prevention has been shown to work (para 7). The USA campaign between 1979 and 1991 coincided with a dramatic drop in usage and Sweden's extremely low use of drugs is due almost entirely to their unceasing efforts in prevention.

Also at that time in the USA a PRIDE (Parent Resistance Information for Drug Education) Survey in 1983, found that the largest number, more than 70% of young people, abstained from cannabis use because of fears of physical or psychological damage, 40% due to the law and 60% because of parental disapproval.

In 2005 a survey among year 10 children (14–15s), in which my school took part, was published. It was a doctoral thesis from Brunel University by Dr Barry Twigg. "Drugs Education and Young People".

Six schools took part (around 1,000 children). In a survey of factors helping them to abstain from using drugs, the commonest one in 90% of them was "danger to my health", over 80% worried that drugs could kill them, 70% feared side-effects, over 60% worried about parental disapproval, nearly 60% were concerned about the illegality, around 40% about their school grades. Others were: how drugs might affect the memory, being caught and the fact that they thought that drugs were not cool.

This is why it is essential that children get the whole truth about drugs—they are entitled to no less.

Of the six schools, all very different, mine had the lowest rate of regular drug use (3%), the highest was 18%, the average 6%. One school—a very restrictive boarding school, had 0% use.

Prohibition has worked. Only around 10% of UK citizens use drugs regularly. The law and common sense deter the other 90%. The incidence of cigarette smoking is falling. Around 20% of the population now smoke, down from 30% a few years ago, due in no short measure to prohibition in public places. Many now regard tobacco smoking as anti-social. Are we to accept the smoking of cannabis in public places?

In many respects, not least in terms of health, Prohibition of alcohol in the United States did work (Emerson H 1927/8). Alcohol Prohibition in the USA was dismissed in the meeting as having failed.

- Less alcohol was drunk.
- Liver cirrhosis deaths fell by over one third.
- Cases of alcohol-induced psychosis plummeted.
- Alcohol-related divorce, delinquency and child neglect all halved.

I repeat from my former written evidence (para 8) the fact that: overall drug use may have fallen in the last 10 years but the last BCS reported that there had been a 1% increase in the "last year" use of cannabis among 16 to 24 year olds in the UK. This amounts to around 55,000 people—there is no room for complacency.

I informed the meeting of the change in strength of THC in cannabis (para 14) over the years and the fact that skunk now occupies about 80% of the cannabis market. I want to expand on another three items listed in my written evidence.

Para 15 explains how the THC unlike the other commonly abused illegal drugs, persists for weeks in the cell. The presence of THC impairs the transmission of the many neurotransmitters (chemicals carrying messages between cells). Every function of the brain is affected and many essential connecting fibres will not be made. Brain development stalls, the younger they are the greater the damage. They are more likely to drop out of education, become addicted, move on to other drugs or suffer from psychosis. This very negative effect of THC on the brain started my campaign against cannabis. I witnessed some of my very bright grammar school boys throw away their futures. Most parents on being alerted did not want to know.

Paras 16 and 17 were about psychosis. Because of the work of Murray, D'Souza and others, there can now be little doubt that "THC can induce a transient acute psychotic reaction in psychiatrically well individuals". Arguably we have more proof for cannabis causing psychosis than for cigarettes causing lung cancer: Tobacco can be "painted" on the skins of animals and shown to cause cancer. With humans, all we have are statistical correlations. Yet the vast majority of the population believe that the correlation with tobacco/lung cancer exists.

Professor Murray and his team have actually given THC to healthy volunteers, and produced a "transient acute psychotic reaction" in them. Add that to the fact that dopamine (the pleasure neurotransmitter) is increased in the brain. Those suffering from psychosis or schizophrenia have an excess of dopamine. There are numerous statistical correlations and emerging evidence of brain damage (para 21) in the relevant regions. I cannot believe that we need or indeed can find any more convincing proof. It surely is essential to err on the side of caution. We must not take risks where the futures of our children are concerned.

There is now general agreement among scientists that there must be a gene or genes which can be triggered by cannabis to cause schizophrenia. Cannabis users double their chances of suffering from this condition. The COMT gene was thought to be responsible but one researcher, Zammit failed to find the connection. The AKT1 gene is now being explored (Van Winkel 2011).

Para 18 "The Gateway theory" is entirely ignored by FRANK. I wrote of evidence from Swedish experiments on animals, and a longitudinal study from birth in New Zealand. Now Mayet in 2012 has added to a long list of other papers showing a correlation. Over 29,000 French adolescents were studied. The risk for other illicit drug initiation was 21 times more with experimenters and 124 times higher among daily users than non-users. Tobacco and alcohol were associated with a greater risk of moving on to cannabis.

Anne Milton was very supportive and assured me that she would do everything she could to help. Charles Walker MP secured an adjournment debate last year on 9 June. He and Anne gave excellent supportive and reassuring speeches.

That was in sharp contrast to my dealings with the members of the FRANK team. Dr Prunty has already been mentioned. I had already sent the team my large scientific updated report on cannabis and was told it would be read as they had a large team. However as they had been in place under the last regime whose policy was harm reduction, they did not appear to have taken on board the new prevention policy. I experienced a great deal of intransigence and opposition (I have the correspondence).

In a patronising way I was told how to talk to teenagers, having spent all my teaching career with 11 to 18s. I was informed that children would consider the "gateway theory" to be Government propaganda. My report with numerous references to papers on "gateway" had obviously not been looked at. They tried to justify giving out harm reduction advice to children including: "advising that needles are not shared to prevent infections like hepatitis B or C and HIV/AIDS…. Using ecstasy….regular breaks … to cool down and prevent …overheating and dehydrating". It is not the role of an official Government website to give out tips on safer drug use. This can be seen as encouragement to experiment—a green light, and interpreted as condoning an illegal activity.

I was assured that Robin Murray's findings had been taken into account. There was no evidence they had ever been looked at. They said, "The risks and harms of drugs are also highlighted. This approach enables individuals to make informed decisions—an approach that is emphasised in the Drug Strategy …". Nowhere in the Drug Strategy could I find reference to "informed decisions" nor did I expect to. This is typical harm reduction "speak".

I was sent the section on cannabis to look at and suggest alterations. I spent a considerable amount of time on it. When FRANK was re-launched, NONE of my suggestions had been accepted. After I sent another e-mail they added two of my points. My dealings with FRANK were entirely unsatisfactory.

Since we are now told (30 April ACPO report) that 21 new cannabis factories/day are being discovered, double the number four years ago, it is obvious there is a huge market, and a renewed urgency to rectify all past mistakes, and to properly inform the population, especially children who are so vulnerable.

The cannabis information on the majority of other drug sites is also inadequate, misleading, out of date and can be wrong. Many seem to take their "facts" from FRANK. I have already mentioned Drugscope's unreliable information, and Lifeline's freely given advice on injecting drugs.

The charity Mentor states on its website: "Mentor is the leading international NGO voice of drug abuse prevention."

However like FRANK it advocates "informed choice". I have already explained why children of seven and upwards are physically and psychologically incapable of making choices. This is not what a prevention charity should be doing. They should be trying to stop children ever starting. And like similar sites, its cannabis information fails young people.

The name "skunk" is not used, no information or warnings about current strength is given. The word "cancer" does not appear. More astonishing, neither do the conditions "psychosis" or "schizophrenia". A huge opportunity is missed to explain to people how and why academic performance dips and adverse personality changes occur BECAUSE of the persistence of THC in the brain cells. Children want to understand. Scientific explanations are invaluable. I repeat they want excuses to say "NO".

Depression is not addressed. It can lead to suicides. There is mention of aggression but not the terrible violence displayed by some psychotic cannabis users. I work in a charity with parents, most of whom have children very badly affected by cannabis use. Some of these parents have been attacked, had ribs broken, been pushed downstairs, had hands squashed in doors and even members of their family murdered. Houses get trashed and money and credit cards go missing.

The gateway theory is ignored as usual as is the immune system and driving.

Addaction boasts of being, "The UK's leading specialist drug and alcohol treatment charity".

Like FRANK, Drugscope and Mentor, the cannabis information is similarly out of date, incomplete and flawed in many respects.

The most reliable site for true scientific up-to-date Facts on cannabis is the USA sites of NIDA (National institute of Drug Abuse). It is run by scientists and commissions scientific research.

In para 32 I wrote that Professor Glyn Lewis's research is being supported. He said, "there is no certainty of a causal relationship between cannabis use and psychosis", announcing that the risk of psychosis from cannabis use is at worst 0.013% and perhaps as little as 0.0030%. He was quoting from a paper by Hickman et al in 2009 which used outdated data from 1997–99 when the THC content was much lower than it is now. His "light" users included "ever taken"—this could have been once!

Only one paper to date has been conducted using skunk—the one by Murray's team in 2009, mentioned in my submission comparing skunk, hash and the risk of psychosis.

May 2012

Written evidence submitted by the UK Drug Policy Commission (DP058)

SUMMARY

This submission is not an exhaustive summary of the evidence for all areas of drug policy, but rather our view of some of the key issues that require attention. We have extracted key points from our reports and submissions, which we have referenced and copies of which are supplied with this submission as appendices. We would be very pleased to add further detail to these areas or to respond on issues that we have not covered.

We have identified 13 key points for consideration:

Understanding the Drug Problem in the UK

1. Drug use is not a single coherent phenomenon: there are many different causes and experiences of use and this complexity needs to be reflected in the range of policy responses. As such, drug use should be seen as one aspect of social policy and not treated in isolation from other issues.

2. Drug policy interventions have harms and unintended consequences that are often not recognised and there is a need for more effort to be made to include these when designing and implementing interventions and overall policies and in evaluating their cost-effectiveness.

The Overarching Aims and Approach to Drug Policy

3. The Strategy aim of enabling people with drug dependence problems to recover is welcomed but it is important that this is person-centred and encompasses a range of different pathways and support services.

4. It is also important to recognise and build on the successes of past strategies and the strong evidence underpinning some public health measures that tackle some of the harms associated with serious drug problems, such as through needle exchanges, substitute prescribing and blood-borne virus (BBV) immunisations.

5. The rapid introduction of PbR for funding treatment services has the potential to disrupt service delivery to vulnerable individuals and requires carefully phased introduction and evaluation with an emphasis on using evidence to design policy. Comparison with alternative models for incentivising recovery should be an important component of any evaluation programme.

6. The Drug Strategy should have two other overarching aims: one to improve the health and wellbeing of drug and other substance users and their families, the other to improve public safety in relation to the operation of drug markets.

Measuring Impacts and Effectiveness

7. Despite the explicit aim of basing the Drug Strategy on evidence, there are a number of parts of the strategy for which evidence is weak, in particular in the area of enforcement. These gaps require mitigation by carefully targeted and well-designed trials of competing interventions.

8. We recommend the inclusion of a clear programme for research development and evaluation of drug strategies and policies alongside the promotion of evidence amongst professionals (ie a "knowledge pillar") in future drug strategies.

Getting the Legal Frameworks Right

9. The current legal control systems for psychoactive substances are inconsistent. The new psychoactive substances provide an opportunity to develop and evaluate new approaches to drug control. This could provide evidence to support a complete review of the legal framework for controlling all psychoactive substances.

Challenges of Implementation

10. Disinvestment, fragmentation and marginalisation pose threats to the continued success of drug policies. It is important that drug issues continue to be highlighted and championed both at the national and local level, and that we deal with drug issues with a focused, integrated and evidence-based approach.

11. Stigma experienced by recovering drug users is a fundamental barrier to delivery of the Drug Strategy. A campaign should be developed to address this.

Rethinking how we make Drug Policy

12. The current system for provision of independent advice and analysis of the evidence for drug policy to inform the government, parliament and the public could benefit from review and reform.

13. National and international evidence indicates that the current system of drug control produces negative unintended consequences, and that realistic alternatives exist that have the potential to address these without leading to significant new problems. These alternatives, such as the replacement of criminal sanctions for personal possession of controlled drugs with a system of civil sanctions, are worthy of serious consideration.

Introduction

In responding to the inquiry, we have grouped the questions posed by the Committee into a number of broad themes and have addressed these questions and other relevant issues together under these broader headings. To assist the Committee in identifying the sections that have relevance to the different questions, we have placed the questions covered within each theme in italics at the start of the section. We have identified key points from a range of our reports and submissions, which we have referenced; copies of the full documents are

appended with our submission. We would be very pleased to add further detail to these areas or to respond on issues that we have not covered within this submission

Understanding the Drug Problem in the UK

The comparative harm and cost of legal and illegal drugs

The links between drugs, organised crime and terrorism

1. Illicit drugs and their associated problems are often discussed in policy terms as if they were manageable as a single set of issues, with the term "drug problem" synonymous with heroin or crack addiction, and any drug use seen as being qualitatively different from use of legal psychoactive substances, such as alcohol.

2. It is important to acknowledge that different drugs do not present the same level of potential harms, even if the relative rankings are the subject of debate.[24] While for many of the estimated 12 million or more people in the UK who report having used drugs at some time in their lives, such use will have been without serious consequences, there is a range of problems that may be associated with different types of use. For example, amongst "recreational" users there is a strong overlap with alcohol use; there is a potential public health issue with the use of cutting agents which may affect both occasional and dependent users; and injecting drug use is still strongly associated with blood-borne virus infections.

3. The drivers for use are similarly varied and drug use is influenced by a wide variety of factors, including employment opportunities, inequality, social trends and other cultural influences. These factors also include the perceived benefits derived from use, which may include relief from mental or physical distress, cognitive enhancement, as well social benefits. People also vary in how they respond to drugs and in their ability to deal with any negative effects associated with use.

4. Given this variety amongst individual users, in the contexts of use, and among different drugs, there is a need for a more considered and nuanced policy response that recognises this diversity and goes beyond simply targeting drug-consuming behaviours (eg seeking to restrict access to drugs). Recognising this allows us to identify a wider set of opportunities and levers that can be used in order to influence drug use. Drug use cannot be seen in isolation from other social and economic policy issues.

5. The 2010 Drug Strategy goes some way towards recognising this complexity, in that it seeks to address dependence on all drugs and recognises the overlaps between alcohol and drug dependence. However, it still emphasises the traditional responses that focus primarily on the drugs themselves rather than the drivers and contexts that are associated with harmful drug use. We should instead expect to take very different approaches to different kinds of drug issues.

6. The best estimate of the relative costs associated with drug misuse is £15.4 billion for Class A drug use in 2003–04[25] but there were many limitations to the data on which that was based, and some people think this is an overestimate. The estimates for alcohol also vary considerably for example, The Institute for Alcohol Studies has reported the estimated costs of alcohol misuse are in excess of £15billion in 2004[26] while a 2008 BMA report cited figures ranging between £20–50billion+.[27]There are clear taxation and other economic benefits also associated with the alcohol trade which off-set some of these costs; these have been estimated at between £18 and £24 million.

7. The Impact Assessment for the Drug Strategy 2010 contained no figures for either the costs or benefits of the various interventions. It also made many assumptions about costs and benefits of policies that are not backed up by any evidence (eg the benefits of temporary banning powers for legal highs, an issue that is discussed in more detail below). Currently, there is a great deal of emphasis on the costs involved in drug use and the benefits in reducing consumption, but very little attention to the unintended harms incurred by interventions. There should be more effort made to calculate this, for example recognising the financial and opportunity costs of enforcement as well as the harms that misplaced enforcement can cause. It should also be recognised that many people perceive their own drug use to have a benefit that outweighs its potential harms, including in substitution for other more harmful drugs, as well as pleasure and cognitive enhancements.

8. In this submission we have not sought to analyse the link between drugs, organised crime and terrorism. The Home Affairs Committee explored some of this in its previous report about the cocaine trade and we anticipate organisations such as SOCA and Transform will provide additional information about the perceived links.

---

[24] Nutt, D et al, *Development of a rational scale to assess the harm of drugs of potential misuse*, *Lancet* 369, 24 Mar 2007; Nutt et al. *Drug Harms in the UK: a multicriteria decision analysis*, *The Lancet*, 376, 1558–1565, 6 Nov 2010 and subsequent correspondence in *The Lancet*, 377, Pages 551–555, 12 Feb 2011.

[25] Home Office Online Report 16/06,*The economic and social costs of Class A drug use in England and Wales, 2003/04*

[26] http://www.ias.org.uk/resources/factsheets/economic_costs_benefits.pdf

[27] http://www.bma.org.uk/images/Alcoholmisuse_tcm41–147192.pdf

Key Point 1

Drug use is not a single coherent phenomenon: there are many different causes and experiences of use and this complexity needs to be reflected in the range of policy responses. As such, drug use should be seen as one aspect of social policy and not treated in isolation from other issues.

Key Point 2

Drug policy interventions have harms and unintended consequences that are often not recognised and there is a need for more effort to be made to include these when designing and implementing interventions and overall policies and in evaluating their cost-effectiveness.

The Overarching Aims and Approach to Drug Policy

The extent to which the Government's 2010 drug strategy is a "fiscally responsible policy with strategies grounded in science, health, security and human rights" in line with the recent recommendation by the Global Commission on Drug Policy

The extent to which public health considerations should play a leading role in developing drugs policy

9. There have been some notable successes in UK drug policy over the years, for example: public health "harm reduction" approaches have delivered rates of HIV among injecting drug users that are among the lowest in the world[28] and saved thousands of lives; different types of drug treatment services, whether provided through the criminal justice system or outside, have helped many people overcome dependency; more money has been invested in treatment capacity so that there has been an increase in the numbers of people accessing drug treatment with lower waiting times; and information about drugs and other substances has secured a place in the national curriculum, although the impacts of this are hard to ascertain.

10. Successive UK drug strategies have recognised the need for these to be evidence-based but in practice the extent to which this has been the case is patchy. Treatment for drug dependency and addictions has a robust international scientific evidence base to justify the provision of public expenditure and has proven efficacy.[29, 30] The use of methadone and other prescribed medications as part of a treatment package has substantial research evidence in support, including use in prisons. Regrettably, this evidence has become the subject of considerable and unwarranted misrepresentation by those seeking to promote their favoured interventions. On the other hand, it is in the area of enforcement of the law to tackle drug markets and those involved in them, where the scientific evidence base is most thin. This has been remarked upon by the NAO[31] and was highlighted by a review of the evidence base underpinning law enforcement drug policies undertaken on behalf of UKDPC in 2008.[32] Important questions remain unanswered, like: whether it is more efficient to invest in upstream efforts in other countries, border and organised crime interventions or local policing; whether asset seizure offers value for money in enforcement; and which of the different sentencing and justice approaches are most effective.

11. The focus on recovery in the 2010 Drug Strategy is welcomed as is the fact that this did not constrain treatment and recovery services to "abstinent only" approaches, as the current evidence base does not support that. Abstinence-oriented interventions should play an important part in a balanced treatment and recovery system, along with self-help and mutual-aid groups. But current evidence suggests that recovery is as varied as the individuals who suffer from dependence and a range of recovery pathways and support services will be necessary. As we have noted, recovery is a process, not an end state.[33] Research to establish how best to deliver recovery-oriented services that are person-centred and respect the different circumstances and needs of individuals should be part of the knowledge development associated with the Drug Strategy. While there is a pilot and associated evaluation of Payment by Results for Drug and Alcohol Recovery, this is only one means for incentivising recovery and we have some concerns about the approach being adopted.[34] A wider research effort should be undertaken given the centrality of the concept of recovery to the strategy and the varied ways in which the principle of "payment by results" is being implemented across many associated service delivery areas.

12. The 2010 Drug Strategy sets out as overarching aims to reduce illicit and other harmful drug use; and to increase the numbers recovering from their dependence. Unfortunately, the Strategy avoids identifying

[28] Mathers et al "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." *The Lancet*, 372, pp 1733–1745, 15 Nov 2008

[29] National Audit Office, *Tackling problem drug use*, 4 Mar 2010

[30] National Institute for Health and Clinical Excellence: *Methadone and buprenorphine for the management of opioid dependence, NICE technology appraisal 114*. 2007; *Naltrexone for the management of opioid dependence, NICE technology appraisal 115*. 2007; *Opiate detoxification for drug misuse. Clinical Guideline 52*. 2007; *Psychosocial management of drug misuse. Clinical Guideline 51*. 2007.

[31] National Audit Office, op cit

[32] Appendix 1: UKDPC, *Tackling Drug Markets and Distribution Networks in the UK*, Jul 2008 (http://www.ukdpc.org.uk/publications.shtml#drug_markets_report)

[33] Appendix 2: UKDPC, *The UK Drug Policy Commission Recovery Consensus Group: A Vision of Recovery* , Jul 2008 (http://www.ukdpc.org.uk/Recovery_Consensus_Statement.shtml)

[34] Appendix 3: UKDPC, *By their fruits… Applying payment by results to drug recovery*, Feb 2011(http://www.ukdpc.org.uk/resources/UKDPC_PbR.pdf)

specific metrics by which success overall will be evaluated. UKDPC support both of the stated aims but would wish also to see a stronger emphasis on positive measures to improve the health and wellbeing of drug and other substance users and their families, along with an aim of improving public safety in relation to the operation of drug markets.

Key Point 3

The Strategy aim of enabling people with drug dependence problems to recover is welcomed but it is important that this is person-centred and encompasses a range of different pathways and support services.

Key Point 4

It is also important to recognise and build on the successes of past strategies and the strong evidence underpinning some public health interventions that tackle some of the harms associated with serious drug problems, such as through needle exchanges, substitute prescribing and blood-borne virus (BBV) immunisations.

Key Point 5

The rapid introduction of PbR for funding treatment services has the potential to disrupt service delivery to vulnerable individuals and requires carefully phased introduction and evaluation with an emphasis on using evidence to design policy. Comparison with alternative models for incentivising recovery should be an important component of any evaluation programme.

Key Point 6

The Drug Strategy should have two other overarching aims: one to improve the health and wellbeing of drug and other substance users and their families, the other to improve public safety in relation to the operation of drug markets.

Measuring Impacts and Effectiveness

The criteria used by the Government to measure the efficacy of its drug policies

The cost effectiveness of different policies to reduce drug usage

13. The collection and analysis of evidence should be central to the development of drug policy, and evaluation of policies should be built into the implementation process. This does not currently happen effectively in practice. For example, there is no clear linkage between the overarching aims of the current Strategy (to reduce illicit and other harmful drug use; and to increase the numbers recovering from their dependence) and any objective outcome measures. Nor is there any clear model (with underpinning knowledge base or knowledge development strategy) between the interventions identified and the aims of the Strategy. As discussed earlier, the 2010 Drug Strategy Impact Assessment was extremely limited and was insufficient for predicting its likely impact and effectiveness. It therefore provides no foundation for a thorough evaluation of the Strategy and the promised evaluation framework has yet to be published.

14. This absence of logic models and measurement frameworks is a problem that we have also identified with respect to individual enforcement interventions and is, at least in part, responsible for the lack of evidence of effectiveness for enforcement. We have suggested a framework for approaching enforcement that could help to address this problem.[35] We believe the UK has a unique opportunity internationally to become a beacon of developing practice around measuring the impact of supply side interventions, but this would require political will and resource to invest in opening up to scrutiny what is, effectively, a closed system.

15. While the commitment in the current Strategy to developing and publishing the evidence base on what works, to develop an evaluation framework to assess the effectiveness and value for money of the strategy overall, and to review it on an annual basis is welcome, it is not clear how this will be done given the lack of clear outcomes or a model for interventions, let alone the necessary spending on research and evaluation. To address the shortfall, we have recommended in the past that a "knowledge pillar" should be included as part of future drug strategies.[36] This would encompass a clear commitment and programme to build a stronger evidence base through independent research and development, evaluation of interventions and a subsequent programme of evidence promotion and workforce development amongst relevant professionals in the treatment, recovery, prevention and enforcement fields. This should introduce a greater emphasis on respecting where the evidence is strong, and identifying where further work is needed to evaluate existing policies and identify promising alternatives. It should also include a commitment to cease doing things that have been shown not to work. In the United States, SAMSHA has created and supported a series of regional "knowledge transfer

[35] Appendix 4: UKDPC, *Refocusing Drug-Related Law Enforcement to Address Harms*, Jul 2009 (http://www.ukdpc.org.uk/publications.shtml#hre_report)

[36] Appendix 5: UKDPC, *A Response to Drugs: Our Community, Your Say Consultation Paper*, Oct 2007 (http://www.ukdpc.org.uk/resources/Drug_Strategy_Consultation_Response.pdf); Appendix 6: UKDPC , *A Response to the 2010 Drug Strategy Consultation Paper*, Sep 2010 (http://www.ukdpc.org.uk/resources/Drug_Strategy_2010_Consultation_Final1.pdf)

centres" to spread knowledge and good practice in the addictions treatment field.[37] The Substance Misuse Skills Consortium in England offers a foundation on which to develop a new approach.

Key Point 7

Despite the explicit aim of basing the Drug Strategy on evidence, there are a number of parts of the strategy for which evidence is weak, in particular in the area of enforcement. These gaps require mitigation by carefully targeted and well-designed trials of competing interventions.

Key Point 8

We recommend the inclusion of a clear programme for research development and evaluation of drug strategies and policies alongside the promotion of that evidence amongst professionals (ie a "knowledge pillar" in future drug strategies).

Getting the Legal Frameworks Right

The relationship between drug and alcohol abuse

The availability of "legal highs" and the challenges associated with adapting the legal framework to deal with new substances

16. The inconsistencies in the ways we control various psychoactive and harmful substances have been widely noted. This becomes particularly evident in our approaches to new psychoactive substances ("legal highs"), where the response in the Drug Strategy is to simply seek to place these within the controls of the Misuse of Drugs Act (MDA) as a precautionary measure without any robust evidence of harms or of the likely impact of these controls. Resorting to the use of the "precautionary principle" may provide comfort to some politicians and sections of the media. But in practice it has little utility and should be avoided in the field of drug control. The current policy of introducing temporary banning powers under the MDA relies on an enforcement capacity that may not exist. It also fails to take account of the potential harms associated with such controls if people continue to use the drugs (as the evidence suggests they will), ie the shift of supply to organised criminal groups, the loss of any possibility of control over content and quality, and the potential for substitution of even more harmful substances. Criminalising suppliers also makes it difficult to collect the information needed for assessing the harms, providing advice to users and mounting credible prevention campaigns. It also does not acknowledge the potential positive aspects that may be associated with new drugs, such as that they may substitute for more harmful ones, as may have been the case for mephedrone for which it is plausible to suggest that the recent decline in cocaine deaths may have been, at least in part, a result of people substituting mephedrone for cocaine.[38]

17. These problems would also apply to the ACMD's proposed solution of analogue controls. There are other drawbacks with this solution, as identified by Dr Les King in his submission to this inquiry.[39]

18. As we highlighted in our recent project looking at so-called "legal highs",[40] a fundamental concern with the current approach is that it appears neither to be targeting clear desirable outcomes nor to be based on evidence of effectiveness. As indicated above, criminalising supply of all new psychoactive substances is likely to have negative unintended consequences. An approach that targeted the outcome of reducing harms to young people might draw on other legal responses such as using enhanced consumer protection powers (eg trading standards) to regulate the availability and nature of certain new substances. Approaches taken in other countries and the experience of regulation under the Intoxicating Substances (Supply) Act 1985 indicate the potential for this approach of using the legal control system to improve health and wellbeing, and public safety.[41]

19. We feel there is a clear missed opportunity here to test alternative approaches to control of substances and to begin to develop a more coherent, staged approach to regulation of the whole range of harmful substances. This would recognise that the evidence suggests that use of psychoactive substances will persist and that the freedom to use substances is best limited proportionately to the known harms they cause. In the longer term, we suggest there would be value in a complete review of the way we control all psychoactive substances, legal and "illegal", in order to reduce the clear inconsistencies and anomalies in the way we treat them and to develop a coherent and effective substance control framework, such as a Harmful Substances Control Act.

[37] See: http://www.attcnetwork.org/index.asp

[38] Bird, S, *Banned drug may have saved lives, not cost them*, *Straight Statistics*, 22 Nov 2010, www.straightstatistics.org/article/banned-drug-may-have-saved-lives-not-cost-them

[39] King, L, Submission to the Home Affairs Committee, Dec 2011

[40] Appendix 7: UKDPC/Demos, *Taking Drugs Seriously*, May 2011 (http://www.ukdpc.org.uk/publications.shtml#legalhighs)

[41] New Zealand Law Commission, *Controlling and Regulating Drugs—A Review of the Misuse of Drugs Act 1975*, May 2011; EMCDDA *Responding to new psychoactive substances. Drugs in focus*. 22. December 2011; Hughes & Blidaru *Legal Responses to New Psychoactive Substances in Europe* EMCDDA, 19 Feb 2009.

Key Point 9

The current legal control systems for psychoactive substances are inconsistent. The new psychoactive substances provide an opportunity to develop and evaluate new approaches to drug control. This could provide evidence to support a complete review of the legal framework for controlling all psychoactive substances.

Challenges of Implementation

Whether drug-related policing and expenditure is likely to decrease in line with police budgets and what impact this may have

The impact of the transfer of functions of the National Treatment Agency for Substance Misuse to Public Health England and how this will affect the provision of treatment

Whether the UK is supporting its global partners effectively and what changes may occur with the introduction of the national crime agency

20. The amount of change to delivery structures at the local level is unprecedented and is taking place during a period of serious financial constraints. As the changes are currently on-going it is not yet possible to be certain of the impact but it is important to identify both potential threats and opportunities in order to mitigate the former as far as possible and try and ensure advantage is taken of the latter. To this end we are undertaking research which seeks to document these issues.

21. As powers are devolved and ring fences are removed from some funding, it is apparent that there is a risk that funding for drug services will be deprioritised. There is some evidence that services for young people with substance abuse problems have begun to be reduced, and UKDPC research has identified an expectation among police forces that they will have less funding and time to proactively address drug problems. Our report on this is appended.[42] At the heart of this is the risk that, without strong local leadership, drug-related issues will be considered a lower priority than more "mainstream" concerns within public health and law enforcement. A further challenge is the growing difficulty, under increasing devolution and localism, of identifying costs and benefits of particular policies, when funding may be allocated in one area (eg public health) and benefits felt in another (crime reduction). Sharing of evidence to ensure efficiency and best practice also stands at risk in a fragmented and increasingly market driven economy. Improved practices do not simply happen by osmosis and competition.

22. A fundamental impediment to successful implementation of drug policies is the huge barrier of stigma experienced by recovering drug users and their families as they seek to turn their lives around. This stigma stops people seeking help, promotes feelings of hopelessness that act as a barrier to change, and makes it difficult for them to obtain the jobs and accommodation needed to sustain recovery. Wide-ranging research carried out by UKDPC (appended) illustrates the many examples of stigmatisation by professionals in services, employers, the media and the general public and the ways this stigma has an impact on recovery.[43]Addressing this is an important issue for sustaining more responsible behaviours and also touches on the human rights of those recovering from drug use. In value for money terms, the financial gains made through treatment will be lost if reintegration is not achieved.

23. To achieve the desired goal of increasing recovery it is vital to tackle this stigma through a wide-ranging anti-stigma campaign, such as that which has successfully changed attitudes to mental health. This will take time but will be essential for effective delivery of much of the Drug Strategy.

Key Point 10

Disinvestment, fragmentation and marginalisation pose threats to the continued success of drug policies. It is important that drug issues continue to be highlighted and championed both at the national and local level, and that we deal with drug issues with a focused, integrated and evidence-based approach.

Key Point 11

Stigma experienced by recovering drug users is a fundamental barrier to delivery of the Drug Strategy aims. A campaign should be developed to address this.

[42] Appendix 8: UKDPC, *Drug enforcement in an age of austerity,* Oct 2011 (http://www.ukdpc.org.uk/resources/Drug_related_enforcement.pdf)

[43] Appendix 9: UKDPC, *Getting Serious About Stigma: the problem with stigmatising drug users*, Dec 2010 (http://www.ukdpc.org.uk/publications.shtml#Stigma_reports)

Rethinking how we make Drug Policy

The independence and quality of expert advice which is being given to the government

Whether detailed consideration ought to be given to alternative ways of tackling the drugs dilemma, as recommended by the Select Committee in 2002 (The Government's Drugs Policy: Is It Working?, HC 318, 2001–02) and the Justice Committee's 2010 Report on justice reinvestment (Cutting crime: the case for justice reinvestment, HC 94, 2009–10).

24. Concerns have been raised about the pressures experienced by the ACMD, particularly concerning the timeframes under which they are required to act, and the shortage of resources available to them. This notwithstanding, we have broader concerns about the lack of evidence-based advice available to the government on all aspects of drug policy, beyond the ACMD's expert and scientific remit. The Omand Review of the ACMD in 2010 considered some of these issues, but we are concerned that it was limited by narrow terms of reference. It may also be noted that there appears to be a lack of responsiveness by governments to the advice that is received, whether provided by the ACMD (for example the rejection of advice about the classification of cannabis and ecstasy) or by other informed bodies. We note that many of the recommendations of the Home Affairs Committee's 2002 report on drug policy were not acted upon, and that there has been no explanation for why these were not taken up.

25. UKDPC has recently launched a review of the governance of drug policy; the findings from this will be available in autumn 2012. This study involves an international comparison of governance systems, in the UK countries and in a number of other countries. Our review covers such issues as: the nature and role of independent expert advice; the nature and contribution of the media and public engagement exercises; parliamentary accountability systems and the availability of robust evaluation, evidence and performance data.

26. We finish this submission with some reflections about the perennial debate as to whether the UK government should rethink its drug policy in more fundamental ways. Unfortunately this debate has become polarised, requiring people to be identified with one camp or the other. There has been much discussion and analysis in many countries about the wisdom of processing people who use or possess drugs for personal use though the criminal justice system. The UNODC and the EU have considered this and attention was drawn to various initiatives taken in such countries as Portugal, Czech Republic and the Netherlands to remove or relax the use of criminal sanctions for small amounts of drugs, both possession and production/supply. Some of the results have been disputed but at the least we draw one broad lesson from these developments, which is that change is possible without leading to significant increases in consumption or associated harms.

27. In the UK, warnings, cautions, small fines for small personal possession offences lower level penalties have been introduced in recent years, alongside the use of community justice interventions to steer those with drug-related offences into treatment programmes.

28. While the UK processes a substantial number of people for minor drug offences through the criminal justice system (there were just over 200,000 recorded drug possession offences in England & Wales in 2010/11,[44] the majority of which were cannabis warnings and cautions), given the scale and everyday prevalence of drug use (it is estimated that well over a million people in England and Wales used drugs at least once in the past year[45]) the risk of receiving any penalty is quite low. Nevertheless, the costs to individuals, their families and society, of applying these penalties are significant. It might be argued that the UK has been heading in the direction of decriminalisation for some time. Crucially, this has corresponded with a trend of overall reduced drug prevalence and especially of cannabis, along with a stabilisation of the numbers of those with drug dependency and addiction problems. We conclude this trend could be carried further with either the replacement of criminal penalties with civil sanctions or other actions for personal possession offences, as the ACMD has also suggested.

29. When it comes to examining whether to change control and regulatory systems for the production and supply of drugs, the evidence is much more ambiguous. There is no doubt, as the ex-head of UNODC has said, there are many unintended consequences that have stemmed from the international and parallel domestic drug control systems that have been built up over the past half-century. The costs of production and supply control are considerable and yet there remain vibrant and innovative drug markets. As with any market, supply and demand co-exist and normal economic rules apply. Strict control of supply through enforcement does place increased costs on illicit producers and suppliers and it is plausible that these additional costs reduce demand to some degree through the normal pricing mechanisms. This is as true for controlled drugs as it is for alcohol and tobacco. What is open to question is whether the public spending costs of this enforcement activity is balanced through benefits such as less demand on health care, improved productivity and tax receipts.

30. Unfortunately, there is little concrete evidence to support arguments on both sides. What must remain of concern is that the example of tobacco and alcohol control and regulation is not encouraging about what a possible increased commercialisation of production and supply could bring. Whether such a regime could be applied to very widely used drugs like cannabis remains unclear. At the moment, the only substantial example of change in the production and supply control regime is the case of the production and sale of medical marijuana through approved outlets in the US. As with decriminalisation of personal possession cases in other

[44] Chaplin et al *Crime in England and Wales, 2010/11(*2nd *edition)*. Home Office Statistical Bulletin 10/11, July 2011.
[45] Smith & Flatley *Drug Misuse Declared 2010–11*, Home Office Statistical Bulletin 12/11, July 2011.

countries, we conclude that change is feasible and consumption does not appear to have gone out of control. As to whether such change to the control and regulatory system would prove cost effective, in the absence of more robust and reliable data, we remain cautiously agnostic.

Key Point 12

The current system for provision of independent advice and analysis of the evidence for drug policy to inform the government, parliament and the public could benefit from review and reform.

Key Point 13

National and international evidence indicates that the current system of drug control produces negative unintended consequences, and that realistic alternatives exist that have the potential to address these without leading to significant new problems. These alternatives, such as the replacement of criminal sanctions for personal possession of controlled drugs with a system of civil sanctions, are worthy of serious consideration.

January 2012

Written evidence submitted by Mentor (DP060)

"Evidence regarding prevention is always welcome, but it still will not gain much funding."

Robert J Maccoun. The Implicit Rules of Evidence-Based Policy Analysis Updated[46]

Summary

Mentor believes it is the role of Government to promote drug education in schools and more widely, using programmes that have proven to be effective in achieving public health outcomes. Evidence shows such programmes deliver widespread benefits to the individual and to society.

- While prevention has been a consistent theme of recent drug policy there is little evidence of commitment to widespread implementation of effective programmes.
- There is increasing evidence that particular programmes and approaches to drug education can be effective in reducing substance misuse by young people.
- International cost benefit analysis shows that universal prevention could in the longer save $18 for every $1 invested.

Mentor would be delighted to give oral evidence on any aspect of our submission should the Committee feel this to be useful.

1. About Mentor

1.1 Mentor is a UK charity which believes that prevention is better than cure. We focus on protecting children from the harms caused by drugs and alcohol through evidence based programmes, inspiring them with choices to achieve their best as individuals and citizens, and working in partnership with schools, parents and carers and communities.

1.2 Unless otherwise stated, in this submission "drugs" refers to all drugs including medicines, volatile substances, alcohol, tobacco, "legal" highs, and illegal drugs.

2. Government Policy

"Education about drugs is vital and we should make sure that education programmes are there in our schools and we should make sure that they work."

David Cameron, March 2011[47]

2.1 While prevention and education has long been recognised in government strategies there has been a failure to invest in researching what works and implementing evidence based programmes.

2.2 For example, the previous government's response to the Committee's 2002 report, "*The Government's Drugs Policy: Is It Working*?" states:

> *"Education works. Credible drug education and information helps young people understand the risks and dangers of drug misuse and develop the confidence to protect themselves. It plays an essential part in preventing young people from becoming problematic drug users."*

[46] Maccoun, R, The Implicit Rules Of Evidence-Based Policy Analysis, Updated, Addiction 105: 1335–1336. doi: 10.1111/j.1360–0443.2010.02936.x

[47] Interview with Al Jezeera, http://bit.ly/uISf2Z

2.3 The current government's drug strategy, "Reducing demand, restricting supply, building recovery", states:

> *"All young people need high quality drug and alcohol education so they have a thorough knowledge of their effects and harms and have the skills and confidence to choose not to use drugs and alcohol."*

3. Government Spending on Drug Prevention

3.1 In 2006–07, school based primary prevention spending for children and young people was about 0.04% of the total spend on health.[48] This included support for the National Healthy School programme, which has since been cut.

3.2 Nationally, the UK annual reports to the European Monitoring Centre for Drugs and Drug Addiction reveal that public expenditure on drugs classified as "education" decreased from £5.4 million in 2006–07 to £4.2 million in 2007–08, £4.1 million in 2008–09, £3.9 million in 2009–10 and to £0.5 million in 2010–11.[49]

3.3 The median local authority budget for substance misuse services (which focuses on specialist treatment) is £3 per capita population of under 18s.[50]

3.4 In addition, central government support for the national Continual Professional Development training for drug education has been cut, and the Tellus survey (which collected school level data on young people's drug use amongst other health and well-being measures) has been stopped.

4. Universal drug prevention: not very universal

"Drug education needs to be consistent. [Otherwise it is] cheating young people out of the [opportunity] to make a decision which can have lifelong impact".

Mentor Youth Advisor, 15 years

4.1 Ofsted has found drug education to be one of the weaker aspects of PSHE, finding that it can suffer from a lack of continuity and from being delivered by non-specialist teachers with insufficient support and training.[51]

4.2 In a recent mapping study of PSHE education (Formby et al., 2011), drugs, alcohol and tobacco was found to be covered once a year or less by at least 60% of schools.[52]

4.3 An in depth piece of research with secondary school pupils and teachers found that 70% of pupils could not recall receiving drug education since primary school; while teachers "recognised that schools' drugs policies were rarely implemented in practice and that drugs education was not a priority."[53]

4.4 Around a third of local authorities responding to a National Health Education Group survey in early 2011 said they would not be actively supporting drug education in schools. Just two-fifths were confident that they would be, with the remainder unsure.[54] Data was collected in early 2011 from 79 of 152 local authorities.

5. Evidence for drug prevention

5.1 Research is increasingly clear that universal drug prevention programmes in schools can have a cost effective impact on the most common substances used by young people: alcohol, tobacco and cannabis.[55]

5.2 The approaches which appear to be most effective are generic rather than substance-specific, and based on understanding social influences and developing life skills. These include a normative education component: correcting misperceptions about how common and acceptable substance misuse is among the young people's peer group. They also teach interpersonal skills to help handle situations where alcohol or drugs are available. Interactive learning seems to be necessary for success, with more didactic methods being less effective.

5.3 Examples with a strong evidence base include the *Life Skills Training* programme, developed in the United States and *Unplugged*, which was tested in a large-scale evaluation across several European countries.

---

[48] http://www.mentoruk.org.uk/2011/11/prevention-expenditure-in-england/

[49] UK Drug Situation: UK Focal Point on Drugs 2011 Edition, Centre for Public Health, Liverpool John Moores University, UK, Dec 2011, Annual Report to the European Monitoring Centre for Drugs and Drug Addiction.

[50] Section 251 Benchmarking tables of LA planned expenditure: 2011–12.

[51] Ofsted (2010) Personal, social, health and economic education in schools. Ofsted.

[52] Formby, E, Coldwell M, Stiell B, Demack S, Stevens A, Shipton L, Wolstenholme C, Willis B (2011) Personal, Social, Health and Economic (PSHE) Education: A mapping study of the prevalent models of delivery and their effectiveness. Department for Education.

[53] Adam Fletcher, Chris Bonell, Annik Sorhaindo, "We don't have no drugs education": The myth of universal drugs education in English secondary schools?, International Journal of Drug Policy, Volume 21, Issue 6, November 2010, Pages 452–458, ISSN 0955–3959, 10.1016/j.drugpo.2010.09.009.

[54] http://www.drugeducationforum.com/index.cfm?PageURL=blog&ArticleID=7988&ArticleMonth=

[55] James, C. (2011) Drug prevention programmes in schools: What is the evidence? Mentor UK.

5.4 Young people who are disengaged from school are at very high risk of substance misuse. Another type of intervention that has been successful focuses classroom management to reduce this risk. One of the most striking examples is the "Good Behaviour Game". This programme which is aimed at primary school pupils does not discuss drugs or alcohol. However, by keeping children engaged and improving behaviour in the classroom, it can significantly reduce later anti-social behaviour including problematic drug use, as measured at age 19 or 20.[56]

6. Approaches that are Ineffective

6.1 It is important to be clear about which prevention approaches the research evidence so far shows are not effective in reducing drug use among young people. These include fear-based approaches and programmes which only provide information without considering skills, values or perceptions of peer norms. Interactive teaching also seems to be necessary for success, with more didactic approaches generally unsuccessful.

6.2. Mentor is also concerned about the use of ex-drug users in classroom sessions. International evidence suggests that where they give talks to pupils without an evidence based programme, the session can have significant unintended consequences. An Israeli study found that this approach lead to a 4% increase in the proportion saying they were "eager" to use drugs, and a fall of 9% in those saying they would not use cannabis because it might lead to other drugs.[57] This is particularly worrying given the current drug strategy's commitment to using those in recovery to deliver prevention activities in schools.

7. Need for Guidance/Database

"It is not the role of Government to dictate decisions that are best made locally by professionals, so the Department does not issue guidance to local authorities on the commissioning of drug education programmes."

Sarah Teather, Hansard[58]

7.1 The government aims to promote local decision-making with schools being given more autonomy. Many external organisations offer to assist them with drug education, but schools currently lack national guidance as to which models are effective and which may even be counterproductive.

7.2 There are examples from other countries which could provide a useful model. In Canada, for example, detailed guidance can be found in the Canadian Standards for Youth Substance Abuse Prevention. Separate standards cover school, community and family-based programmes, as part of a five-year youth drug prevention strategy.[59]

7.3 In particular, schools and commissioners may value guidance on evidence-based drug prevention programmes. In the United States, the Substance Abuse & Mental Health Services Administration hosts a database on evidence-based prevention programmes which can be accessed by school administrators and others in order to choose the programme that may be right for their school (http://nrepp.samhsa.gov/). Another source of information for US commissioners is the Blueprints project at Colorado University mission which identifies evidence-based and promising violence and drug prevention programs (http://www.colorado.edu/cspv/blueprints/index.html).

7.4 In the UK, the Social Research Unit at Dartington is currently adapting a US model which calculates the return on public investment from evidence-based prevention and intervention programmes and policies.[60]

7.5 We welcome the commitment in the government's Positive for Youth statement to a set of standards for evidence based youth programmes, commissioned from the Centre for the Analysis of Youth Transitions.

8. Cost-effectiveness

"When benefits are measured as public sector costs saved, there is evidence that the following interventions are cost-effective... school-based programmes to prevent illicit drug use (specifically, life skills training)..."

Health England, 2009[61]

8.1 Drug misuse—legal and illegal—represents a significant public health burden with additional costs to society. PricewaterhouseCoopers has estimated the additional costs to society incurred by a problematic drug user over their lifetime, in comparison with the average person, to be over £800,000.[62]

---

[56] Foxcroft D R, Tsertsvadze A. Universal school-based prevention programs for alcohol misuse in young people. *Cochrane Database of Systematic Reviews* 2011, Issue 5. Art. No.: CD009113. DOI: 10.1002/14651858.CD009113.

[57] Israelashvili M, The Paradox of Realism in exposing students to ex-addict, presented at the European Society for Prevention Research http://bit.ly/ttNqOD

[58] Hansard, 13 December 2011 http://bit.ly/vkKUa1

[59] http://www.ccsa.ca/ENG/PRIORITIES/YOUTHPREVENTION/Pages/default.aspx

[60] http://www.dartington.org.uk/sites/default/files/WSIPP%20Project%20Summary_0.pdf

[61] Prevention and Preventative Spending, Health England Report No. 2, Health England 2009.

[62] PwC (2008) Review of Prison-based Drug Treatment Funding, London: Ministry of Justice.

8.2 Cost-effectiveness calculations for drug prevention programmes are mostly based on avoiding or delaying use of alcohol, tobacco, and/or cannabis, which are by far the most widely used drugs among young people. For example, a study on cost-effectiveness by the US Department of Health and Human Services concluded that national implementation of an effective programme which cost $220 per pupil could in the long term save $18 for every $1 invested (Miller and Hendrie, 2009).[63]

9. Legal vs Illegal Drugs

9.1 We believe that to reduce drug-related harm in society, it is rational to consider legal drugs alongside illegal ones. Among both adults and young people, the use of alcohol and tobacco is more widespread than any other drug, and dependence can occur with both legal and illegal substances.

9.2 Drug education in the National Curriculum reflects this, starting in primary schools with an understanding of the proper use of medicines, then the effects of drugs such as alcohol and tobacco. While young people need to understand the law around drugs, they should also be given realistic information about the effects of both legal and illegal drugs. Underpinning this should be a focus on generic drug prevention based on skills and values since evidence suggests that this is much more effective than focusing on knowledge of specific drugs.

9.3 In recent years, the emergence of novel psychoactive substances has posed a challenge to education and prevention work. The example of mephedrone shows that the use of new drugs can rapidly spread amongst a proportion of young adults. There is a widespread misperception that untested drugs will be safer than those whose dangers are known. The recent report from the Advisory Committee on the Misuse of Drugs recommended that these substances be included in drug education in schools, even in the latter stages of primary education. Developing general health literacy and supporting healthy decision making was seen as key by the Committee.[64] We endorse this recommendation.

10. Conclusion

10.1 Considerable energy and resources are devoted to improving the delivery and outcomes for drug treatment. In our view this is entirely welcome. However, it is not sufficient.

10.2 Despite significant falls in the numbers of people using drugs, the number of problem drug users appears to have remained static over the last five years, with estimates putting the numbers at over 320,000.[65, 66] In our view this should not be a surprise to policy makers, given, as we have shown throughout our submission to the Committee, the lack of sustained action to invest in preventing drug misuse.

10.3 Until we do more to provide every child in the UK with the information, skills and resilience to make informed decisions about drugs, we do not believe the number of problem drug users will shrink significantly, and the cost to the individual and to society will continue to grow.

10.4 Mentor is already familiar with programmes that have been trialled and evaluated and can reduce the likelihood of 5–15 year olds becoming the drug and alcohol problem users of tomorrow, bringing with them the massive social and financial consequences we all seek to address.

10.5 We know there would be multiple benefits in introducing such programmes to mainstream education: they would help children get a better education and become more productive members of society; fewer lives would be ruined by problematic drug use; and health and criminal justice costs could be significantly reduced.

10.6 Mentor is at the hub of research into youth intervention programmes. We know the universities, the programmes, the studies and the trials. what has worked, what has failed, and what is promising. The pool of good evidence based programmes is not vast, but they do work and the fact that they are there, sitting on shelves, waiting to help solve this problem is an terrible indictment of successive government policies. It is an admission that, to date, we are failing to bring the best available evidence based programmes into the classroom where teachers are ready to teach them so children can have a degree of protection they currently do not have. We urge the Committee to do everything in its power to remedy this situation.

January 2012

---

[63] Miller, T R and Hendrie, D (2009). Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis. Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

[64] Advisory Council on the Misuse of Drugs (2011) Consideration of the Novel Psychoactive Substances ("Legal Highs").

[65] The Health and Social Care Information Centre (2011) Statistics on Drug Misuse: England, 2011.

[66] National Treatment Agency for Substance Misuse (2010) National and regional estimates of the prevalence of opiate and/or crack cocaine use 2008–09.

Written evidence submitted by the National Treatment Agency for Substance Misuse (DP062)

Addressing the following terms of reference, from a drug treatment perspective:

1. The extent to which the 2010 Drug Strategy is fiscally responsible and grounded in science, health, and security.
2. The criteria used to measure the efficacy of drug policy.
3. The extent to which public health considerations play a role in drug policy.
4. The impact of the transfer of NTA functions to Public Health England on treatment provision.

SUMMARY

— Drug treatment and recovery services in England have a successful track record of reducing crime and protecting public health, and are increasingly enabling more people to overcome dependency and sustain their recovery.

— Bringing together responsibility for tackling drug dependency and severe alcohol dependency, at both national and local level, will be welcomed by the field, since many drug users have alcohol problems and service providers treat both sets of clients.

— Locating commissioning with local authorities also offers the exciting prospect of integrating treatment with the local factors that sustain recovery—access to jobs, stable homes, education opportunities and children's services.

— However, the principle of local authority discretion means there are risks that not every area may focus on improving employment opportunities or housing need, and some may even chose to divert resources from tackling drug dependency and reducing crime to other public health priorities.

BACKGROUND ON THE NTA AND THE DRUGS SYSTEM

— The NTA was created as a Special Health Authority in 2001 to ensure that treatment services in England delivered on both the public health and criminal justice agendas, reflecting the interests of the Department of Health (DH), responsible for funding the NHS as well as public health services, and the Home Office, the lead Whitehall department on drugs policy and crime reduction.

— The commissioning of drugs services is undertaken locally by partnerships representing Primary Care Trusts, local authorities and criminal justice interests (police and probation). The NTA's role is to allocate central funding, provide support and guidance to local areas, and measure outcomes to assure value for money.

— The NTA is accountable to government for the objectives agreed in its business plan every year. Given our specific role in supporting local drugs systems, the Home Office has agreed to us providing a separate submission to the Home Affairs Select Committee.

1. *The evidence supporting the government's approach to tackling drug dependence*

1.1 Investment in drug treatment services has been a significant element in successive drug strategies since the first needle and syringe exchanges were piloted in 1986 by Margaret Thatcher's administration.

1.2 Drug treatment is now available to anyone who needs it in England, and 96% of clients start treatment within three weeks. The average wait has fallen from nine weeks in 2002 to five days. About one-third of clients are referred via the criminal justice system.

1.3 The evidence base for drug treatment was evaluated by the National Institute for Health and Clinical Excellence (NICE), and its recommendations enshrined in NICE guidance and UK Clinical Guidelines (2007). These promote a range of therapeutic interventions—involving psychosocial, pharmacological and social approaches—to help people overcome addiction and reduce the physical and psychological harms it causes.

1.4 The Home Office estimates that crimes committed by drug dependent offenders (mainly heroin and/or crack users) cost society £13.9 billion a year. In addition NICE estimates the lifetime NHS bill for every injecting drug user is £480,000.

1.5 Research indicates that retaining an individual in treatment for 12 weeks or more provides lasting benefit for them, their families and the community. It also shows that treatment breaks the link between crime and drug dependence, leading to significant reductions in offending.

1.6 John Major's government commissioned the National Treatment Outcomes Research Study (first published 1998) which showed that acquisitive crime by drug dependent offenders halved after entering treatment, and was subsequently maintained.

1.7 Ten years later the Home Office commissioned a follow-up, the Drug Treatment Outcomes Research Study (DTORS, 2009), which confirmed that offending halved after entering treatment, as did illegal drug use.

1.8 The NTA commissioned a study to cross-check Police National Computer records with drug treatment data and found that on average offending nearly halved once prescribing treatment began (2008).

1.9 A National Audit Office (NAO) review in 2010 endorsed the DTORS value-for-money finding that every £1 spent on drug treatment saved the taxpayer £2.50 in reduced crime costs and improved health.

1.10 The NAO also found that the cost of funding each adult in effective treatment (12 weeks or more) fell 17% in real terms over five years to £3,000 per person in 2008–09.

1.11 Drug treatment has a high level of public support. Surveys show 75% believe drug treatment is a sensible use of money; 80% think it makes society better and safer; and 66% say they fear crime would increase without it.

2. *The efficacy of drug treatment and how it is measured*

2.1 Four out of five people in drug treatment in England are heroin and/or crack addicts. Research by Glasgow University estimated the prevalence of addiction to these drugs fell from a peak of over 332,000 in 2005–07 to 306,000 in 2009–10. This reduction was most marked among younger adults.

2.2 Lower prevalence is feeding through into reduced demand for treatment. The total number of adults in treatment in 2010–11 was 204,473, compared to a peak of 210,815 in 2008–09, and is expected to drop below 200,000 in 2011–12. Waiting times remain low, so we are confident the fall reflects demand, not any shortfall in services.

2.3 Data collected from treatment providers by the National Treatment Monitoring System (NDTMS) is validated by the National Drug Evidence Centre at Manchester University for publication as National Statistics. This data shows fewer drug users coming into treatment, but more recovering from addition, and more getting over their addiction quickly.

2.4 The number of adults newly entering treatment for heroin and crack has fallen by 10,000 in two years (from 62,963 to 52,933). The reduction is fastest in younger age groups, with the number of new 18–24 year-old heroin and crack users halving over five years. As the drug-using population ages, the over 40s have become the largest age group starting treatment.

2.5 The 2010 Drug Strategy set two aims: to reduce illicit and harmful drug use, and to increase the numbers recovering from dependency. Treatment and recovery services contribute indirectly to the former, and directly to the latter.

2.6 The previous strategy (2008) measured activity, with a Public Service Agreement target (that was achieved) to increase by 3% the numbers in effective treatment for 12 weeks or more, in order to reflect increased investment.

2.7 In line with the recovery ambition of the new strategy (2010), the focus of measurement is now on outcomes (through individuals completing treatment free of dependency). The NTA has sought to focus local systems on improving performance using this metric.

2.8 The numbers successfully completing treatment free of dependency doubled from 11,208 in 2005–06 to 23,680 in 2009–10. There was a further 18% increase in 2010–11 to 27,969, and NTA figures for the first six months of 2011–12 suggest this improvement is being sustained.

2.9 A retrospective analysis in the most recent national statistics found that of the 255,556 unique individuals who started treatment for the first time since 2005, 71,887 (28%) left free of their dependency and did not subsequently re-present to treatment services.

2.10 Further analysis by the NTA to be published shortly will show the proportion of unique individuals starting treatment for the first time in the past three years, leaving free of dependency, and not returning to services, was 33%.

2.11 This rate of successful completion and non-return is accepted across government as a key benchmark for measuring recovery. It will be one of the national outcome indicators by which local authorities will be held to account by Public Health England from 2013.

2.12 The rate of completion and non-return is also one of the agreed outcomes for the eight local areas which are piloting methods of Payment by Results for drugs recovery. The other measureable outcomes are reduced drug use, and reduced offending.

2.13 From April 2012, a significant proportion (20%) of the central pooled budget for drug treatment (approximately £400 million) will be allocated to local partnerships on the basis of their rate of completion and non-return, in order to incentivise them to further improve recovery outcomes.

3. *The extent to which public health considerations should play a leading role in developing drugs policy*

3.1 Drug treatment has been a key aspect of public health policy since the mid-1980s, when the Thatcher government responded to the assessment of the Advisory Council on the Misuse of Drugs that the transmission of HIV via injecting drugs represented a bigger threat to public health than drug misuse itself.

3.2 Since then treatment services have expanded to include protecting the public and drug users from blood-borne viruses and injecting risks, preventing overdose death by promoting safer practices amongst users, and stabilising troubled families to protect children and vulnerable adults.

3.3 The Glasgow University prevalence research calculated the number of injecting drug users in England fell by a quarter from a peak of 137,141 in 2004–05 to 103,185 in 2009–10. NDTMS data shows a 10% fall in the proportion of new treatment entrants currently injecting over the last six years.

3.4 The UK now has one of the lowest rates of HIV amongst injecting drug users in the western world. The overall incidence of hepatitis C among current injectors in England (around 45%) is one of the lowest in Europe.

3.5 Drug-related deaths increased steadily in England during the 1990s to 1,697 in 2001, then fell as treatment expanded. Despite a small rise in the late 2000s the 2010 figure was 1,625. The flat trend is reassuring as the injecting population is ageing and becoming more vulnerable.

3.6 The 2010 Drug Strategy introduced a new emphasis on building recovery in communities—not just tackling the symptoms and causes of dependence, but enabling former addicts to get off drugs for good and successfully reintegrate into society.

3.7 One vital aspect of this agenda is the recognition that to sustain recovery and form positive relationships, people need something to do and somewhere to live. The importance of jobs and houses was acknowledged in the roles of the Department for Work and Pensions and the Department for Communities and Local Government on the Inter-Ministerial Group on Drugs.

3.8 The other aspect of the recovery agenda was a drive to transform the treatment system into a recovery system, so individuals became free of dependence, no longer needed to offend, stopped harming themselves and their communities, and contributed to society.

3.9 Local systems are already reconfiguring to deliver recovery-orientated treatment; with greater emphasis put on enabling individuals to overcome dependency, and on working with the support services needed to achieve full recovery. Providers who deliver recovery outcomes are gaining market share, but those unable to adapt are shrinking.

3.10 Local treatment systems are forging new relationships with mutual aid networks like Narcotics Anonymous. New pathways between treatment and recovery support are being established, and new models of intervention are prospering, such as SMART Recovery which delivers peer-led support in partnership with conventional treatment providers.

3.11 To support the recovery agenda, the NTA established an expert group of clinicians and practitioners to review prescribing practice and ensure that those clients receiving methadone maintenance treatment or similar substitutes for heroin addiction were getting adequate opportunity to overcome their addiction.

3.12 In July 2010 the interim report of the expert group identified a check list for clinicians to audit their local prescribing services to ensure they are appropriately recovery-focused.

3.13 The NTA also set up an industry-wide body, the Substance Misuse Skills Consortium, to work collaboratively with NHS and voluntary sector providers to promote the specialist skills required by their 10,000 employees to deliver high-quality services.

4. *The impact of the transfer to Public Health England*

4.1 From April 2013, full responsibility for commissioning drug and alcohol treatment and recovery services will move from existing partnerships to local authorities, as part of a new duty on councils to promote the health of their local populations.

4.2 This role will be supported by Public Health England (PHE), the authoritative national voice for public health, providing specialist skills, expert services, and expertise, information and advice, based on the best available evidence of what works.

4.3 As set out in the white paper *Healthy Lives, Healthy People* (2010), the NTA's critical functions will transfer to PHE in April 2013, contributing to its overall mission to protect and improve the health and wellbeing of the population, and to reduce inequalities in health and wellbeing outcomes.

4.4 Part of PHE's role is to help authorities discharge their responsibilities in a way which reflects both local priorities and the interest of the Secretary of State for Health and other government ministers. How this balance is struck will become apparent as PHE takes shape during 2012.

4.5 Meanwhile the NTA is working with the DH, local authorities and the public health community to identify the roles that will transfer to PHE and establish a smooth transition process, while continuing to ensure the effectiveness of the existing system during 2012–13.

4.6 Bringing together responsibility for tackling drug addiction and severe alcohol dependency, at both national and local level, will be welcomed by the field, since many drug users have alcohol problems and service providers already treat both sets of clients.

4.7 Locating responsibility for commissioning drug and alcohol treatment with local authorities, under the leadership of local Directors of Public Health, also offers the exciting prospect of integrating treatment with the local factors that sustain recovery—access to jobs, stable homes, education opportunities and children's services.

4.8 However, the principle of local authority discretion means there is a risk that not every area will use their new powers to make further progress in securing local employment opportunities or tackling local housing needs.

4.9 The local public health system will be co-ordinated with NHS and social care services through new Health and Wellbeing Boards. It is vital that the Boards also establish effective working relationships with existing Crime Reduction Partnerships and new Police and Crime Commissioners.

4.10 The current central funding for drugs (the Pooled Treatment Budget) will be subsumed into a wider ring-fenced public health budget. Alongside the risk that drug spend could be diverted to other local priorities, there is a risk that reduced priority may be given to the crime reduction benefit of treatment.

4.11 Over the past year, the commissioning of integrated treatment in prisons and the community has been aligned to improve the continuity of care and reduce the risk of overdose, relapse and reoffending among ex-prisoners. From 2013 responsibility for prison treatment will move to the NHS Commissioning Board, posing a potential threat to these arrangements.

January 2012

Supplementary written evidence submitted by the National Treatment Agency for Substance Misuse (DP062a)

1. *Methadone and buprenorphine in the NICE clinical guidelines?*

1.1 Prescribing the opiate substitute medicines methadone or buprenorphine accompanied by appropriate psychosocial interventions is the front-line treatment for heroin dependent people in the UK.

1.2 This is based on NICE's conclusion that both medicines are clinically effective and cost effective.[67]

1.3 Recently an expert review, chaired by Professor John Strang of the National Addiction Centre, urged clinicians to look at ways of improving the recovery orientation of opioid substitution treatment.[68]

1.4 The NICE recommendation you highlight is: "*If both drugs are equally suitable, methadone should be prescribed as the first choice*." NICE concluded that methadone was more cost effective following an extensive systematic review of evidence.

1.5 They also said that the decision about whether to use methadone or buprenorphine in opioid substitution should be made on a case by case basis, taking into account a number of factors including the client's history of opioid dependence and an estimate of the risks and benefits of each treatment.

2. *Suboxone*

2.1 In the UK, the first line pharmacological treatments for opiate dependence should be methadone and buprenorphine, in line with the NICE guidelines. If a clinician feels that it is appropriate to prescribe buprenorphine, but there is a significant risk of the client injecting buprenorphine, they may decide to prescribe Suboxone.

2.2 The clinical rationale for using Suboxone is to prevent users from injecting the drug (ie misusing it). If taken orally as intended, the naloxone element of the drug (which precipitates withdrawal in opiate dependent patients) does not diminish the effect of buprenorphine (which prevents cravings). If it is injected (ie misused), the naloxone element will trigger withdrawal—an effect that is meant to discourage abuse of this medicine.

2.3 The 2007 Clinical Guidelines concluded that "*it is too early to indicate the relative positions of these two versions of buprenorphine.*" NICE, in its Technology Appraisal of methadone and buprenorphine, did not mention Suboxone, although it might be argued that as Suboxone is a version of buprenorphine, with an added antagonist, it could be governed by most of the same considerations as buprenorphine (without naloxone). The NTA is aware that some partnerships have decided to prescribe Suboxone for all clients for whom buprenorphine is indicated.

---

[67] Methadone and buprenorphine for the management of opioid dependence, NICE January 2007.

[68] NTA (2012) Medications in recovery Re-orientating drug dependence treatment http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf

3. *What percentage of those on OST would be prescribed methadone and what percentage would be prescribed suboxone?*

3.1 This data is not centrally collected. The National Drug Treatment Monitoring System (NDTMS) collects information on the number of people receiving substitute prescribing interventions for substance misuse in England, but does not distinguish between methadone and other drugs such as buprenorphine.

November 2012

Written evidence submitted by the Serious Organised Crime Agency (DP065)

1. This submission sets out the Serious Organised Crime Agency's (SOCA) written evidence to the Committee's inquiry into drugs policy. It specifically seeks to address the following areas:

— the availability of "legal highs" and the challenges associated with adapting the legal framework to deal with new substances; and

— whether the UK is supporting its global partners effectively and what changes may occur with the introduction of the National Crime Agency.

2. This submission supplements the Home Office's submission which addresses the full range of questions the inquiry is set to explore.

3. As set out in the SOCA Annual Report and Accounts 2010–11 one of SOCA's strategic priorities is the dislocation of criminal markets where SOCA has the lead responsibility for UK law enforcement (as well as contributing to the dislocation of those criminal markets where other agencies have the lead responsibility). This includes the drugs market. SOCA works closely with intelligence and law enforcement agencies both in the UK and overseas, as well as government departments, agencies and the private and third sector in so doing. SOCA's strategic priorities are set out in full at Annex A.

The availability of "legal highs" and the challenges associated with adapting the legal framework to deal with new substances

4. The European Monitoring Centre for Drugs and Drugs Addiction, (EMCDDA) state "Recent developments allowing organic chemicals to be synthesised cheaply, combined with the information exchange and marketing possibilities afforded by the Internet, have led to new psychoactive substances becoming widely available throughout Europe at an unprecedented pace. The speed at which new psychoactive substances can appear and be distributed now challenges the established procedure of passing legislation to control a substance in each country. Suppliers are making substantial profits during the months required to control a new substance under criminal law and while the risks associated with its use have yet to be determined."[69] SOCA, as part of a wider initiative to disrupt criminal activity, has taken action against UK based websites that offered mephedrone or naphyrone for sale following their classification as Class B drugs in April and July 2010 respectively. In 2010–11 over 120 websites were closed down as a result of SOCA action, causing disruption of the supply of these drugs.

5. SOCA, the Home Office and forensic providers are working together to gather more information about the range of psychoactive substances (both controlled and "legal") that are traded in the UK. Under the arrangements for bringing a drug under control of the Misuse of Drugs Act 1971 (MDA), the Advisory Council for the Misuse of Drugs undertakes a full assessment of a drug's medical and societal harms, which can necessarily take between three and six months. However, temporary class drug orders provide a pragmatic and effective legislative tool to ensure that these potentially harmful drugs do not get a foothold in the UK's drug market and cause serious harm to individuals, communities and businesses.

6. It is important that the decision to invoke a temporary class drug order is made at the right time and on the best possible evidence. Work is therefore in progress to align and integrate existing early warning systems and to develop forensic responses and intelligence collection plans on the threat from newly identified substances. Although quantifying the scale and assessing the consequences of misuse of these emerging substances remains problematic, SOCA and partners are seeking to improve understanding of the threat in order to inform decision making still further and enhance the effectiveness of the broader multi-agency response.

7. The UK has also engaged competent authorities within source countries and sought international leverage when a substance has been banned in the UK. For example, China has increased its controls of on-line sales by making mephedrone a controlled substance.

8. Following the classification of mephedrone in the UK as a class B drug under MDA many internet based traders ceased openly offering the substance for sale and the wholesale kilogram price in the UK increased.As well as traditional methodologies for smuggling illicit substances into the UK, mis-description of substances is now commonly detected at point of entry to the UK as overseas suppliers attempt to circumvent UK border controls. This has included the growing tendency for suppliers to use "European hubs"' to ensure that "parcel/

[69] EMCDDA: Responding to New Psychoactive Substances 2011.

courier post" enters the UK from a European country rather than from source countries such as China, a displacement of activity that renders the profiling of such importations for interdiction less effective.

Whether the UK is supporting its global partners effectively and what changes may occur with the introduction of the National Crime Agency

9. Organised crime does not recognise national, international or jurisdictional boundaries. But, while it is a global problem, its effects are felt in communities across the UK, from significant social and personal harm, through to financial costs to the taxpayer, businesses and the government.

10. International collaboration will continue to be vital for the response to organised crime and wider national security for the following reasons:

— Force multiplier: work overseas enables the UK to leverage local intelligence and law enforcement assets to counter shared threats.

— Value for money: upstream interdiction tackles the problem at source with maximum effect results (focus on high value targets, disruption to production facilities, multi-tonne seizures).

— Collaboration: to combat organised crime can provide common ground with other nations.

11. The UK continues to work closely with partners in the EU and more widely to disrupt drugs trafficking routes. Such upstream efforts form part of the "golden thread" of law enforcement in the UK—the connectivity from local, neighbourhood policing through to international work—and allows end-to end disruption of organised crime groups. This approach, with strengthened links between domestic and international enforcement agencies, is reflected in the Drugs Strategy, published by the Home Office on 8 December 2010.

12. Law enforcement activity in the UK and overseas by SOCA and its partners has had a demonstrable effect on the drugs market in the UK. In late 2010 and early 2011 shortages of heroin were reported in several locations across the UK. Wholesale prices for heroin have increased throughout the supply chain, making it more difficult for criminals to operate their businesses. In the UK in 2009–10 the wholesale price of one kilogram of heroin was around £15–17,000. There is now evidence that, when they can source it, dealers are prepared to pay £20,000 and upwards, and there are reports that some organised crime groups are trading high-quality heroin for around £40,000 per kilogram. Street purity fell from 46% in September 2009 to around 32% in September 2010, with suppliers adding more cutting agents to maintain their levels of profit. The heroin route via Turkey has been squeezed by multi-agency international activity against the main traffickers, which has resulted in an increase in the direct trafficking of heroin via Pakistan. SOCA and UKBA anticipated and reacted to this and for example SOCA increased its operations against heroin trafficking from Pakistan by 50% within three months.

13. In addition, wholesale prices for cocaine remain at historically high levels and average purity at dealer level has also fallen sharply from 62% in 1999 to around 20%.

14. Examples of the SOCA's support to global partners

EU

— The EU-funded Maritime Analysis and Operation Centre (MAOC (N)) based in Lisbon, coordinates the law enforcement and military assets of EU partner nations (UK, Italy, Ireland, Netherlands, France, Portugal and Spain) in joint counter-drugs work in the Atlantic and off the coast of West Africa. MAOC (N) has facilitated the seizure of more than fifty tonnes of cocaine and over forty-five tonnes of cannabis since 2007. In June 2011, acting on intelligence provided by SOCA and the French Customs Investigative Service (DNRED), UKBA officers at Southampton seized 1.2 tonnes of 90%-pure cocaine from a pleasure cruiser from South America which was being transported by container ship from the British Virgin Islands to the UK en route to the Netherlands. A Dutch law enforcement investigation was then carried out, assisted by SOCA and UKBA, to identify the group attempting to traffic the cocaine. Six arrests were made on 2 August 2011. Links with DNRED, the British Virgin Islands Police and MAOC (N) were crucial in this operation.

West Africa

— The SOCA-led International Liaison Unit (ILU) in Ghana is an international platform with a mixed European, Canadian and US membership, designed to help coordinate law enforcement activity and share operational or strategic intelligence. The platform in Ghana and the French led platform in Senegal allow for joint working, sharing of intelligence and a coordinated approach to capacity building.

— Capacity building in west Africa includes activity aimed at enhancing the ability of the authorities in that region to tackle drug trafficking. In June 2011, working in conjunction with the Gambian National Drug Enforcement Agency, SOCA discovered a hidden bunker behind a fake wall in a building that was being used as a large-scale cocaine distribution centre. This discovery led to the seizure of 2.1 tonnes of cocaine "bricks"—a record for west Africa, and worth more than £100 million at UK wholesale prices.

Turkey

— SOCA works closely with LE partners on the heroin route from Afghanistan to Turkey and onwards across Europe under the SOCA chaired multi-agency International Drugs Threat Reduction Board. The strong working relationship with the Turkish National Police has contributed to the imprisonment in Turkey of key figures involved in the trafficking of heroin through the country, towards Europe and into the UK.

— Close cooperation between SOCA and the Turkish National Police (TNP) resulted in the arrests of four organised crime group members in Turkey, seven arrests in the UK, the seizure of 100kg of heroin following a UK controlled delivery, the seizure of a further 50kg in a stash and the confiscation of £350,000. The Turkey-based OCG was responsible for transporting large quantities of heroin by airfreight from Iran directly to the UK. So far, three people have been convicted, with sentences totalling 58 years.

Afghanistan

— SOCA contributes to UK efforts to foster good governance, stability and security in Afghanistan and reducing the impact on the UK of the Afghan narcotics trade. SOCA activity in Afghanistan includes support and assistance to units of the Counter-Narcotics Police of Afghanistan (CNPA). This has delivered good operational results with seizures for the year 2011[70] by the SOCA mentored Intelligence and Investigation Unit (IIU) of the CNPA being over 3 tonnes of heroin and around 5 tonnes of opium. Examples of operational successes include the following:

  — In August 2011 following an investigation by the IIU, officers of the CNPA stopped a vehicle in the Western part of Afghanistan and seized 456 kg of crystal heroin destined for Iran which led to the arrest of one of Afghanistan's most prolific traffickers and many members of the network.

  — In September 2011 CNPA officers supporting an IIU operation seized 10,500 litres of acetic anhydride (AA), a vital precursor in the production of heroin, which had been smuggled into Afghanistan from Iran. That amount of AA costs over £3 million and is sufficient to produce some 5 tonnes of heroin hydrochloride.

Latin America

— Operational activity in Latin America in conjunction with law enforcement partners results in large seizures of cocaine and the arrest of significant traffickers engaged in the supply of cocaine to Europe and the UK. SOCA works closely with Law Enforcement partners in Latin America and the Caribbean, the latter which remains a significant transit route for cocaine ultimately destined for Europe and the UK. For example:

  — In October 2011, 24 members of an organised crime network were handed jail terms totalling more than 250 years for their roles in plots to smuggle up to 40 tonnes of drugs into the UK which included a significant amount of cocaine from Latin America. The complete dismantlement of the entire network was only possible because of joint working with a number of law enforcement agencies which included partners in Latin America.

15. The creation of the National Crime Agency (NCA) presents the UK with an opportunity to achieve a further step change in the response to organised crime. It will build on the capabilities, techniques and skills SOCA has developed in recent years enable further refinement of the understanding of organised crime and harmonise efforts across the law enforcement community. It will also ensure more law enforcement activity takes place against more organised criminals, at reduced cost, which is necessary given the size and scale of the problem.

16. The NCA will need to work with a wide range of partners, including other law enforcement agencies and government departments, the intelligence agencies, wider public and private sectors and partners overseas. To do this effectively it is necessary to be able to receive, share and manage data, and to be able to provide partners with reassurance that such data will be appropriately protected. The new approach of national tasking and coordination will bring greater coherence and provide reassurance over the reach and coverage of law enforcement efforts against organised crime.

Annex A

SOCA'S STRATEGIC PRIORITIES

— the dislocation of those criminal markets where SOCA has the lead responsibility for UK law enforcement and contributing to the dislocation of those criminal markets where other agencies have the lead responsibility;

— the systematic management, on a risk basis, of all SOCA Persons of Interest (PoIs) identified as involved in organised crime, causing harm to the UK, through effective information management and planned interventions;

— delivery of more law enforcement activity against more organised criminals, at reduced cost and securing criminal convictions against the most serious criminals; and

[70] All in-year figures are subject to validation at year-end.

— to support the seamless transition of SOCA into the NCA while maintaining the tempo of SOCA's operational activity.

January 2012

Supplementary written evidence submitted by the Serious Organised Crime Agency [DP065A]

LETTER FROM TREVOR PEARCE QPM, DIRECTOR GENERAL, SERIOUS ORGANISED CRIME AGENCY, TO THE CHAIR OF THE COMMITTEE, 10 AUGUST 2012

During my appearance before the Committee on the 10 July to give evidence on the Drugs Inquiry, I promised to write to you with information on a number of questions:

1. *Would your organisation be able to provide us of estimates as to the elasticity of demand for various illicit drugs*?

The recently published UNODC World Drug Report 2012 reported the positive effect of supply-side interventions on drug use: "One key effect of the drug control system, notably of supply control interventions, is the increase and maintenance of high prices above the equilibrium that would have been reached in a legal market. Thus cocaine and heroin retail for many times their weight in gold, while their potential legal price may be similar to that of coffee. This reduces, first of all, the initiation of drug use. Secondly, many empirical studies show that problem drug users respond to increases in purity-adjusted prices by reducing consumption levels. In addition, supply shocks generated by means of supply control interventions have been shown to produce substantial and sometimes long-term reductions in drug availability, purity, use and harm in consumer countries".

However, organised criminals operate like businesses and diversify, managing the risk they face from other criminals and law enforcement, including by placing themselves outside jurisdictional boundaries, changing commodity, changing supply routings and altering their modus operandi (including their communication methods). SOCA believes there is room for more drugs to come into the market if more supply routes become available. The fluid nature of drugs markets is also evidenced by the increasing demand for New Psychoactive Substances.

2. *To write to the Committee with details as to whether those that have left SOCA under the early exit scheme are allowed to be reemployed by the NCA*

I can confirm that the cost of the early exit scheme has been £8.7 million.

In respect of reemployment in the NCA, fair and open competition to vacancies within the NCA would allow any applicant to apply, including those who had left other Government departments and agencies, including SOCA, under approved early exit or release schemes. Pension scheme rules of approved early exit or release schemes would apply abatement rules.

3. *Money laundering and European banks*

One of the factors behind SOCA's approach of tackling the drugs trafficking close to source is that it can be more effective to take action before profit has been taken. Notwithstanding the success achieved in this area, as described to the Committee, the drugs trade offers organised criminals the opportunity to make substantial profits along the supply chain.

As I set out in my evidence to the Committee, the proceeds of the drugs trade are laundered across the entire supply chain with placement of proceeds taking place in source, transit and consumer countries. SOCA does not have any data on the overall value of money laundered through the banking sector.

The FATF Global Threat Assessment of Money Laundering and Terrorist Financing, produced in July 2010, through a project co-led by SOCA, highlighted some of the drivers behind laundering through the banking sector. It highlights:

> "The factor that drives criminals and terrorists to use the banking sector to transfer value for MUTF is their need to move funds securely, quickly and with the appearance of legitimacy. There is also a need to convert funds into various other products and to move funds away from predicate offences. Another identifiable driver is the need to move funds to where they may be needed f accessible including for the commission of more criminal activity...". I would welcome the opportunity to further show the Committee first-hand the skills and capabilities that SOCA will bring to the NCA, including those in respect of tackling the end-to-end supply chain and working with partners effectively overseas.

Trevor Pearce, Director General
Serious Organised Crime Agency

August 2012

Further supplementary written evidence submitted by the Serious Organised Crime Agency (DP065b)

1. The UK and Spain work closely together to reduce the threat from both British criminals that are resident in Spain and that posed to the UK from British organised crime groups in the region. Under Operation Captura, a joint SOCA and Crimestoppers initiative, cooperation between Spain and the UK has resulted in the arrest of 49 fugitives wanted in the UK. In addition, wider cooperation has resulted in the seizure of large quantities of drugs and money, which has contributed to making Spain less attractive to British criminals.

2. However, operational activity does not cease when arrests have been made. Such displacement often forces organised crime groups to alter their operating methods or change their physical location, therefore making themselves more vulnerable to law enforcement intervention. For example, it is known that law enforcement activity, targeting Class A drugs and associated criminal finances in Spain and the Netherlands has resulted in some British criminals relocating from these countries. SOCA-led activity continues to put pressure on organised crime groups through a number of approaches ranging from financial investigation through to more non-traditional techniques.

3. Despite law enforcement action and some consequential displacement of British criminals to other countries, there are still a large number of British criminals resident in Spain, some of which are wanted in the UK and may be residing under false identities. SOCA continues to work with Spanish law enforcement partners to target these individuals. The UK remains a key partner for Spanish law enforcement in tackling organised crime, due to the quality of support, extensive cooperation and the continued British criminal presence in Spain.

4. The presence of Eastern European organised crime groups is not only seen in Spain but also in other parts of Europe. It is not possible to quantify the extent to which this is directly linked to any displacement as a result of SOCA and Spanish law enforcement action against British criminals. However, it is the case that organised criminals are entrepreneurial, agile and resilient. They operate like businesses and do not respect regional, national or international boundaries, managing the risk they face from other criminals and law enforcement, including by changing commodity, location, changing supply routings and *modus operandi* according to opportunity and risk.

5. As organised crime is a global phenomenon, the response to it has to take place in an international context. For this reason SOCA has an international network of over 130 officers enabling operational reach across more than 150 countries. Our international work allows us to work with international partners in order to jointly address the problem of organised crime.

November 2012

Written evidence submitted by Tom Lloyd [DP070]

"I joined the police service to help people and catch criminals; arresting drug users does neither."

1. Personal Introduction

Chief Constable Cambridgeshire Constabulary 2002–05.

International Drug Policy Adviser Lead, Law Enforcement Project, International Drug Policy Consortium.

I was a police officer from 1974 to 2005. I achieved the rank of Commander in the Metropolitan Police Service and was the Director, Strategic Co-ordination at New Scotland Yard until January 2000 when I was appointed Deputy Chief Constable, Cambridgeshire Constabulary. I became Chief Constable in 2002 and retired in 2005 with over 30 years service.

I am an independent campaigner for drug policy reform. Since 2009 I have led the International Drug Policy Consortium's Law Enforcement project, engaging with senior law enforcement officials and others in various countries,[71] speaking at seminars and conferences and running drug policy courses for senior police officers.

2. Oral Evidence and Confidentiality

2.1 This is a very complex and wide-ranging subject so I would like to give oral evidence in support of this submission.

2.2 Nothing in my submission needs to be treated confidentially.

3. Executive Summary

3.1 This submission is neither an academic paper nor a list of facts and statistics. I am sure that the committee has access to relevant data from other sources; I would only be quoting data second-hand.

3.2 It is based on over 30 years police service at all ranks and subsequently on observations of drugs law enforcement in the UK and a number of countries around the world, meetings with users, recovering addicts, health and social workers in NGOs and government organisations, drug policy reformers, law enforcement

[71] Austria (UNODC), Brazil, Canada, Georgia, India, Malaysia, Mexico, Peru, Thailand, Turkey, Uruguay, USA.

officials of all ranks and politicians. I have arrested users, led operations against dealers and supervised complex drugs investigations as a very senior officer.

3.3 A key issue informing my approach is the reality that human beings like taking mind-altering substances. Efforts to prohibit this powerful behavioural trait have failed in the past and continue to do so. Managing rather than banning drug taking stands a much better chance of minimising harmful consequences.

3.4 My main conclusions are that law enforcement efforts to reduce the supply and consumption of drugs in the UK have failed, been very costly and have caused avoidable harm to individuals, institutions and society as a whole. In fact, they have probably caused more harm than good.

3.5 My view that we need a change of approach is shared by others in law enforcement and related professions in the UK and around the world.

3.6 I attach the "Rio de Janeiro Declaration", of which I am a co-signatory, for information.[72] I have noted in my travels that law enforcement officials are increasingly frustrated with traditional approaches to drug law enforcement and are demanding evidence-based debate and consequent change.

3.7 I recommend, *inter alia*, that drugs are immediately *de facto* decriminalised, treatment options should include heroin prescribing and an inquiry should consider the control and regulation of all drugs.

4. Introduction

4.1 I joined the police service to help people and catch criminals. Increasingly I found that drug users were not criminals in the ordinary sense of the word[73] and that I and my colleagues weren't helping them, or anybody else, by arresting them. Many seemed to be doing no more than seeking some temporary, relatively harmless, enjoyment and others were clearly in need of help and treatment for their serious medical and psychological conditions, including addiction.

4.2 It did seem to be of benefit to arrest dealers as they were clearly trying to profit through criminal enterprise. However, despite huge efforts to make arrests, the number of dealers didn't decrease, nor did the supply of drugs. In fact, over the last 40 years, drug supply and consumption has increased dramatically and drugs are relatively easy to obtain in all parts of the country.

4.3 The prohibition of drugs creates huge value in otherwise relatively cheap products. This creates massively profitable, relatively low-risk illegal drugs markets that excel in recruiting every new generation into drug use. The only control over drugs is exercised by criminals; regulation doesn't exist.

4.4 I have witnessed at first hand, and at all ranks, our efforts to combat the harms of drug abuse. I have been very impressed with the professionalism, bravery and ingenuity of law enforcement officials as they have tried to work in the best interests of the country. It is a great sadness to me that those efforts have often been wasted and counter-productive.

4.5 It is a greater sadness that there is such a reluctance to stop and think, to assess our effectiveness, to consider the reality of current circumstances and, at the very least, conduct a debate with open minds and consider what might be a better way forward.

4.6 What is the point of the police service if it is not to maintain law and order and serve and protect the public? When it comes to drug law enforcement the answer is unclear to say the least, largely contradictory and certainly very problematic.

5. The Users

5.1 Human beings have taken mind altering substances as long as they have been able to make or obtain them. The reasons for taking mind altering substances are various:

(a) Personal development.
(b) Spiritual enlightenment.
(c) Enhanced enjoyment of art and music.
(d) Enhanced (enjoyment of) physical activity.
(e) Creativity.
(f) Non-specific relaxation.
(g) Reduce inhibition/shyness.
(h) Stress reduction.

[72] Rio de Janeiro Declaration, September 2011, http://www.idpc.net/sites/default/files/alerts/Declaration_ENGLISH.pdf

[73] Most laws are intended to protect citizens from the harm that might be inflicted on them by others, such as assault or theft of property. Some laws seek to regulate or prohibit behaviour that is considered to be undesirable, immoral or harmful to the individual themselves. Sexual and religious activities, as well as possessing certain substances, are covered here. There is a clear distinction between the two types and that leaves room for proper debate about the need for, and efficacy, of the latter. The prohibition of drugs is not the same as the prohibition of theft or assault (and their many variations).

(i) Self-medication.

(j) Pain reduction.

(k) Blocking out unwanted thoughts or feelings.

(l) Oblivion.

The criminal law makes no distinction between the various motives of users (possession of cannabis at a party is legally the same as possession for the relief of medical symptoms) however inappropriate that may be.

5.2 Problematic users are often very damaged individuals, suffering from the effects of sexual, physical and emotional abuse, in need of support not condemnation. Those who collapsed from overdoses in Piccadilly and ended up in the "pit" (a bare room with mattresses thrown on the floor in the local hospital in Marylebone) needed help not ostracism and, almost certainly, an early and avoidable death. Every addict is someone's child.

5.3 Many users, ostracised by society at large, feel no allegiance to that society and, even if they do not resort to criminality, will indulge in insensitive and anti-social behaviour.

5.4 There are avoidable harms for users associated with the enforcement of the drugs laws. These are often referred to as "Unintended Consequences" (an increasingly inappropriate term for such predictable consequences) and were acknowledged in 2008 by the then Executive Director of the UNODC, Antonio Maria Costa.[74]

Harms include:

(a) Drugs supplied by criminals are of unknown concentration/strength.

(b) Drugs supplied by criminals are often adulterated with dangerous substances.

(c) Users are necessarily exposed to the criminal market, and often encouraged to take more profitable (and dangerous) drugs.

(d) Many users are forced into risky behaviours and contract blood borne diseases such as HIV/AIDS and Hepatitis C.

(e) Many users die of accidental overdoses.

(f) Fellow users may be reluctant to call emergency services when needed.

(g) Many users resort to prostitution to support their habit.

(h) Many users resort to crime to support their habit.

(i) Many users acquire criminal convictions that prevent them from taking opportunities later in life.

(j) Criminalisation deters many from seeking the help they need.

(k) The law has fallen into disrepute for many people who feel resentful that their own use is criminalised, whereas those who consume other, possibly more dangerous, substances are not.

5.5 Prevention in the form of education is limited and often confounded by misleading or incorrect information. For example, in April 2008 Gordon Brown, then Prime Minister, described "skunk" cannabis as "lethal".[75] Not only is this wholly wrong it is perceived to be wrong by many whose mistrust of the views of their "elders and better" will be even more justified.

6. The Producers and Dealers

6.1 Criminals have taken advantage of the prohibition of drugs to take over the production and supply of drugs and make enormous profits.

6.2 Criminal drug dealers have sufficient financial motivation and funds to protect, maintain and increase their trade despite enormously costly and extensive law enforcement efforts.

6.3 Experience has shown that the arrests of drug dealers does not stop supply, other than temporarily and locally, but it does result in new dealers taking over the supply.

6.4 Drug dealing provides an opportunity for young people to obtain funds and an incentive to join gangs.

6.5 Drug dealers pay scant regard to the safety and security of the users (being only interested in their money) or the neighbourhood more broadly. Drug dealers will often use intimidation to create an environment in which they can deal more easily with reduced risk of interference.

6.6 Many so-called dealers are either that week's "buyer" for a group of friends or just trying to subsidise their own habit.

6.7 The people making money out of this are the high level "drug barons" and the workers in the criminal justice system.

[74] http://transform-drugs.blogspot.com/2008/03/unodc-director-declares-international.html

[75] http://news.bbc.co.uk/1/hi/uk_politics/7372876.stm

7. Crime

Crime associated with the illegal drugs trade has proliferated in a number of ways:

7.1 Violence is used to settle disputes between dealers, increasingly involving the use of firearms.

7.2 Innocent bystanders have been victims of violence.

7.3 Violence and coercion is used to intimidate citizens from giving evidence against dealers.

7.4 The profits from drug dealers are used to corrupt law enforcement officials.

7.5 The profits from drug dealers are used to pervert the course of justice by bribing with witnesses and others.

7.6 A substantial amount of acquisitive crime (including burglary, robbery and shoplifting) is committed by users stealing to pay for drugs.

7.7 A substantial amount of prostitution is driven by the need to obtain money for drugs. Prostitution is not a crime in itself but the consequences can be very damaging to neighbourhoods and, tragically, the people involved.[76]

7.8 Drug dealing provides income for, and attracts young people to, criminal gangs.

7.9 Law enforcement officials are tempted by the substantial amount of money involved and turn to crime themselves.

8. The Costs of the "War on Drugs"

The costs of enforcing the drugs laws are substantial:

8.1 The costs to the Criminal Justice System amount to many billions per annum.[77]

8.2 A great deal of effort is put into planning and prosecuting investigations into dealing at all levels, including undercover operations, surveillance and other covert tactics.

Personal examples include:

(a) a planned raid on a pub garden in Hampstead that resulted in the arrest of 15 black men and youths for dealing in cannabis (with attendant allegations of racism);

(b) a 10-week surveillance operation in Westminster that resulted in over 20 street dealers being imprisoned;

(c) the arrest of more than 100 street dealers in Peterborough[78] (against my better judgement-and thereby hangs a tale of Home Office interference); and

(d) an operation lasting more than a year in Cambridgeshire that eventually resulted in the convictions for drug dealing of several family members.

None of these operations had any long-term impact on drug supply and consumption.[79]

8.3 Examining seized substances at forensic science laboratories.

8.4 Imprisoning or in other ways punishing offenders.

8.5 Despite the huge effort put into investigating large-scale drug trafficking operations convictions are hard to achieve and the overall success rate in preventing supply or deterring new entrants into drug crime is minimal.

8.6 Police officers, and others, are at physical risk when enforcing the drugs laws.

8.7 Opportunity costs lost to policing other crimes are substantial. This is a growing issue as the funds available to support policing are decreasing and the pressure on pursuing efficient activities increasing.

8.8 Despite financial constraints and the supposed discipline of accounting for government expenditure I was never asked to justify the cost effectiveness of drug law enforcement activity. As far as I am aware not only has this not happened, it is actively opposed.[80] This stance is directly opposed to evidence-based policy making.

8.9 The law has fallen into disrepute for many people who realise how much of a failure it has been.

[76] http://news.bbc.co.uk/1/hi/england/suffolk/7256402.stm

[77] The economic and social costs of Class A drug use in England and Wales, 2003–04. Home Office Online Report 16/06. http://www.tdpf.org.uk/MediaNews_FactResearchGuide_SocialAndEconomicCosts.htm

[78] http://www.guardian.co.uk/society/2002/sep/29/drugsandalcohol.drugs

[79] http://www.peterborough.gov.uk/safer_peterborough/news/2011/operation_a_success_as_more.aspx

[80] http://transform-drugs.blogspot.com/2010/01/gordon-brown-responds-to-transforms.html

9. Concluding Thoughts

9.1 Everybody agrees that we should be reducing harmful drug consumption, reducing the power and profits of serious and organised criminality and increasing safety and security for all citizens, wherever they live. We also agree that we should be offering honest, effective education and guidance to our children, protecting them from the temptations and harms of drug abuse.

9.2 In the current financial climate we must also be even more aware how we spend our money, ensuring that we get the very best returns for every penny spent.

9.3 However, it is the criminals, not us, who are in charge of the supply, variety, quality and quantity of drugs, causing untold damage. I firmly believe that the evidence points to an urgent need to change our approach.

10. Recommendations

10.1 Declare an immediate amnesty by means of de facto decriminalisation for possession of all drugs for personal use, pending legal changes.

10.2 Consider deploying cheaper and quicker police tactics to disrupt drug dealing that causes public harm.

10.3 Focus more resources on tackling serious and organised criminality.

10.4 Do not regard abstinence as the only measure of success; managing addiction can bring huge benefits, including in the longer term.

10.5 Offer what is necessary to those who need it (including heroin prescribing) to stop them resorting to harmful activities to support their addiction.

10.6 Overhaul education about drug taking (of all types) so that it is based on properly evaluated methods. The work of Timothy Wilson, Professor of Psychology at the University of Virginia, challenges current practices and proposes evidence-based successful approaches.[81]

10.7 Conduct a comprehensive inquiry into UK drug policy to consider implementing proper control and regulation of drugs by the government.

January 2012

Written evidence submitted by Release (DP 082)

Release is the national centre of expertise on drugs and drugs law—providing free and confidential specialist advice to the public and professionals. Release also campaigns for changes to UK drug policy to bring about a fairer and more compassionate legal framework to manage drug use in our society. Release's campaign "Drugs—Time for Better Laws" was launched in June 2011 and calls for the Government to carry out an urgent review into the UK's drug policy giving proper consideration to decriminalisation of drug possession (www.release.org.uk/decriminalisation).

Release's submission will provide evidence on the following: the impact of policing drugs in the UK; the experiences of jurisdictions that have adopted a decriminalised approach to drug possession; the failure of successive UK Governments to properly consider the advice of the Advisory Council on the Misuse of Drugs ("ACMD"); the misinterpretation of the role of the classification system as defined by the Misuse of Drugs Act 1971 ("MDA 1971"); and the recommendations of previous Committees in respect of alternative ways of tackling drugs. It is our opinion that this information will be of assistance to the Committee in relation to the following:

- — the extent to which the Government's 2010 drug strategy is a "fiscally responsible policy with strategies grounded in science, health, security and human rights";
- — the criteria used by the Government to measure the efficacy of its drug policies;
- — the independence and the quality of expert advice which is being given to the Government;
- — the cost effectiveness of different policies to reduce drug usage;
- — whether detailed considerations ought to be given to alternative ways of tackling the drugs dilemma as recommended by previous Committees.

An effective drug strategy will be dependent on a number of factors including investment in drug treatment and harm reduction services.[82] One of the major components of an effective policy is the approach taken to the policing and prosecution of drug offences, in particular, possession offences. Release's submission will focus on this aspect of the UK's drug policy and will demonstrate that the current criminal justice system ("CJS") approach fails in its aim to deter drug use and in fact creates significant harms for certain sections of society.

[81] Redirect: The Surprising New Science of Psychological Change, Timothy D Wilson, ISBN: 978–1-846–14229–1.

[82] Release refers the Committee to the submission from the UK Drug Policy Consortium which properly asserts that that drug use and drug policy should not be seen in isolation from other social policy issues (UKDPC, Evidence to the Home Affairs Select Committee Inquiry into Drugs, January 2012, page 6).

1. *The impact of policing drugs in the United Kingdom*

One of the major failings of the current drugs laws is the disproportionate application of those laws and the policing of them. The reality is that the vast majority of people who use controlled drugs in the UK will never face prosecution nor will they be subject to a police stop and search.

The British Crime Survey estimates that one in three adults in England and Wales have used an illicit drug in their lifetime.[83] Nearly 3 million people used an illegal substance in the last year,[84] during the same period almost 80,000[85] were found guilty of or cautioned for possession, a further 95,000[86] were dealt with under the cannabis warning scheme. Even if it is accepted that none of these individuals were repeat offenders it would appear, based on the statistics, just over 5% of those who used illicit drugs in the last year actually fell foul of the law.

It is impossible to police and prosecute everyone who uses drugs within the UK. In practice what is occurring is that those from black and Asian communities, the young and those from areas of deprivation are disproportionately policed. Research has found that black people are 9.2 times more likely to be stopped and searched for drug offences; 6.1 times more likely to be arrested and 11.4 times more likely to go to prison.[87] This is despite the fact that the British Crime Survey shows that drug use is higher amongst the white population than the non-white population.[88]

In 2010, the Metropolitan Police carried out over half a million stop and searches,[89] of this number over 50% were for drugs. Over half of those stopped and searched were under the age of 24 and both those from the black and Asian communities were significantly overrepresented. The arrest rate resulting from these stops and searches was 8%.

Release is currently undertaking research with the London School of Economics which further examines the disproportionate policing of drug offences. On initial analysis it would appear that less harsh criminal justice responses, such as cannabis warnings, are more readily available to those from a white background.

The policing of drugs significantly undermines community relations. It is young black and Asian men from certain communities who are subject to such police interference from an early age. In most cases these stops occur using the powers conferred on police by the MDA 1971. The fact that these young people are repeatedly stopped and searched results in a breach of trust between them, the police and other state actors. Further to this, studies have shown that black people are twice as likely to enter the criminal justice system following stop and search.[90]

The unequal application of a law**,** that is essentially unenforceable, is a powerful reason for other alternatives to be considered. A system which adopted a civil legal approach to drug possession would see a reduction in policing of drug use and divert people away from the criminal justice system.

2. *The experiences of jurisdictions that have adopted a decriminalised approach to drug possession*

The main concern of those that oppose a decriminalisation model for drug possession is that it would be a "green light" for drug use and would result in a cataclysmic increase in consumption. The evidence shows this is not the case.

---

[83] Smith & Flatley, Drug Misuse Declared: Findings from the 2010–11 British Crime Survey, July 2011, Home Office at page 12 (http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1211/hosb1211?view=Binary) page 12

[84] *Ibid* p.12.

[85] Ministry of Justice, Criminal Justice Statistics 2010, Supplementary Tables "All Courts", Volume 5, Table 5.1 (http://www.justice.gov.uk/publications/statistics-and-data/criminal-justice/criminal-justice-statistics-editions.htm) details convictions at Court—a total of 43,406 people were convicted of possession of a controlled drug in England & Wales in 2010. Supplementary Table, Volume 3 Part 7, Table 3A provides details of cautions and confirms that 35,998 people received a caution for drug possession in 2010.

[86] Taylor & Chaplin, Crimes Detected in England and Wales 2011, July 2011 (HOSB:11/11) at page at page 10 (http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1111/hosb1111?view=Binary)—the total figure was 95,408 and includes PNDs issued for cannabis possession.

[87] Stevens A Prof, "Drugs, Crime and Public Health", 2010, Routledge at page 96—a copy of the chapter relating to disproportionate policing of drug offences has been appended to this submission. Further to this the *Guardian* recently undertook an analysis of more than one million court records, their results showed that those from black and Asian backgrounds received a harsher sentence than their white counterparts. In respect of drug offences those of black ethnicity were 27% more likely to be sentenced for drugs possession. Asian offenders were 41% more likely to receive a custodial sentence for drug offences than their white counterparts (http://www.guardian.co.uk/law/2011/nov/25/ethnic-variations-jail-sentences-study)

[88] Smith & Flatley, Drug Misuse Declared: Findings from the 2010–11 British Crime Survey, July 2011, Home Office at page 21 (http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1211/hosb1211?view=Binary)

[89] Metropolitan Police Authority, "Stop and Searches Monitoring Mechanism", December 2010, (www.met.police.uk/foi/pdfs/priorities_and_how_we_are_doing/corporate/mps_stop_and_search_monitoring_report_december_2010.pdf) these searches were based on "reasonable suspicion" based searches such as section 1 PACE 1984 or s23 Misuse of Drugs Act 1971, it excludes s40 Terrorism Act 2000 and s66 Criminal Justice and Public Order Act 1994 searches.

[90] Bowling B Prof & Phillips C, "Disproportionate and Discriminatory: Reviewing the Evidence on Police Stop and Search", The Modern Law Review, (2007) 70(6) 936—961.

Release has recently undertaken a review[91] of jurisdictions that have adopted a model of decriminalisation. For clarity, the term "decriminalisation" is generally accepted by those in the policy field as meaning that drugs are still illegal, but either the police decide not to enforce the laws (a de facto model) or that possession and use are dealt with through the civil system (a de jure model). Based on this definition, it is estimated that between 30–35 jurisdictions have adopted some form of decriminalisation.[92]

The main aim of the paper is to ascertain what impact the enforcement policy adopted has on the drug prevalence rates within that jurisdiction; the conclusion is that the model adopted has very little relationship with the levels of drug use. The paper has been submitted to the Committee in draft form and it is expected to be published in the next two months. However, to assist the Committee the following examples support the conclusion put forward:

2.1 Portugal

In 2001 Portugal decriminalised possession and use of all illicit drugs. Along with significant investment in treatment and harm reduction services, Portugal introduced a civil legal system for dealing with drug possession. Those caught in possession of illicit substances[93] are now referred to a "dissuasion commission" (CDT), a three person panel made up of medical experts, social workers and legal professionals.[94] The Panel can recommend treatment or can impose a low level sanction such as a fine or community service. However, on the first occasion the person does not receive a sanction and does not have to access treatment unless they choose to do so. In such cases, the offence is recorded and is kept on record for six months, after this period it is removed from the system. A person only receives a sanction or is mandated to treatment if they appear before the CDT within the prescribed six month period.

When first introduced many critics of the scheme expected it to be a disaster which would result in rocketing rates of drug use and drug tourism. This was not the case. The Portuguese model has been extensively reviewed and there is broad agreement that whilst there has been a slight increase in the overall drug use amongst the population, (this is an experience shared with the country's neighbours) there has been a small reduction in the number of young people using illicit drugs (cannabis use is significantly lower in Portugal than in the neighbouring countries of Spain and Italy[95]) and a reduction in the numbers who use drugs problematically. Furthermore, HIV transmission rates have significantly reduced from 907 new cases in 2000 to 267 in 2008. There has also been a reduction in drug related deaths attributed to overdose.[96]

On the criminal justice side, Portugal has reduced the number of criminal drug offences from approximately 14,000 per year to an average of 5,000 to 5,500 per year after decriminalisation.[97] This has led to a significant reduction in the proportion of individuals in Portuguese prisons for drug related offences—in 1999, 44% of prisoners were incarcerated for drug-related offences; by 2008, that figure had reduced to 21%. This resulted in a major reduction in prison overcrowding in Portuguese prisons.[98] Since decriminalisation, Portuguese law enforcement statistics have also revealed an increase in operational capacity resulting in more domestic drug trafficking seizures and an increase in international anti-trafficking collaborations that have provided for greater targeting of drug traffickers by sea.[99]

2.2 Australia

To date, three Australian states[100] have laws in place decriminalising possession and use of cannabis.[101] In the review of analytical literature about the impact of decriminalisation on cannabis usage in Australia, we found: one study finding a significant increase in cannabis usage in decriminalised states;[102] one study demonstrating a decrease in cannabis usage after decriminalisation;[103] and four studies finding decriminalisation

[91] Rosmarin A & Eastwood N, "A Quiet Revolution: Drug Decriminalisation Policies in Practice Across the Globe". 2012, Release—the paper is currently in draft form and has been appended to this submission [not separately printed]. The final paper will be made available to the Committee by mid-February.

[92] In some jurisdictions only cannabis has been decriminalised.

[93] There is a threshold amount of 10 days' worth of drugs.

[94] Kreit, Alex 2010, The Decriminalization Option: Should States Consider Moving from a Criminal to a Civil Drug Court Model? University of Chicago Legal Forum. pp 299–326.

[95] EMCDDA, "Lifetime prevalence of drug use by age and country, most recent national general population survey available since 2000", Statistical Bulletin 2011, Table GPS-1, (http://www.emcdda.europa.eu/stats11/gpstab1c)

[96] Hughes, Caitlin Elizabeth and Alex Stevens. 2010. What Can We Learn From The Portuguese Decriminalization of Illicit Drugs? British Journal of Criminology 50, pp 999 at page 1008.

[97] Hughes and Stevens at 1015.

[98] Hughes and Stevens at 1010.

[99] Hughes and Stevens at 1012–1013.

[100] An early adopter of decriminalisation, some Australian states have had cannabis decriminalization schemes in place for nearly 25 years.

[101] Until August 2011, there were four decriminalised states. Western Australia repealed its decriminalisation policy then.

[102] Damrongplasit, Kannika (with Cheng Hsiao and Xueyan Zhao). Decriminalization and Marijuana Smoking Prevalence: Evidence from Australia. Journal of Business and Economic Statistics, 28, 344–356.

[103] *Fetherston, James and Simon Lenton, 2007. Effects of the Western Australian Cannabis infringement Notice Scheme on Public Attitudes, Knowledge, and Use. National Drug Research Institute. p 54.*

had no significant impact on cannabis usage prevalence.[104] Collectively, these studies suggest that cannabis decriminalisation in Australia has had a minor, if any, impact on cannabis usage.

Yet the decriminalised states have shown a capacity to keep individuals out of the criminal justice system. One study compared individuals given a cannabis enforcement notice (non-criminal response) in South Australia and individuals given a criminal sentence in Western Australia (pre-decriminalisation) and found that the individuals given criminal penalties were more likely to suffer negative employment, relationship, and accommodation consequences as a result of their cannabis charge and were more likely to come into further contact with the criminal justice system than the South Australia individuals.[105] The data also suggests decriminalisation can save States scarce fiscal resources as opposed to criminalisation policies.[106]

2.3 Czech Republic

The Czech Republic decided to legislate to decriminalise drug possession after carrying out a cost-benefit analysis of the criminal system. After a two year project that was concluded in 2002, research found that:

1. Penalisation of drug use had not prevented the availability of illicit drugs.
2. There was an increase in the levels of drug use within the country.
3. The social costs of illicit drugs increased significantly.

As a result of this analysis, the Czech Republic formally decriminalised possession of illegal drugs in 2010. It is too soon to determine the impact of the new policy approach but it is interesting to see a country adopting a new model for addressing drug use based on an evidenced assessment of a criminal justice approach.

Based on the review undertaken by Release the evidence appears to support the position that the law enforcement approach taken has little impact on the levels of drug consumption within a country. The question that should then be asked is why pursue an expensive law enforcement approach that criminalises individuals creating significant harms in terms of employability and education.

According to the European Monitoring Centre on Drugs and Drug Abuse the UK spends the highest proportion of GDP on "the drug problem" and yet has some of the highest rates of drug use within Western Europe.[107] It would certainly appear that the current strategy is not "fiscally responsible" and that criminalising drug possession does not meet its aim of deterring use. In fact, research has shown that criminalisation plays a significant factor in stigmatising those who use drugs problematically and can therefore act as a deterrent in seeking treatment.[108]

3. *The failure of successive Governments to properly consider the advice of the ACMD*

Successive governments have ignored or failed to act upon the advice of the ACMD. Evidence of this is well established and decisions relating to the reclassification of ecstasy and cannabis or to the debacle around mephedrone clearly demonstrate the weakness of the ACMD. A more benign example includes the ACMD's recommendation that foil be added to the list of paraphernalia exempted under section 9A of the MDA 1971. The recommendation was made by the ACMD in November 2010—to date no action has been taken by the Home Secretary.

Policy should be based on evidence and the ACMD must be given a stronger mandate in developing the UK's drug strategy. However, recognition should be given to the lack of clarity as to the role of the ACMD. The MDA 1971 states that the Council is required to examine the harm associated with drugs yet there is no definition of harm which the ACMD can use to properly evaluate the impact of a substance on an individual or society.

The reality is that we have an arbitrary system where drugs are irrationally classified[109] within the three main groupings, where movement between those groupings based on evidence becomes impossible, and no consideration is given to possible alternatives for dealing with a substance.

[104] *See* Donnelly, Neil, Wayne Hall, Paul Christie. 1999. Effects of the Cannabis Expiation Notice Scheme on Levels and Patterns of Cannabis Use in South Australia: Evidence from the National Drug Strategy Household Surveys 1985–1995. Drug and Alcohol Services Council, South Australia; Lenton, Simon, Paul Christie, Rachel Humeniuk, Alisen Brooks, Mike Bennett, Penny Heale. 1999. Infringement versus conviction: the social impact of a minor cannabis offence under a civil penalties system and strict prohibition in two Australian States. Drug and Alcohol Services Council, South Australia. 1999; Lenton, Simon. 2000. Cannabis policy and the burden of proof: is it now beyond reasonable doubt that cannabis prohibition is not working? *Drug and Alcohol* Review 19; Single, Christi, Ali.

[105] McLaren, Jennifer and Richard P Mattick. 2007., Cannabis in Australia: Use, supply, harms, and responses. National Drug and Alcohol Research Centre, University of New South Wales. p 57 at p 60.

[106] Single, Eric, Paul Christie and Robert Ali., 2000. The Impact of Cannabis Decriminalisation in Australia and the United States. Journal of Public Health Policy. Vol 21, No 2. pp 167.

[107] EMCDDA, November 2011, 2011 Annual report on the state of the drugs problem in Europe, page 22 (http://www.emcdda.europa.eu/publications/annual-report/2011)

[108] Lloyd C, August 2010, "Sinning and Sinned Against: The Stigmatisation of Problem Drug Users", UKDPC, page 9 (http://www.ukdpc.org.uk/resources/Stigma_Expert_Commentary_final2.pdf)

[109] Nutt D Prof *et al*, "Drug harms in the UK: a multicriteria decision analysis", The Lancet, Volume 376, Issue 9752, Pages 1558–1565, 6 November 2010. Professor Nutt's paper clearly demonstrates how the classification system bears no resemblance to the hierarchy of harms associated with specific controlled drugs.

Beyond the controversy over the role of scientific advice provided by AMCD is an underlying problem of government being prepared to base drug policy on the evidence. The Committee has referred to the report of the Global Commission on Drug Policy in this inquiry, the Home Office's rejection of the report was so quick and dismissive it ran the danger of sending the signal that any critique or suggested improvement of the current policy would not be given an evaluation based on merit.

A failure to base drug policy on evidence is linked to the perception that even the most minimal deviation from the existing policy is akin to abandoning any attempt at drug control, even when policy changes may in fact improve our ability to control both drug use and supply. This block on policy development has resulted in:

- A highly limited scope to piloting innovation and to further test the findings of successful pilots.
- Preventing police forces feeling free to focus resources on local priorities rather than policing drug possession.
- A failure to effectively tackle problematic drug use through joint working between the police, NHS and drug services.
- The ability for drug policy to be mainstreamed with other policy areas to seek outcomes that bring a wider benefit to society.

4. *Misinterpretation of the role of the classification system as defined by the MDA 1971*

As already indicated, the legislatures responsible for the MDA 1971 were vague when it came to defining the classification system and how the ACMD assessed the harm(s) of a particular drug. The Act states that drugs should be "controlled" where it appears they "are being or appear to them [ACMD] likely to be misused and of which the misuse is having … harmful effects sufficient to constitute a social problem".[110] In recent years, the classification of drugs has been used to send "a message to young people",[111] this is an un-evidenced approach to drug policy and undermines the government's credibility in terms of messaging the actual harms associated with a drug. This use of the classification system to send "messages" was strongly criticised by the House of Commons Science and Technology Committee.[112]

5. *Previous Committee's advocating an alternative approach to tackling drugs*

The past decade has seen increasing calls for a review of the current legal approach to tackling drug use in our society and greater acknowledgment of the failure of the current system. The Strategy Unit Drugs Report undertaken by No 10 in 2003 identified that *"the drugs supply market is highly sophisticated, and attempts to intervene have not resulted in sustainable disruption to the market at any level"*.

This Committee's previous inquiry in 2002 recommended that the Government initiate a discussion within the CND of alternative ways to tackle the global drug dilemma.

In addition to the above are an increasing number of high profile figures who have added their voices to the calls for reform.[113]

Despite these calls for reform and the growing evidence demonstrating the failure of the current system there has been no significant change to the UK's drug policy in the last 40 years.

Recommendations

1. The Committee endorses a call for decriminalisation of drug possession.
2. A Royal Commission is established to look at drug legislation and policy reform within the UK and that an expert body is set up to participate in or advise the Commission on alternative models for tackling drugs.
3. The Committee calls for a full independent Impact Assessment of UK Drug Policy as recommended by Transform Drug Policy Foundation in their submission. As part of this process a Human Rights Impact Assessment should also be undertaken, Release would refer the Committee to the submission of the International Centre on Human Rights and Drug Policy which provides a detailed analysis of the human rights implications for this policy area.

January 2012

[110] Misuse of Drugs Act 1971, Section 1 (2), (http://www.legislation.gov.uk/ukpga/1971/38/section/1)

[111] "Gordon Brown: I overrule drugs advisors to avoid sending mixed messages to the young", *The Daily Mail*, 3/11/09. (http://www.dailymail.co.uk/news/article-1224830/Sacked-adviser-Nutt-wrong-risks-drugs-say-scientists.html)

[112] "Drug classification: making a hash of it?" Fifth Report of Session 2005–06, House of Commons Science and Technology Committee. 6 Evidence base for classification (80) (http://www.publications.parliament.uk/pa/cm200506/cmselect/cmsctech/1031/103109.htm#a24)

[113] Kofi Annan, former Secretary General of the United Nations, Cesar Gaviria, former President of Mexico, Ernesto Zedillo, former President of Mexico as well as other world leaders have all called for an end to the war on drugs, Report of the Global Commission on Drug Policy, June 2011. In the UK former Chairman of the Bar Council, Nicholas Green QC called for a review of UK drug policy and Sir Ian Gilmore Former Chair of the Royal College of Physicians has called for drug possession to be decriminalised.

Written evidence submitted by Independent Scientific Committee on Drugs (DP 084)

EXECUTIVE SUMMARY

1. The current UK government's drug policy is not founded upon the evidence base. Basing it on such would offer far greater scope to effectively reduce drug harms to the individual and to society as would a shift from criminal justice to public health. The Global Commission on Drug Policy's recommendations have much to offer in this area.

2. The Independent Scientific Committee on Drugs (ISCD) welcomes this much needed review of the Government's 2010 drugs strategy and policies. We would be happy to give evidence to the Committee on this matter.

3. The Independent Scientific Committee on Drugs reviews and investigates the scientific evidence relating to drugs, free from political concerns.

The ISCD provides accessible information on drugs to the public and professionals. The ISCD works in the UK and internationally and addresses issues surrounding drug harms and benefits; regulation and education; prevention, treatment and recovery. Our vision is that that there will be widespread, informed public understanding about drugs which can promote effective policies and practice in the UK and at international level. More information on the ISCD and its work can be found at www.drugscience.org.uk.

The extent to which the Government's 2010 drug strategy is a "fiscally responsible policy with strategies grounded in science, health, security and human rights" in line with the recent recommendation by the Global Commission on Drug Policy

4. The Global Commission's report rightly makes the issue of drug use a public health issue rather than one of criminal justice, which unfortunately is the current focus of the Government's drug policy. The success of a public health-focused, evidence-based drug policy can be seen with the success of Portugal's policy of the past ten years, see Hughes and Stevens[114] and EMCDDA.[115]

The criteria used by the Government to measure the efficacy of its drug policies

5. Our suggested criteria would be a favourable change in one or more of the 16 parameters set out by the ACMD in 2007 and expanded upon in our 2010 paper[116] in the *Lancet*, attached. It is imperative that alcohol is included in drug policy and that the broader social context of drug policy is properly considered—policies cannot be assessed in isolation from the social issues that contribute to them. A solid evidence base for policies along with proper assessment is critical.

The independence and quality of expert advice which is being given to the government

6. Following the sacking of David Nutt, the subsequent resignation of a number of the ACMD's members and the recent removal of the statutory requirement for relevant experts to sit on the ACMD, the independence and quality of advice being given to the government on drug policy has inevitably been affected. As a fully independent organisation comprised of many of the top experts in the field and highly trusted by the public, the ISCD would be happy to provide the government with scientific evidence and advice to inform drug policy.

The extent to which public health considerations should play a leading role in developing drugs policy

7. Public health considerations should be the primary consideration of drug policy to most effectively reduce harms.

The relationship between drug and alcohol abuse

8. Alcohol is a drug and should not be arbitrarily separated from other recreational drugs. Differentiation could in fact be harmful—users may infer a higher level of safety because of its legal status and underestimate its harms both taken alone or when combined with other drugs.

The comparative harm and cost of legal and illegal drugs

9. The comparative harms of drugs used recreationally are considered in depth in our 2010 Lancet paper.[117]

The availability of "legal highs" and the challenges associated with adapting the legal framework to deal with new substances

10. "Legal highs" present a new set of problems for those that seek to reduce their harms. The speed with which suppliers can alter the chemical composition to evade legislation and the ease with which users can buy

[114] *What Can We Learn From The Portuguese Decriminalization of Illicit Drugs?* Hughes and Stevens 2010.
[115] *Drug policy profiles—Portugal*. EMCDDA 2011.
[116] *Drug harms in the UK: a multicriteria decision analysis*. Nutt *et al*, 2010.
[117] *Ibid.*

these substances over the internet mean that the traditional methods of controlling drugs, which have generally moved fairly slowly, are even more ill-equipped than usual to address the issue. The new Temporary Banning Orders (TBO) will not be an effective alternative as there is likely to only ever be one outcome for a drug subject to a TBO: classification. Anything less than this could be seen as a government sanction of the drug. This scenario would negate the potential benefit of TBOs—what is the point of gathering evidence if the outcome will be the same regardless?

The ISCD has drafted a minimum data set, attached, which sets out the evidence needed on a substance to enable effective and coherent legislation and policy.

Whilst there are undoubtedly both (a) legally available legal highs in abundance as anyone can see from the internet and also (b) an illegal market has developed in previously legal highs like mephedrone (eg Fiona Measham's Year 1 and now also Year 2 Vauxhall data published in JSU in 2011 and 2012 shows the prevalence and popularity of mephedrone), this does not necessarily mean that there is an interest in them. Mephedrone remains popular (as the Year 1 and Year 2 Vauxhall surveys showed) but there has not been any legal high since then which has taken its place. The current contender is methoxetamine but prevalence rates for all the new legal highs remains very low in all the surveys being carried out. Some of the disillusionment with the purity and content of Class As in 2009 that led to the rise of mephedrone has now rubbed off on legal highs too, combined with re-emergence of higher purity ecstasy.

A more effective and rational system would be something similar to the Dutch DIMS system[118] which would enable drug users to know the composition, strength and purity of the drugs they take as well as offering a far more accurate picture of drug trends for government. The relatively unknown nature of many of these substances and their appearance as adulterants and substitutes in more commonly used drugs makes it all the more important that users are given the opportunity to understand what is in the substances they take.[119]

Whether detailed consideration ought to be given to alternative ways of tackling the drugs dilemma, as recommended by the Select Committee in 2002 (The Government's Drugs Policy: Is It Working?, HC 318, 2001–02) and the Justice Committee's 2010 Report on justice reinvestment (Cutting crime: the case for justice reinvestment, HC 94, 2009–10)

11. Absolutely—the current approach to the issue of drugs has not reduced use or harms significantly at all.

January 2012

Written evidence submitted by Angelus Foundation (DP088)

SUMMARY

The Angelus Foundation is dedicated to combating the huge increase in use of legal highs/party drugs in UK in recent years. This submission is restricted to addressing that specific (and related) points of the Committee's terms of reference ("the availability of 'legal highs' and the challenges associated with adapting the legal framework to deal with new substances").

These drugs are particularly attractive to our young people given their price and purity—the UK market is one of the biggest in the world and growing rapidly. Taking these drugs damages lives, costs society millions and current limited interventions are struggling to have any effect.

No one knows what the harms of the new drugs (legal and some now illegal) because there is insufficient laboratory data nor has the little knowledge we have been effectively communicated through health messages to the users and their families.

MEMORANDUM

The first priority for Government must be to ensure the establishment of a world class analysis laboratory to establish the harms of these drugs There must a demonstrable commitment to drugs education including adding it to PHSE.

The Misuse of Drugs Act 1971 has not shown it can be used to reduce prevalence of the new drugs—it should be fully reviewed.

The vital co-ordination between Departments needed to make an effective long-term Drugs Strategy is lacking. Consideration should given to establishing a dedicated cross Departmental Agency answering directly to Prime Minister (similar to MILDT in France).

---

[118] *The Drug Information and Monitoring System (DIMS) in the Netherlands: Implementation, results, and international comparison*. Brunt and Niesink, 2011.

[119] *We need an antidote to the agony of Ecstasy.* Andrew M Brown, 2011.

Introduction

The Angelus Foundation was founded in 2009 by Maryon Stewart, the well-known health practitioner, author and broadcaster. Her 21 year-old daughter Hester, a medical student and athlete, passed away after consuming a legal high (GBL) in April 2009. The Foundation has since attracted a group of world-class experts, known as the Angelus Advisory Group, who bring together expertise from chemical, medical and behavioural sciences, as well as having considerable expertise in both the areas of enforcement and misuse of social substances.

Our Mission Statement

To help society understand the dangers of 'legal high' (unclassified substances), to reduce the harm they cause to young people and their families, and to save lives.

Our Aims and Objectives

We aim to become the acknowledged expert and knowledge centre on the subject of the dangers of legal highs and to maximise public understanding of the risks.

The Foundation's Work

We are planning, subject to adequate funding, internal and external projects which will:

- scope the problem;
- raise awareness of legal highs;
- educate about the risk;
- detect and analyse new unclassified substances and their impact on the human body;
- make the use of party drugs less socially acceptable;
- enable parents to have informed conversations with their children on the use of legal highs;
- empower young people to make more responsible lifestyle choices; and
- improve the understanding of the physiological and psychological impact of these substances on the human body and mind.

Angelus Foundation is committed to help raise awareness about the dangers of legal highs and party drugs and now have a group of 20 world class experts to advise on its work programme. We now know that simply adding substances to the list of controlled drugs is not the solution: each time something is banned the chemists just tweak the molecules and put something else on the market.

We have had many joined up meetings with Ministers for Education, Health and Work and Pensions as well as their senior Civil Servants. While there was broad agreement that the issues were urgent and needed addressing in a co-ordinated manner that has unfortunately not become a reality.

Potential Dangers

Young people are using potentially very dangerous substances, due to:

- Misleading labelling and marketing; long lists of herbal and vitamin ingredients obscure the fact that the active ingredient is actually far from natural.
- Unregulated manufacturing leads to products of extremely variable quality and purity.
- Price—most are cheaper than alcohol.
- Constant manipulation of the substance's composition keeps manufacturers ahead of the law and makes legal intervention highly problematical.
- Substances have been found to contain fertiliser, plant food, rat poison and some traces of Class B drug.
- Reported side effects include panic attacks, respiratory problems, nose bleeds, paranoia, depression, anxiety, suicidal thoughts and aggression.
- Our mission is to help society to understand the dangers of legal highs, to reduce the harm caused to young people and to save lives. The Foundation is the only charity in the UK with this specific remit.

Cost Associated with Abuse of Social Substances

The potential for real harm to individual users either physically or psychologically is ever present. But it is not just the impact on the individual which is of concern:

- It costs £250 per ambulance call out, £500 for a night in hospital and £3,000–£4,000 for an Intensive Care Unit (ICU) bed per night. This means just 100 ambulance call outs per week as well as 100 nights in hospital per week cost £3.9 million per year—100 ICU nights per week cost at least another £15.6 million per year as well as taking up valuable medical resources.

— Research shows the financial cost to society of children who become serious drug users is likely to be in the region of £1 million each by the time they reach 30.

— It is estimated that NEETs (16–18 year olds who do not engage with education or training), who are more likely to experiment with toxic substances, will cost society over £31 billion during their lifetimes.

The Foundation's Work Programme

The projects are grouped into four programmes:

Problem scoping

Populus or a similar research group will carry out quantitative surveys of parents, educators and young people.

— Focus groups with young people and parents to determine which messages are most likely to encourage wiser choices.

— Work with statisticians to determine the measurement of outcomes.

Raising awareness

— Films outlining new developments.

— Tips for wise conversations in the form of downloadable material and films by young people, experts and celebrities enabling parents to discuss their children's drug use.

— The production of a "Wise Up" campaign and materials for both young people and parents which will be tried and tested by the Angelus Foundation and partnering charities prior to broad dissemination.

— Workshops and online resources in eight different modules for GPs and nurses.

— Outreach programmes for higher education and university campuses.

— Outreach support programmes, including staff training for social scene venues.

Laboratory Services

— Testing to identify substances, the cornerstone of the Angelus Foundation work, will be the establishment of a laboratory with the aim of monitoring new synthetic drugs.

— A dedicated, specialised laboratory will plug this much needed gap. Its facilities will enable toxicologists to provide new information on a regular basis on the toxic substances which make up each new legal high as it emerges onto the market so that there is broad understanding and knowledge of the harms of these substances.

— The laboratory work will be complemented by the establishment of a "novel substance assessment" team will undertake studies of the physical impact of the new drugs on the human body and systematically record their findings to produce a definitive reference source—the first of its kind in the country. This will provide valuable information to medical professionals in Accident and Emergency departments who are presented with cases of acute harm ("toxicity") associated with novel recreational drugs. There will be continued analysis of newly confiscated items and test-purchasing legal highs from suppliers to detect new substances on the market. This vital facility, the basis for saving lives, does not currently exist anywhere in the world.

Positive interventions include

— Evaluate current family therapy and early intervention programmes used in the USA.

— Pilot a project to assess the impact of functional family therapy on 100 young drug users in the UK.

— Do we need to add in the education programmes like Preventure and Climate here?

Points for the Committee on Drugs Strategy

The Foundation's founder Maryon Stewart has met several times with Government ministers and senior officials, particularly in the Home Office. There initially seemed to be some good momentum in getting to grips with legal highs when James Brokenshire was drugs minister in 2010.

However he since been replaced twice which means there have been eight drugs ministers in as many years. Most drug ministers in recent years have little or no previous experience of drug issues and have only approached the point of useful knowledge when they are moved on.

Departmental Co-operation

There has also been a discernible deterioration in departmental co-operation on drug strategy matters since 2010. The Home Office have concentrated their efforts on a legal change (Temporary Orders) which may have no bearing on prevalence at all. There was no regulatory impact assessment carried out to defend the Government's policy principle that the illegality of a drug will reduce demand for it.

The vital co-ordination between Departments needed to make an effective long-term Drugs Strategy is lacking. Consideration should given to establishing a dedicated cross Departmental Agency answering directly to Prime Minister (similar to MILDT in France)

The Department of Education has a vital role to play in prescribing a National Curriculum for PSHE with proved positive outcomes—currently drugs education is implemented on by region and on an ad hoc basis, often with negative outcomes as a result of inexperience and lack of knowledge.

The Home Office and the Departments of Education and Health should therefore work closely together to guarantee best practice.

Review of the Act

The Misuse of Drugs Act 1971 was drafted in a very different era for drug misuse. The pace of change cannot be sustained by the legislation The Angelus Foundation advocates a review of the act similar to the one carried out by in New Zealand by their Law Commission.

Laboratory Analysis

In 2010 there were 41 new substances introduced into the UK but there is no dedicated laboratory to assess the harms of these drugs and get basic information out to practitioners. This scale of drug innovation is clearly too much to ask the unpaid advisors of the ACMD to carry out. Due to cutbacks in test purchasing in 2011 because of budgetary constraints it is not known how many new substances entered the market, but it is known that there were 20 detected in the first four months of the year.

Education

The educational need in the UK on advertising the potential dangers of the new party drugs is acute but the Department for Education have not made any significant contribution to preventing harms by giving young people simple additional advice (for example on what drugs can be fatal if mixed with alcohol).

Every stakeholder agrees we are in the midst of a revolution in drug taking yet DE has not responded with anything like the necessary resources. There does not appear to be any acknowledgement by that department of the seriousness of the situation and their responsibilities in addressing it.

There is no PHSE on the National Curriculum which means that drug education is not compulsory. When it is taught, there is no measurement of its efficacy.

The Government is not giving any direction to the regions from central Government to steer them towards the proven successful initiatives. There have been negative interventions in schools in the recent past which have resulted in worsening outcomes.

The Drugs Education Forum, which is the umbrella body that is committed to improving the practice and profile of drugs education in the UK, has no funding in place for 2012 and faces closure.

Conclusion

Legal Highs through the internet, have transformed the market for drugs in just three or four years. Government ministers, although committed to tackling this potential social tragedy, have been slow to deploy effective measures. This is partly because often the only lever they feel they can pull is a legislative one. The Misuse of Drugs Act is not equipped to deal with such rapid change in the drugs landscape and research on Mephedrone prevalence shows simply illegalising a drug does not reduce prevalence and harms. Temporary Orders are simply a stop-gap for that out-dated process.

The main point about the new wave of party drugs is the harms are unknown to science, practitioners users and their parents. The best response would be to:

(i) Gather as much scientific and clinical knowledge as possible which would mean establishing a dedicated laboratory (the ACMD is not sufficiently resourced to carry this out).

(ii) A comprehensive programme of education for the population on the harms of these drugs.

At present there is little to suggest the Government accepts this revolution in drug-taking merits an exceptional response. Nor are Departments working in a co-ordinated fashion to implement the current strategy

and a restructuring may be overdue. Angelus Foundation wants to work with ministers and officials to address the perilous situation but first all parties/stakeholders must agree how urgent the situation is.

January 2012

Written evidence submitted by the Royal College of Psychiatrists (DP096)

This submission has been prepared by Dr Owen Bowden-Jones, Chair of the Faculty of Addictions, Royal College of Psychiatrists.

1. Summary

1.1 The Royal College of Psychiatrists (RCPsych) is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

1.2 The RCPsych Faculty of Addictions comprises medical doctors who have completed extensive training in psychiatry and addiction, and service users with lived experience of addiction and addiction services. It thus has expertise in all aspects of addiction, including individual brain mechanisms, behaviour, and its overall effect on the family, society and the economy. It has unique expertise in the management of addiction problems in complex cases, particularly co-morbid mental health problems.

1.3 The Faculty supports a holistic approach that considers how biological, psychological and social factors impact on a person's life and recovery journey.

1.4 We welcome the opportunity to submit evidence to this important Inquiry. Our evidence identifies 13 key points for consideration:

(a) Drug policy should be based on evidence of clinical effectiveness and value for money. Cost alone is an inadequate measure: cost-effectiveness requires study of effectiveness divided by cost.

(b) There is strong national and international evidence for a range of cost-effective substance misuse treatments.

(c) There remain significant gaps in the evidence base, particularly with respect to recovery interventions. These gaps need to be explored using rigorous research methods.

(d) The Drug Strategy 2010 themes of reducing demand, restricting supply and building recovery should be broadened to include improving the public health and well-being of the individual, their family and their community. The role of Public Health England and Health and Wellbeing Boards in its implementation needs to be fully considered.

(e) Patterns of drug use in the UK appear to be changing. Close attention should be paid to the increasing prevalence of new psychoactive substances and their potential harms.

(f) High quality drug treatment requires an appropriately trained and qualified workforce. There are currently serious concerns about the loss of psychiatric addiction expertise from the treatment system and an urgent review is recommended of re-tendering processes to ensure commissioned services continue to meet the needs of all service users.

(g) Drug policy needs strong leadership, particularly at a time of great change. This leadership, with particular expertise in substance misuse, should be embedded in Public Health England and in local Health and Wellbeing Boards.

(h) It is important to protect drug treatment monies from being diverted into other services. There is currently no clear mechanism for preventing such disinvestment.

(i) Drug and alcohol payment by results models are operating quite separately, with the potential for much confusion. It is also possible that in their current form they might fail the most vulnerable users.

(j) A change in individual treatment for a stable patient to a more challenging aspirational approach can be constructive but must be properly supported. There must also be safeguards to protect against unintended destabilisation.

(k) Similarly, a change in policy to a more challenging aspirational approach can be constructive but must be properly supported. Good intentions alone are not enough: actual measurable benefits must be identified and tracked.

(l) Gains from treatment are various and differ between individuals and over time. Movement to abstinence from the problem drug(s) is a typical early objective. This will often involve consideration of the individual relevance of alcohol and prescription drugs.

(m) Health gains and other benefits may sometimes be supported by medications. When this is constructive, they should be available and utilised, but their continuation over time should be regularly reviewed.

2. Evidence-based Policy

2.1 We welcome the 2010 Drug Strategy, particularly its focus on building recovery.

2.2 Building recovery in communities is an opportunity for the treatment field to refocus on the personal aspirations of people with substance misuse problems.

2.3 Treatment and rehabilitation should be seen as a balance of reducing harm and accruing positives for individuals and their communities.

2.4 The Drug Strategy commitment to "using the evidence to drive the very best outcomes" rightly underpins the document.

2.5 Drug policy should be focused on interventions with strongest the evidence of clinical and cost effectiveness.

2.6 The College supports the Drug Strategy's ambition to identify where the evidence is "too sparse or weak" and to tackle any "evidence gaps".

2.7 There is now a very strong body of UK and international evidence supporting a range of drug treatments (including pharmacological and psychological treatments), and public health interventions. Authoritative NICE Technology Appraisals and Guidelines are available for several areas of substance misuse treatment.[1–6]

2.8 Effective treatment has been shown to deliver a range of benefits for patients, families and communities including reduced illicit use, increased health and social functioning, reduced overdose, reduced transmission of blood-borne viruses, and reduced crime.

2.9 Additionally, there are widely available, well-accepted good practice guidelines for clinicians.[7–9]

2.10 NICE-approved Quality Standards are available for alcohol treatment and are being developed for drug treatment. These provide a very valuable benchmark.

2.11 Even treatments strongly supported by science will only be effective if delivered by a workforce skilled to provide them. There is considerable concern nationally about the loss of psychiatric addictions expertise from the drug field and the effect this will have on the quality of care. In some cases, cost savings are resulting in the commissioning of services with insufficient expertise to meet the needs of this often complex group of patients.

2.12 Of particular concern is the lack of robust evidence supporting the recovery interventions described in the Drug Strategy when compared to the international research.[10] In this context, the work of the Recovery Orientated Drug Treatment (RODT) working group, exploring the integration of current evidence-based treatments with recovery systems, is welcome.[11]

2.13 Given the financial climate, there is concern about investment in treatments that have not yet been shown to be efficacious or cost-effective.

2.14 There is a significant risk that parts of the Drug Strategy are moving ahead, before the evidence has caught up. With this comes the danger of investment in interventions which may later be discovered to be ineffective, or worse, have unintended negative consequences for particularly vulnerable groups of people, for example those with more severe dependence on single/multiple drugs and those with co-existing psychiatric or physical health problems.

2.15 We recommend that in this context a clear framework is devised for developing the evidence base and that new interventions should be trial led, with clear outcomes and on a small scale, before they are rolled out more widely.

Criteria used by the Government to measure the efficacy of its drug policies

2.16 The current National Drug Treatment Monitoring System (NDTMS) is well established, with high levels of compliance from services.

We recommend that the NDTMS should continue and be further developed to better capture co-morbid mental illness and newer drugs.

2.17 Payment by results pilots have been established for alcohol and drugs recovery. This is an ambitious and complex initiative with little existing national or international evidence guiding this approach. Drug and alcohol payment by results models are operating quite separately, with the potential for much confusion.

2.18 We are also concerned that the proposed drug payments systems do not mirror the well established "clustering" payment by results model used in mental health. The clustering payment by results system now has a developing evidence base in contrast to the drug recovery pilots.

2.19 While we support the Drug Policy's definition of recovery as "an individual, person-centred journey", we have concerns that the payment by results systems in their current form will fail to take account of the most vulnerable individuals, with the most severe and complex addictions, for whom the recovery journey will be most difficult. In particular, it would be counter-productive for patients to be encouraged prematurely to

attempt excessively challenging change pathways without proper prior consideration and planning of safety measures in the event of destabilisation.

2.20 We recommend that appropriate safeguards are built into the proposed payment by results systems to protect those with the most severe and complex problems.

3. Independence and Quality of Advice to Government

3.1 The main statutory source of independent advice to Government is the Advisory Council on the Misuse of Drugs. The College strongly supports the role of this body on scientific matters.

3.2 We also support the continued use of working groups to tackle complex clinical/service delivery issues. A recent example is the Recovery Orientated Drug Treatment working group, exploring the integration of evidence-based prescribing treatments with recovery principles.

3.3 The Royal Medical Colleges and other professional bodies provide another source of independent and quality expert advice to Government.

3.4 Recently a "quartet" of such organisations—the Royal College of Psychiatrists, the Royal College of General Practitioners, the Royal College of Nursing and the British Psychological Society—has come together to provide expertise on substance misuse issues to Government.

Such support to Government, which should include the perspective of service users, is to be encouraged.

4. Public Health

4.1 Public health is defined as "preventing disease, prolonging life and promoting health". This definition fits well with the ambition of drug policy.

4.2 There has been considerable success in the UK with respect to public health initiatives relating to substance misuse problems.

4.3 In particular, the use of needle exchange programmes to combat the spread of HIV/AIDS as well as other blood-borne viruses has resulted in some of the lowest transmission rates for HIV in Western Europe.

4.4 People with substance-misuse problems are particularly vulnerable to a range of health problems, including smoking.

4.5 The Royal College of Psychiatrists and the Royal College of Physicians will be producing a report in 2012 addressing "Substance misuse and public health". This document will highlight the importance of public health in drugs policy.

4.6 We recommend that, in addition to the Drug Strategy's three broad themes of "reducing demand, restricting supply and building recovery", a further specific theme should be included: "improving public health and well-being of the individual, their family and the community." We hope that this would encourage a more holistic and integrated approach to drug misuse and its impact, not only on users themselves but on their families and wider community. We know, for example, that substance misuse is a significant factor in many child protection cases.

The impact of the transfer of functions of the National Treatment Agency for Substance Misuse to Public Health England and how this will affect the provision of treatment

4.7 It has yet to be announced which functions of the National Treatment Agency are to be transferred to Public Health England.

4.8 It is essential that the drugs field continues to have strong political leadership with a national oversight of quality.

4.9 The current reorganisation of local and national structures poses a very real threat that the focus on drug policy will be lost.

4.10 We have a number of concerns about the transfer of local drug treatment budgets to the Public Health leads within Local Authorities.

4.11 There is a need to brief Public Health leads on the broader health needs and priorities of this population. This is particularly important, as Local Authorities will be assuming control for the budgets previously held by the Primary Care Trusts.

4.12 People with drug problems are a vulnerable and often disenfranchised group who suffer significant stigma. They are often less able to advocate for their needs when compared with other health groups.

4.13 In this context, it is particularly important to protect drug treatment monies from being diverted into other services. There is currently no clear mechanism for preventing disinvestment.

4.14 Having drug services only within the wider health managed by Local Authorities and not by clinical commissioning groups could be detrimental, as alcohol and drugs are so prevalent and overlap with some many

other health issues. Health and Wellbeing Boards should ensure that drug and alcohol issues are a major focus of Joint Strategic Needs Assessments.

4.15 There is also concern that Local Authorities may insist on all drug and alcohol services being put forward for tender within their procurement policies. There is a major risk that this will significantly destabilise the entire system.

4.16 It is equally important that drugs services should not only consider opiates but also over-the-counter drugs, abuse of prescribed medications and all internet-sourced drugs. Many of those with drug problems also misuse or are dependent on alcohol, hence there must be clear co-ordination with all health commissioners and providers.

4.17 We recommend an urgent review of re-tendering processes to ensure that commissioned services are able to meet the needs of all service users, including those with complex use and co-morbidities such as mental health problems.

5. Novel Psychoactive Substances

5.1 Discussion of this area is complicated by terminology. "Legal highs" are by definition legally available, however some of the most frequently used (Mephedrone) and harmful (*Gamma*-Hydroxybutyric acid [GHB]/ *Gamma*-Butyrolactone [GBL]) drugs in the UK, were once "legal highs" but are now illegal.

5.2 One approach would be to adopt the term "novel psychoactive substance" (NPS) used by the ACMD in its recent report.[12] NPSs remain easily available in the UK, typically via the Internet.

5.3 Their level of use and the degree to which they cause harm remains unclear due to the current reliance on self-reporting.[13, 14] There are, however, reports from clinical services of significant harms associated with GHB/GBL, Ketamine and Mephedrone.

5.4 New NPSs are appearing on the European illicit market at an alarming rate, with little opportunity for assessment of risk.

5.5 The ACMD has proposed a temporary banning order, which could be applied to chemical classes. There is contradictory evidence on the effect of banning legal highs on subsequent levels of consumption. Further research is urgently needed.

5.6 Understanding the prevalence of the use of NPSs is essential but there must now also be a focus on their potential harms and how to treat those who use them.

5.7 There is significant evidence of changing drug use both in the UK and internationally. Of particular concern is the apparent rise in the use of club drugs, over-the-counter medications, abuse of prescription medications and internet sourcing.

5.8 We recommend there is robust surveillance of these changes as well as the development and evaluation of psychosocial and prescribing treatments.

6. Poly-substance Use

The relationship between drug and alcohol abuse

6.1 Poly-substance misuse is the norm for many. Some people who give up illicit drugs subsequently develop dependence on alcohol.

6.2 In this context it is important to have a highly skilled workforce able to comprehensively assess all potential substances of misuse, understand the complexities of managing polysubstance misuse and be alert to the risks of cross-addiction between different substances.

6.3 Poly-substance misuse presents a particular challenge for payment by results for drugs and alcohol recovery in that the identified outcomes are less likely to be achieved by the most complex cases and thus the most vulnerable individuals.

References

[1] NICE (2007) *Drug misuse: Methadone and Buprenorphine.* NICE technology appraisal 114. London: National Institute for Health and Clinical Excellence.

[2] NICE (2007) *Naltrexone for the Management of Opioid Dependence.* NICE technology appraisal guidance 115. London: National Institute for Health and Clinical Excellence.

[3] NICE (2007) *Drug Misuse: Psychosocial Interventions.* NICE clinical guideline 51. London: National Institute for Health and Clinical Excellence.

[4] NICE (2007) *Drug misuse: Opioid detoxification.* NICE clinical guideline 52. London: National Institute for Health and Clinical Excellence.

[5] NICE (2011) *Psychosis with coexisting substance misuse.* NICE clinical guideline 120. London: National Institute for Health and Clinical Excellence.

[6] NICE (2009) *Needle and syringe programmes.* NICE Public Health guideline 18. London: National Institute fro Health and Clinical Excellence.

[7] Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health.

[8] Royal College of Psychiatrists. *Substance misuse detainees in police custody. Guidelines for clinical management* (Fourth Edition). College Report 169 November 2011.

[9] Evidence-based guidelines for the pharmacological management of substance misuse, addiction and comorbidity: recommendations from the *British Association for Psychopharmacology. Journal of Psychopharmacology* 18 (3), 2004; 293–335.

[10] Strang *et al.* Drug policy and the public good: evidence for effective interventions. *Lancet* 2012; 379: 71–83.

[11] Recovery Orientated Drug Treatment. Interim report of the expert working group. National Treatment Agency 2011.

[12] Advisory Council on the Misuse of Drugs. *Consideration of the novel psychoactive substances.* Home Office, London, 2011.

[13] Winstock *et al.* Mephedrone, new kid for the chop. *Addiction.* January; 106 (1): 154–61.

[14] Drug Misuse declared: Findings from the 2010–11 British Crime Survey. Home Office, London, 2011.

January 2012

Written evidence submitted by Kathy Gyngell (DP116)

1. A Comprehensive Review of Drug Policy

Background

The field of drug policy and practice has changed beyond all recognition over the last thirty years. This is the result of the influence of one idea more than any other, namely harm reduction. There has been no more controversial a set of ideas and practices than those associated with this philosophy. No idea has more shaped UK and global drug policy since the late 1980s.

Arising from the concern in the 1980s to reduce drug injectors' risks of acquiring and spreading HIV infection, it was also based on the medical notion that opiate addiction is an unrecoverable medical condition.

Yet epidemiological evidence suggests that the disproportionate rise of addiction, in the context of a post war rise in all psychiatric disorders, is an outcome as much of cultural, psycho social and economic conditions as of a genetic predisposition.

In contrast with the "chronically relapsing disease" mantra and justification, epidemiological evidence also shows that addicts do and can recover, largely outside the purview of medical treatment *(see Addiction a Disorder of Choice, Gene Hayman, Harvard University Press, 2009).*

The effectiveness of "harm reduction"

Harm Reduction "treatment", mainly methadone (a synthetic opiate) substitution dominated the medical response to addiction from the 1980s but became national drug policy between 1997 and 2008. Successive Labour governments set national targets to "engage" and retain "service users" in treatment—giving this task to the newly formed National Treatment Agency.

Labour's commitment to getting as many "problem drug users" (heroin and crack cocaine addicts) into treatment was dually motivated: to reduce drug related crime as well as other public health harms associated with drug use.[120] This was the treatment "war" on drugs Labour decided to fight.

Drug Policy Expenditure

Expenditure on harm reduction dominated UK labelled drugs policy expenditure—eclipsed budgets for enforcement, prevention or rehabilitation over these years. This labelled expenditure is not to be confused with various speculated "costs" of illicit drug use drawn largely from addict self reported estimates of their drugs related crime (a crime motivation that would continue under "legitimised" or "decriminalised" regimes unless Class A drugs were to be supplied free on demand by the state).

[120] Education.gov.uk [Internet] Updated Drug Strategy 2002. [updated 2002 Dec; cited 2011 Jan 27]. Available from: http://www.education.gov.uk/publications/standard/publicationdetail/page1/HO-Drug-Strategy

This "harm reduction" commitment was mirrored by a decline in funds directed to abstinence based (residential, quasi residential and day) rehabilitation treatment—the only "intervention" that recovered addicts report being helpful.

Today the bulk (some two thirds) of the UK's £1.1 billion drug policy budget is spent on harm reduction treatment as it has been for the last six years or so.

The scientific "evidence base" for harm reduction

The "scientific" idea is that prescribing methadone as a medical substitute for heroin would, by retaining these "high harm causing (polydrug) users" in treatment, eliminate their need to finance drug use through crime, prevent overdose and blood-borne virus transmission, and improve their health and functioning. NICE and the NTA advocacy of this "default" approach is based on a much hyped, but in fact limited, set of some 11 randomised control opiate substitution trials. Each though was no longer than of a year's duration—too short a period to see the social or health consequences—whether "reduced harms" could be sustained or at what dosage employment or responsible parenting might be viable.

Unintended consequences

NICE and the NTA appear to have put subsequent data (evidence) to one side as unimportant—data showing "methadone" reductions in drugs-related re-offending to be partial (30% reductions only) and unsustained, the continuation of the underlying dependency suggesting that any "cost benefits" of such treatment reduce rapidly with time. National treatment data shows that the majority of treatment clients remain street drug dependent, an "in treatment" cohort study of treatment effectiveness reveals.[121] The Drugs Treatment Outcomes Research Study in Scotland (DORIS) found that methadone offered a window of opportunity on crime reduction of no more than a year.

They appear not to relate this to:

— Alarming rises in blood-borne infections: the prevalence of HIV amongst injecting drug users has increased from 0.7% to 1.5%, twice as high as in 2000 despite the massive national expansion of methadone prescribing and needle exchange;[122] 90% plus of Hepatitis C infection is still acquired by injecting drug users -. 4484 cases reported in 2000 doubled to 8605 in 2009.[123]

— Rising drug misuse deaths—from 1608 in 2005 to 1876 in 2009.[124] Deaths involving methadone rose over this period from 220 to 408, by 85%. These now constitute a quarter of all drugs poisoning deaths.[125]

Were such a rise of deaths found in any other population (other than addicts) as a result of, or relating to, the medical treatment they were receiving, it would, in likelihood, be the subject of a major inquiry.

A recently published longitudinal cohort study (of 794 addicts in Edinburgh followed over a 30 year period) found that being on methadone adds anywhere between five to 20 years to "injecting" careers, along with prolongation of poor health and quality of life and high rates of physical and mental illness. Specifically, the report states "Exposure to opiate substitution treatment was inversely related to the chances of achieving long term cessation."[126] It confirms longitudinal methadone data from the US.

For my full account of the unintended outcomes of Labour's policy please see: http://www.globaldrugpolicy.org/Issues/Vol%205%20Issue%201/UK's%20Treatment%20War%20on%20Drugs.pdf

[121] Marsden J, Eastwood B, Bradbury C, Dale-Perera A, Farrell M, Hammond P *et al*. Effectiveness of community treatments for heroin and crack cocaine addiction in England: a prospective, in-treatment cohort study. *The Lancet*. 2009 Oct 10; 374(9697):1262–1270. doi:10.1016/S0140–6736(09)61420–3.

[122] Health Protection Agency. [Internet] Shooting Up—Infections among injecting drug users in the United Kingdom Update November 2010 [cited 2011 Jan 27]. Available from: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/InjectingDrugUsers/GeneralInformation/idu_ShootingUp/

[123] Health Protection Agency. [Internet] Shooting Up—Infections among injecting drug users in the United Kingdom 2009. [cited 2011 Jan 27]. Available from: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/InjectingDrugUsers/GeneralInformation/idu_ShootingUp/ Appendix Table 1.

[124] Statistics.gov.uk [Internet]. Deaths related to drug poisoning in England and Wales, 2009. ONS Statistical Bulletin, Table 1. London. Office for National Statistics. [updated 2010 Aug 24; cited 2011 Feb 2] Available from: http://www.statistics.gov.uk/cci/nugget.asp?id=806

[125] Statistics.gov.uk [Internet]. Deaths related to drug poisoning in England and Wales, 2009. ONS Statistical Bulletin, Table 4. London: Office for National Statistics. [updated 2010 Aug 24; cited 2011 Feb 2] Available from: http://www.statistics.gov.uk/cci/nugget.asp?id=806

[126] Kimber J, Copeland L, Hickman M, MacLeod J, McKenzie J, De Angelis D *et al*. Survival and cessation in injecting drug users: prospective observational study of outcomes and effect of opiate substitution treatment. BMJ 2010; 341:c3172. doi: 10.1136/bmj.c3172 (794 patients with a history of injecting drug use presenting between 1980 and 2007.

The welfare cost of methadone

The price of opiate substitution therapy is long term, entrenched dual treatment and welfare dependency leaving addicts in the UK on scripts, most often on other illicit and drugs and alcohol too, unemployable and with no recovery in sight.[127]

Yet the treatment bill and associated welfare claims of those in and out of treatment add up to some £3 and a half billion annually for England (including associated child welfare costs). For detailed analysis and references see my recent report for the Centre for Policy Studies, *Breaking the Habit*, http://www.cps.org.uk/publications/reports/breaking-the-habit/.

Prison methadone policy

"Keeping drug addicts in jail under control with prescriptions ensures that the marginalised remain disempowered—and costs a fortune", (Mark Johnson, *Guardian* 16.12.2009)

Methadone has been the default drug treatment across the prison estate since 2006. The Cabinet Strategy Unit had advocated "gripping high harm causing users in treatment". Today some 60,000 prisoners are prescribed methadone—more than half the prison population—at any one time. A written answer to David Burrowes MP revealed that in 2008–09 for 45,000 prisoners were on methadone detox of unspecified duration, that 20,000 were on long-term "maintenance" any time from months to years.

Methadone has, as result, become another illicit drug "currency" in prisons and creates a negative environment for the few and marginalised abstinence based rehabilitation programmes.

The International Narcotics Control Board has warned that drug treatment should not be used as a method of social control.

Policy lesson

If there is a policy lesson to be learnt from the UK it is that Labour's rapid, harm reduction treatment expansion has proved less benign than anticipated, that its gains do not outweigh its costs, that there is evidence it does more harm than good.

The cost benefit calculations that justified it were inadequate. These failed to factor in treatment duration, dependency perpetuation, indefinite recovery delay, welfare dependency costs, inter-generational and collateral family damage costs. Today of the estimated 300,000 problem drug users at any one time over recent years some 160,000 are on methadone—mainly pharmacy dispensed. Nearly a quarter of this population has been prescribed for more than four years. No national record is available for the high numbers on it for longer—from 10 to 20 years is not uncommon.

Enforcement

Contrary to much received wisdom the UK's drug control policy is not unduly punitive nor has the effect of "criminalising" otherwise law abiding drug users. Serious drug offence convictions actually fact fell between 1998 and 2004–05—the period in which cocaine supply and use was going up rapidly. And in 2010 for example, for Class "A", drugs, supposedly the most serious, only 12,175 people were sentenced for simple possession and of these only 779 were sent to prison.

Declining drug seizures

Drug seizures have been declining too, including for cocaine and despite its threefold prevalence since the 1990s (see Drug Misuse Declared 2010). The amount of cocaine seized by border officials in England and Wales continued to fall—by a quarter—in 2010–11 compared with 2009/10, the amount of heroin seized halved. The trend has been downwards for all Class A drug seizures since 2001—by some 50%. (See HOSB 17/11) This indicates a less than committed or active enforcement progamme but regarding which little official concern is shown.

Though there is some evidence of a declining heroin problem, this is not so for cocaine. Since 1999 there has been a 152% rise in cocaine deaths, a 300% rise in cocaine poisoning and 132% rise cocaine in cocaine related mental health disorders.

Prevention

A coherent policy of prevention directed at adults, youth or children has been remarkable for its absence in the UK; there have been no national public health campaigns on the risks associated with either cannabis or cocaine use on a par with the Aids campaign run at the end of the 1980s.

The government's FRANK education website is inadequate on its own even if it was scientifically accurate which it still is not; if it was not patronising in the attempt to be "with it" and did not have the effect of "normalising" and legitimising teen drug use -which it does.

[127] Griffiths A. Written Answer. HC Deb, 1 November 2010, c636W.

2. An Examination of the Effectiveness of the Government's 2010 Drug Strategy

The advent of the Coalition in 2009 has seen a shift of policy strategy—towards goals of prevention and rehabilitation. *Reducing Demand, Restricting Supply, Building Recovery* was published in December 2010 (HM Government 2010a).

The strategy emphasises recovery and supporting people to become drug free. It is far too soon to evaluate its "effectiveness". More importantly, change has been in intent but not yet in practice. There has been as yet no redirection of the drugs policy budget away from harm reduction.

Current drug policy expenditure

Labelled public expenditure in England during 2010–11 was €1.1 billion (£971 million), a 5% reduction on the previous year. The bulk of the drugs policy budget (£637 thousand) is still spent on harm reduction policy, activities and interventions.

Though the UK illicit drugs market was estimated to be valued at £5 billion a year, in 2011 only £270 million or 29% of the drugs budget was spent on social order and "protection", marginally less than the pre ceding year which does not bode well for the renewed policy commitment to prevention.

Payment by Results

All that has changed in practice is the introduction of a new performance management measure—Payment by Results—to focus on outcomes rather than treatment engagement and retention.

But the NTA's current implementation of the concept of successful treatment completions is far from demonstrating substance dependency free, employability or any other indicator of functional living. Routine prescribing continues across the country. Changes have been limited to "re-branding" with recovery language.

It is too early to see whether any change of performance management (in the absence of any new financial commitment to proven abstinence based rehab programmes) will have any impact on improving recovery outcomes or on reducing the unintended consequences associated with the previous drug strategy.

Abstinence and rehab evidence

Evidence that a recovery/rehabilitation strategy could work—given sufficient skilled drugs counsellors and appropriate drug free settings—is available. Research interest and funding in this area of drug treatment has been low. That which does exist is supportive of the merits of residential rehab in supporting people into recovery. Please see http://www.addictiontoday.org/files/residential-rehab-core-briefing-may-2011.pdf and http://www.cps.org.uk/publications/reports/breaking-the-habit/ (see Chapter 4).

At the moment the recovery goals of the new policy are not consonant with the lack of facilities and experienced staff to handle the change. The Coalition shows little awareness of this problem. It needs to be urgently addressed as the majority of drugs workers currently are unskilled in or ignorant of therapeutic recovery programmes such as those practiced in the country's most successful rehabs.

For the extent to which residential rehab has been disinvested and for the most up to date and comprehensive analysis of residential rehabilitation please see Addiction Today's Report http://www.addictiontoday.org/addictiontoday/2011/11/state-of-residential-treatment-england.html

4. The UK's Contribution to Global Efforts to Reduce the Supply and Demand of Illicit Drugs

It has been argued curiously by the recent (and self appointed) Global Commission on Drug Policy that the United Nations international drugs control system constitutes a "war on drugs" and that this war has been lost. Since HASC, as indicated by your published call for evidence outline, is apparently following their line of argument as a basis for enquiry, it is important members of the Committee are made aware that the premise contained within the report—that global drug use prevalence has gone up—is incorrect.

I have already referred the Chairman of your Committee to the misleading and misrepresentative statistics that the Report attributes, incorrectly, to the UN, on which the report's argument is based. The UNODC does not acknowledge these statistics as theirs. For their response please see: http://www.cps.org.uk/publications/factsheets/global-commission-on-drug-policy-statistics-wrong-and-misleading/

In summary and in their words: *"Based on UNODC published best estimates of the number of cocaine and opiate users, the prevalence rates for annual use in the population age 15–64 remained stable at around 0.35% for opiates and 0.36 % for cocaine between 1998 and 2008"*. This is very different from the plus 30% rise the Global Commission press released.

The effectiveness of drug control policies

It is not widely known that a hundred years ago substances that are internationally controlled today were unregulated and far more widely abused. The consumption of opiates in China alone was estimated to be more than 3,000 tons in morphine equivalent, far in excess of global consumption, both licit and illicit, today. In the United States, about 90% of narcotic drugs were used for non-medical purposes.

Nor is it widely appreciated that in the last 25 years cocaine use in the United States of America has dropped by 75%, a figure confirmed by a range of different national surveys, as a result of drug control measures. Except for cannabis (and only since its medical use has been legitimised in a number of states) all illicit drug use in the States has begun to fall. In Europe cannabis use has been declining for some time and the last two years may have begun to see a reversal in cocaine use.

It is hardly the moment to change the international approach to drug control—especially given that under 5% of the world adult population even tried a drug last year (dramatically lower than for legal smoking at 25%).

With over 95% of Member States being parties to the international drug control conventions, multilateral drug control is one of the greatest achievements of the twentieth century. It is important that the United Kingdom continue to give these their full and responsible support as well as to The Right of Children to be Protected from Narcotic Drugs and Psychotropic Substances, enshrined in human rights and international law—by making every effort to reduce the demand for illicit drugs here.

January 2012

Supplementary written evidence submitted by Kathy Gyngell (DP116a)

You may recollect at our oral session we were asked whether we were in favour of "evidence based" policy. We were also invited by the chair to submit further supporting written evidence.

There was no opportunity, given the time constraints for me to explain my response further. But I was left with the impression from Dr Huppert's reaction to my comments that he was taken aback by my provisos about the limited relevance that scientific evidence may have for policy—and dangers of uncritical reliance on it.

My specific concern was with the "justification" provided by methadone substitution randomised control trials for the DoH's opiate substitution prescribing policy.

Not only are these trials of short duration therefore telling us little about the impact of long term prescribing but the evidence of "efficacy" for the patient they demonstrate is extremely narrow.

They tell us that patients will return for more free methadone; that, unsurprisingly, the supply of free opiates on the state reduces their street opiate dependency; but more surprisingly only reduces by a third ie the trials demonstrate that even within the limited timespan of the trial (none are for more than a year) the addict remains street drug dependent.

This is because methadone prescribing does not address the underlying behaviour (or illness depending on your definition) that addiction is.

The trials provide no evidence of efficacy of methadone for "recovery" or for *fundamental* behaviour change in terms of becoming free of dependency (from addiction) from substances.

Longitudinal "methadone" cohort research shows, contrary to the randomised short duration trials, that methadone substitution has its own morbidity and mortality harms—as does national drugs deaths data which show methadone deaths to have risen alarmingly (data to 2009 from ONS summarised attached[128]). A recent paper by Kimber *et al* is also attached for the committee which elucidates the problems caused by methadone prescribing.[129]

[128] Not printed
[129] Not printed
[130] Not printed

For a recent insightful discussion of the limits of scientific evidence for policy please see the attached paper published in the BMJ recently that you might wish to circulate to interested members of the committee.[131]

May 2012

Written evidence submitted Transform Drug Policy Foundation (DP127)

1. Introduction/Summary

1.1 The groundbreaking 2002 HASC drugs report[132] made a number of important observations and recommendations that we hope this new inquiry will learn from and build upon. HASC 2002 rejected immediate moves towards legal regulation:

> **"***While acknowledging that there may come a day when the balance may tip in favour of legalising and regulating some types of presently illegal drugs, we decline to recommend this drastic step"*

Yet, it did have the foresight to keep the issue on the table, recommending:

> *"that the Government initiates a discussion within the Commission on Narcotic Drugs of alternative ways—including the possibility of legalisation and regulation—to tackle the global drugs dilemma"*

1.2 Much has changed in the ensuing decade to make this final recommendation more urgent than ever. The growing prison population; the deteriorating situations in key drug producer and transit regions such as Mexico, Afghanistan and West Africa; and the growing public support for more far reaching reforms (including from former UK drug ministers,[133] prominent medical/health authorities,[134] former and serving heads of state and numerous other public intellectuals,[135] organisations and agencies[136]). The balance has shifted more decisively in favour of law reform. This Inquiry comes at an opportune moment. As foreseen, the day for meaningful Government action and leadership on exploring alternatives to prohibition has arrived.

2. International Drug Control: Free Markets, Prohibition and Effective Regulation

2.1 A spectrum of legal/policy frameworks exists for regulating production, supply and use of non-medical psychoactive drugs. Either end of this spectrum involves effectively unregulated markets; the criminal markets of a blanket prohibition at one end, legal/commercial free-markets at the other. Between these poles—both associated with high and avoidable social costs—exists a range of options for legally regulating different aspects of drug production, supply and use. Transform argues that given the reality of continuing high demand for drugs, and the evident resilience of criminal supply in meeting this demand, despite enforcement efforts, regulatory market models found in this central part of the spectrum will deliver the best outcomes. These outcomes should be measured in terms of minimising potential social and health harms (and creating positive policy opportunities) created by both drug use and drug markets. Contrary to the suggestion of such reform as "liberalisation" or "free market libertarianism", drug market regulation is a pragmatic position involving rolling out of strict government control into a marketplace where currently there is none.

---

[131] Not printed

[132] Home Affairs Select Committee report: "The Government's Drug Policy: is it working?" 9 May 2002.

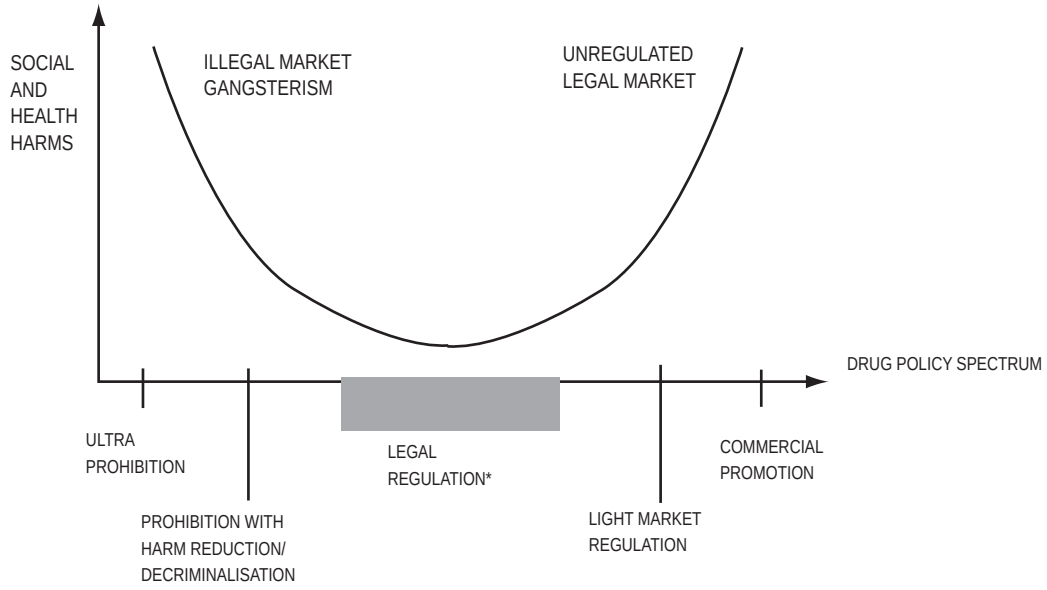
[133] Mo Mowlan—former Minister for the Cabinet Office with responsibility for drugs 1999–2001 www.guardian.co.uk/politics/2003/jan/09/drugsandalcohol.uk,
Bob Ainsworth MP—former Home Office Drugs minister and Secretary of State for Defence http://transform-drugs.blogspot.com/2010/12/legalise-and-regulate-drugs-says-uks.html

[134] Sir Ian Gilmore, former President of the Royal College of Physicians http://transform-drugs.blogspot.com/2010/08/consider-drug-regulation-says-ex.html. The UN special rapporteur on the right to health http://transform-drugs.blogspot.com/2010/10/un-expert-calls-for-fundamental-shift.html and more recently the California Medical Association (re cannabis) www.cmanet.org/files/pdf/news/cma-cannabis-tac-white-paper-101411.pdf

[135] See for example; Global Commission report www.globalcommissionondrugs.org/ and public letter of the Global Initiative for Drug Policy Reform http://reformdrugpolicy.com/partner/public-letter/

[136] For a more complete list see: www.tdpf.org.uk/MediaNews_Reform_supporters.htm

2.2 This thinking is illustrated by the graphic below. To put this in context we are currently witnessing tobacco control moving from the right of the x axis towards the centre, and conversely, illicit drug control also moving towards the centre, but from a starting point on the left. It is entirely consistent to support both of these trends, as Transform does, in pursuit of optimum models of drug regulation.



**Including market regulation models such as prescriptions and licensed retail. See Section 5.*

3. The Historical Context: How we got Here

3.1 The 1961 UN Single Convention on Narcotic Drugs,—the established and continuing legal basis of UK and global prohibition—has two parallel functions. Alongside establishing a blanket global prohibition of some drugs for non-medical use, it also strictly regulates many of the same drugs for "scientific and medical use". These parallel functions have in turn created parallel markets—one for medical drugs, effectively controlled and regulated by state and UN institutions, the other for non-medical drugs, controlled by organised criminals and paramilitaries.

3.2 The 1961 Convention describes non-medical drug use as a threat to the "health and welfare of mankind", and a "serious evil" which the global community must "combat"[137]. Whilst nominally undertaken with the aim of reducing/eliminating drug availability and use, the political narrative is clearly framed as an emergency response to the drug "threat", fuelling the crusading rhetoric of a "war" on drugs and the "securitisation"[138] of the drugs issue then used to justify the extraordinary measures we now engage in.

3.3 The policy environment has changed dramatically since the 1940s and 50s when the 1961 convention was being drafted. Drug use has expanded exponentially, to hundreds of millions of users, with organised criminal networks now accruing hundreds of billions of pounds in untaxed profits from the unregulated market. Due to the associated corruption, crime and violence, drug-related organised crime was, by the 1980s, assessed as a threat to nation states. The world is now effectively engaged in two wars; the initial war on drug use, and now a second war on the organised crime profiting from the opportunities created by the first war.

3.4 Perhaps the starkest illustration of the harms created by prohibition comes from comparing two injecting heroin users—one in a criminal supply environment, the other in a legally prescribed and supervised medical environment.[139] Globally, and even within individual countries, these two policy regimes exist in parallel[140] so a real world harm comparison is possible.

The former:

- Commits high volumes of property crime and/or street sex work to fund their habit.
- Uses "street" heroin (of unknown strength and purity) with dirty, often shared needles in unsafe marginal environments.

[137] Quotes from the convention preamble www.incb.org/pdf/e/conv/convention_1961_en.pdf

[138] For more discussion see Kushlick, D, "International security and the global war on drugs: the tragic irony of drug securitisation", 2010 www.tdpf.org.uk/Security%20and%20Drugs%20-%20Danny%20Kushlick.pdf

[139] For a useful illustration see Csete, J. "From the Mountaintops: What the World Can Learn from Drug Policy Change in Switzerland" OSF 2010 www.soros.org/initiatives/drugpolicy/articles_publications/publications/csete-mountaintops-20101021/from-the-mountaintops-english-20110524.pdf

[140] The legal medical opiate market accounts for around half of global opium production based on International Narcotics Control Board figures for legal opium and UNODC figures for illicit opium.

— Supplies are purchased from a criminal dealing/trafficking infrastructure that can be traced back to illicit production in Afghanistan.

— They have HIV, HCV and a long—and growing—criminal record.

The latter:

— Uses legally manufactured and prescribed pharmaceutical heroin of known strength and purity.

— Uses clean injecting paraphernalia in a supervised quasi-clinical setting where they are in contact with health professionals on a daily basis.

— There is no criminality, profiteering or violence involved at any stage of the drugs production supply or use.

4. Moving Forward: Counting the Costs of the War on Drugs and Exploring Alternatives

4.1 In 2008 the Executive Director of the UNODC noted how:

"the (global drug) control system and its application have had several unintended consequences".

The first is the creation of:

"a huge criminal black market that thrives in order to get prohibited substances from producers to consumers".

The second:

" is what one night call policy displacement. Public health, which is clearly the first principle of drug control… was displaced into the background".

The third is:

"often called the balloon effect because squeezing (by tighter controls) one place produces a swelling (namely an increase)in another place…" .

4.2 Considering these and other "unintended consequences" is of critical importance to the policy debate yet, whilst widely acknowledged, they are not systematically assessed and so largely remain outside of the high level political debate. As highlighted by a series UK Treasury, NAO, and internal Home Office studies, the Government has a history of inadequately evaluating the drug enforcement impacts in particular. Where more meaningful evaluations have been done publication has frequently been suppressed.[141] Despite the obvious need, the Misuse of Drugs Act 1971 has yet to be subject to the scrutiny of an Impact Assessment—now standard practice for all new legislation. A growing group of concerned individuals and organisations has made a call for such an IA to be undertaken.[142]

4.3 Attempting to redress this imbalance at a global level, a broad international coalition of concerned NGOs, the *Count the Costs* initiative, is now calling on Governments and relevant UN agencies to meaningfully count the costs of the 50 years of the war on drugs and explore alternative approaches based on the best available evidence (www.countthecosts.org). The initiative has produced thematic briefings on key areas of concern and we urge the committee to consider these summaries of the wider unintended consequences of prohibition.[143]

— *Crime:*[144] The drugs/crime nexus continues to drive the policy agenda and it is worthy of note that it is the HASC (rather than, for example, the Health Select Committee) that is again enquiring into drug policy efficacy. Prohibition drives this confluence of drugs and crime in the first instance: The vast criminal opportunities created by rapidly expanding demand for prohibited goods, and acquisitive crime fuelled by the inflationary effects of drug control on prices.

— *Development and security:*[145] drug market related conflict and corruption is actively undermining development and security is some of the world's most fragile and vulnerable regions.

— *Human Rights:*[146] drug control efforts result in serious human rights abuses around the world: torture and ill treatment by police, mass incarceration, executions, extrajudicial killings, arbitrary detention, and denial of basic health services.

[141] Transform's submission to the 2010 drug strategy consultation (page 9) for details of the relevant reports including quotes and references.
www.tdpf.org.uk/TRANSFORM%20Drug%20strategy%20consultation%202010%20response.pdf

[142] See Transform's page on Impact Assessment www.tdpf.org.uk/Impactassessmentlead.htm and the briefing on Impact Assessment for drug policy produced by Transform and IDPC
www.tdpf.org.uk/IDPC%20Briefing_Impact%20Assessment_June%202010.pdf

[143] Submitted as supplementary evidence.

[144] www.countthecosts.org/sites/default/files/Crime-briefing.pdf

[145] www.countthecosts.org/sites/default/files/Development_and_security_briefing.pdf

[146] www.countthecosts.org/sites/default/files/Human_rights_briefing.pdf also note Transform's endorsement of the submission from the International Center for Human rights and Drug policy.

— *Health:*[147] as well as the direct health harms associate with drug enforcement, criminalisation increase health harms associated with use, creates new harms associated with the violent illegal trade and creates political and practical obstacles to implementing effective health responses.

— *Environment:*[148] Deforestation and pollution in fragile ecosystems from unregulated illegal drug crop production.

5. Legalisation and Effective Regulation

"*Drug legalisation has to be addressed… the issue presented itself several times in the last 20, 30 years, and it is now a question that is on the table, and what is always important in political debates is to analyse the options present.*"

P Michael McKinley, US Ambassador to Colombia, 2010-present, El Pais, 5 December 2011

5.1 Whilst supporting the immediate decriminalisation of personal possession and use[149] (as already implemented in more than 30 countries, and advocated by the ACMD,[150] heads of international agencies including UNAIDS[151] and the Global Fund[152] and numerous other individuals and agencies[153]). Transform argue it is only the solution to a small part of the prohibition problem. A phased move towards responsible legal regulation of some or all markets for currently illegal drugs would not only reduce or eliminate the problems created or exacerbated by prohibition, but would create a dramatically improved environment for implementing effective responses to problematic use.

5.2 When HASC looked at the issue in 2002 there were no detailed descriptions of a how a regulated regime would work. Since then a number of publications have emerged into this void, including contributions from the King County Bar Association,[154] and The Health Officers Council of British Colombia,[155] and Transform's 2009 publication *After the War on Drugs: Blueprint for Regulation.*[156] The models proposed by Transform have since been explored in the British Medical Journal,[157] and been endorsed by the BMJ editor[158] and President of the Royal College of Physicians.[159]

5.3 Rather than a universal model, a flexible range of regulatory tools are presented with the more restrictive controls used for more risky products and less restrictive controls for lower risk products.

Options for control are explored for:

— products (dose, preparation, price, and packaging);

— vendors (licensing, vetting and training requirements, marketing and promotions);

— outlets (location, outlet density, appearance);

— who has access (age controls, licensed buyers, club membership schemes); and

— where and when drugs can be consumed.

5.4 Options for regulating different drugs in different populations are then explored, suggesting regulatory models that may deliver the best outcomes. Five basic models for regulating drug availability are described:

— Medical prescription model or supervised venues.

— Specialist pharmacist retail model—potentially combined with named/licensed user access and rationing of volume of sales.

— Licensed retailing—including tiers of regulation appropriate to product risk and local needs.

— Licensed premises for sale and consumption.

— Unlicensed sales.

[147] Unpublished health briefing draft will be submitted separately—available online at www.countthecosts.org/seven-costs/threatening-public-health-spreading-disease-and-death February 2012

[148] www.countthecosts.org/sites/default/files/Environment-briefing.pdf

[149] Note our endorsement of the submission from Release.

[150] http://transform-drugs.blogspot.com/2011/10/acmd-repeats-call-for-decriminalisation.html

[151] http://unaidstoday.org/?p=497

[152] www.viennadeclaration.com/2010/06/why-we-should-all-support-the-vienna-declaration-2/

[153] See for example: www.viennadeclaration.com/

[154] King County Bar Association Drug Policy Project (2005). *Effective drug control: toward a new legal Framework*. State-level intervention as a workable alternative to the "war on drugs". Seattle: King County Bar Association www.kcba.org/druglaw/pdf/EffectiveDrugControl.pdf

[155] Health Officers Council of British Columbia (2005). *A public health approach to drug control*. Victoria: Health Officers Council of British Columbia www.cfdp.ca/bchoc.pdf

[156] Rolles, S. "After the War on Drugs Blueprint for Regulation" 2009 Transform drug policy Foundation, online here www.tdpf.org.uk/blueprint%20download.htm

[157] Rolles, S. "An Alternative to the War on Drugs" *BMJ* 2010;341:c 3360. www.bmj.com/content/341/bmj.c3360.full

[158] Godlee, F. "Ideology in the ascendant *BMJ* 2010;341:c 3802 www.bmj.com/content/341/bmj.c3802"

[159] See http://transform-drugs.blogspot.com/2010/08/follow-up-prof-ian-gilmore-for-de.html for detail and media coverage.

5.5 Lessons are drawn from successes and failings with regulation of alcohol, tobacco, medical drugs and other risky products and activities—essentially applying well established regulatory and public health principles to a policy arena where they have been previously absent. Particular attention is given to how availability can be controlled (not increased) and the importance of controlling commercialisation and profit-seeking marketing and promotion that seek to increase or encourage increased consumption.

5.6 Any such moves require negotiating the substantial institutional and political obstacles presented by the international drug control system (the UN drug conventions).[160] They would also need to be phased in cautiously over several years, with close evaluation and monitoring of effects and any unintended negative consequences.

6. Objections to Regulated Market Models?

6.1 The Government's repeated casual dismissal of any real debate on alternatives to prohibition is often based on a wilful mischaracterisation of the reform arguments. Its position appears based on political considerations rather than an assessment of evidence on proposed reforms.

6.2 Standardised wording is now used in these dismissals;[161] including that "Drugs are illegal because they are harmful"—they "destroy lives and cause untold misery to families and communities"; that any "liberalisation" would "send out the wrong message"; that reform proposals are "simplistic" and ignore the realities of drug related harm, and that legalisation would increase availability and use. These positions are almost the polar opposite of what is being proposed.

- Regulation of drugs is proposed precisely because drugs are harmful; but they are even more so when supplied illegally and consumed clandestinely.
- Much of the "untold misery" is the result of prohibition and the illegal trade—the government is conflating the drug harms with policy harms, then using it to justify the policies continuation.
- Introducing legal regulation of markets is the opposite of "liberalisation"; what is proposed would bring strict government control into an arena where currently there is none.
- Mass criminalisation and punitive enforcement should not be the basis for educating young people about sensible health and lifestyle choices—nor has it proven effective historically. Redirecting drug enforcement spending into proven public health interventions (education, prevention, harm reduction, treatment/recovery etc) will be far more likely to deliver the outcomes we all seek.
- Suggesting law reform proposals are "simplistic" is a weak attempt to undermine a growing body of scholarship and research into effective policymaking.
- Regulation allows for controlled rather than increased availability, where currently there is almost no control at all. The implication that drugs are unavailable now, and would be dramatically more available under proposed government regulation is a misrepresentation of both current realities and reform proposals.

6.3 It is clear that a policy and legal framework based on a set of agreed legal, pragmatic and public health principles[162] would look very different to the one we have today. We must ask why prohibition continues when it has so evidently failed. Transform has identified four key factors that prevent us moving beyond entrenched war on drugs positions:

- 6.4 *Ignorance*—Most people know little about drugs—their use and misuse. Most are unaware that much of what we call the drug problem is the consequence of pursuing a prohibition based approach, and most are unaware of well developed alternatives to prohibition.
- 6.5 *Fear*—Many fail to question the entrenched threat-based narrative, and fear-based agenda that conflates drug harms and policy harms. Drug War propaganda has further fuelled these fears. Most governmental and state institutions are not designed for adaptation to fundamental change and therefore fear reform. Politicians fear the consequences of challenging the status quo, (particularly the media response) of being portrayed as weak, waving the white flag, going soft on crime etc.
- 6.6 *Opportunism*—Like alcohol Prohibition in the US, drugs prohibition has created a huge profit opportunity for organised crime. The vast sums of money involved in the illegal trade provide opportunities for corrupt individuals and organisations. The conflation of the problems created by prohibition, with the problems created by drug use, has created a propaganda opportunity for politicians—to portray themselves as tough on drugs and protectors of our youth, and provide a smokescreen for wider failings of social policy. At the same time, institutions fighting the war on drugs have benefitted from ever growing enforcement budgets.

[160] For a detailed exploration of these challenges and ways forward see appendix 1 "reforming the UN drug control system" p 165 in Rolles, S. "After the war on drugs: Blueprint for regulation" Transform Drug Policy Foundation 2009.

[161] Recent examples include rapid and cursory Government responses to the ACMD proposal for non-criminal sanctions for personal possession of drugs, and to the Global Commission on Drug Policy report cited in the committee inquiry terms of reference.

[162] See Transform's "After the War on Drugs; Tools for the Debate" p 20 for discussion on what such principles might be. For a more detailed discussion on this theme see Rolles, S chapter in "The Politics of Narcotic Drugs" Routledge 2010, titled "Principles for rational policy making".

— 6.7 *Indifference*—The war on drugs impacts most heavily upon the marginalised, disadvantaged and powerless—from the urban poor in Mexico and the US, to peasant farmers in Colombia and Afghanistan. Their lives (and deaths) are of little consequence to policy makers in comparison to their more pressing domestic and foreign policy priorities.

"*It's a fundamental debate (legalisation and regulation) in which I think, first of all, you must allow a democratic plurality (of opinions)… You have to analyse carefully the pros and cons and the key arguments on both sides.*"

President Calderon of Mexico, 4 August 2010

7. Recommendations

— 7.1 Make a clear call for decriminalisation of possession of drugs for personal use.[163]

— 7.2 Restate the 2002 recommendation 24, and build on this by calling on the Government to show pro-active leadership in promoting the debate on alternatives to prohibition (including legalisation/ regulation) in a range of international fora, including the Commission on Narcotic Drugs, but also a range of other relevant UN and international fora.

— 7.3 Call for the establishment of a joint select committee inquiry to conduct a cross departmental inquiry into alternatives to prohibition

— 7.4 Noting that the HASC in 2010 recommended a "a full and independent value–for–money assessment of the Misuse of Drugs Act 1971 and related legislation and policy",[164] call for a comprehensive independent Impact Assessment of UK drug policy and legislation, both domestic and international commitments. Such an IA should consider alternative approaches, including intensifying the war on drugs, maintaining the *status quo*, decriminalisation models, and legalisation/ regulation models. This undertaking could potentially involve a series of parallel thematic Impact Assessments (ie human rights, health, development, crime etc).

— 7.5 Call for the UN conventions to be revised to remove the stranglehold on individual states exploring models of legal drug market regulation, allowing experimentation by expanding the menu of available options.

January 2012

Supplementary written evidence submitted by Transform Drug Policy Foundation (DP127a)

This is in response to the Chair's suggestion that we submit extra information, to provide support for our oral evidence.

This is a link to a briefing on why people take drugs, that goes some way to answering Lorraine Fullbrook MP's questions about why so many are addicted to prescription drugs: http://www.tdpf.org.uk/Policy_ PolicyBriefings_WhyDoPeopleTakeDrugs.htm

I thought the following link may be useful in response to Michael Ellis MP's assertion that legal regulation is "grossly irresponsible":

This is a list of supporters of reform, including Professor Sir Ian Gilmore, the Rt Hon Bob Ainsworth MP, Fiona Godlee (editor of the *BMJ*), the Rt Hon David Cameron MP and many more: http://tdpf.org.uk/ MediaNews_Reform_supporters.htm

I hope that this is useful.

Danny Kushlick
Head of External Affairs
Transform Drug Policy Foundation

Notes on policy and legal responses to novel psychoactive substances ("legal highs") and non-medical use of prescription drugs, submitted to the Home Affairs Select Committee Drugs Inquiry by Transform Drug Policy Foundation, 21 September 2012

Danny Kushlick from Transform Drug Policy Foundation gave evidence to the Committee on 10 July 2012. He was asked about how the arguments being made for drug law reform related to "legal highs" and non-medical use of prescription drugs by Lorraine Fullbrook MP, but given time constraints was unable to offer a full answer. The Chair therefore invited Transform to submit additional evidence relating to this question in writing.

[163] See submission from Release for more detail and discussion.

[164] Home Affairs Select Committee report on the Cocaine Trade: www.publications.parliament.uk/pa/cm200910/cmselect/cmhaff/74/7402.htm

Summary Points

The market for legal novel psychoactive substances (NPS), and non medical use of prescription drugs has emerged due to high and resilient demand for certain prohibited drugs. Both phenomena can therefore be seen as an unintended consequence of drug prohibition and the corresponding absence of any legal supply route to meet demand.

The legal NPS market is associated with significant risks that directly relate to the lack of market regulation. Prohibitions on NPS can, however, have unintended consequences; creating a void in the market for new NPS, creating an illegal market for established NPS, or displacing use back to illegal substances for which legal NPS may have been substitutes.

Until demand reduction efforts prove more effective, the reality of demand as it currently exists must be dealt with pragmatically. Recent experiences show that prohibitions do not eliminate the problem and may increase harms.

Policy responses should seek to reduce the health and social costs associated with the use of drugs, and the markets that supply them. Leaving an unregulated legal market, or blanket prohibition (in all likelihood resulting in an unregulated criminal market) as the only options is blinkered and irrational.

There are a range of regulatory models that can be considered, allowing controls over products, vendors and availability—these offer potentially significant reduction in the harms associated with NPS and it would be negligent to rule them out. They have been experimented with in some countries, and are being considered by the current European Commission impact assessment of NPS.

Such developments might appear at odds with the prevailing prohibitionist ethos—but they may in fact offer a unique opportunity for a controlled experiment; guiding drug policy by pragmatic health principles rather than "tough on drugs" posturing or knee jerk populism.

Background and Context

Transform aims to support development of the most effective models for the regulation and control of non-medical drugs. The aim is to reduce the health and social harms associated with use of drugs, as well as wider social harms associated with the drug markets.

To this end we advocate both:

- the establishment of appropriately regulated markets for adult use of currently illegal drugs (as detailed in our 2009 publication *"After the War on Drugs; Blueprint for Regulation"*[1]); and
- Improved regulation of currently legal drugs , most obviously including alcohol and tobacco; including controls on price/taxation, packaging, age controls, branding and advertising etc (See *"After the War on Drugs; Blueprint for Regulation"* chapter 5).

The goal of both processes is to establish the optimal model of regulation to achieve the shared goals of minimised health and social harms (see points 2.1 and 2.2 in our earlier submission[2]). Both involve increased levels of regulation, even if the starting point is different: the former in which regulation has effectively been abdicated to unregulated criminal profiteers, the latter which has seen historical under-regulation and corresponding over-commercialisation, gifting the market to non-criminal profiteers.

Transform's position on the non-medical misuse of prescription drugs and the recent emergence of a range of novel psychoactive substances is informed by the same rationale.

It is vital that both trends—and responses to them—are be seen in the context of:

- historically rising demand for non-medical drugs under a legal/policy framework which strictly prohibits most of those in greatest demand;
- the fact that drugs with similar effects—whether stimulants, psychedelic or depressant effects are easily substituted by users; and
- the reality that there are a range of factors that influence drug user choices between one drug and another—these include relative cost, availability, quality (purity/reliability), perceived risk and legal status.

Novel Psychoactive Substances

These are sometimes referred to in political and media discourse as *"legal highs"*—a term initially coined by those marketing them, and then latched onto by the media, but one that is increasingly unhelpful, not least because many of them are no longer legal (alcohol and tobacco are curiously never included under this moniker). "Novel Psychoactive Substance" (NPS) is a more accurate and focused term. There are a range of substances that come under this broad NPS heading, including a number of psychedelics,[3] but the majority of

the market (and correspondingly, concern amongst the drugs field and policy makers) has been and remains made up of synthetic stimulants, such as BZP, mephedrone, and naphyrone. These drugs meet the demand for stimulants that has historically been met by more familiar illegal drugs including cocaine, ecstasy/MDMA and amphetamines. An additional group of products are made using synthetic cannabinoids that mimic the effect of cannabis.

Focusing on the stimulant grouping; as an alternative to the more familiar illegal drugs, there are a number of reasons why the legally available NPS may be perceived as preferable:

— they are often relatively cheaper;

— they are more consistent in quality/strength (for context cocaine and ecstasy has been deteriorating in purity and consistency over the last decade);

— they are effectively freely available from online suppliers or local "headshops", thus avoiding the risks and pitfalls of engaging with the criminal market place; and

— whilst there is little evidence to suggest illegality is a significant deterrent , legal NPS still have the relative advantage of not being associated with the risk of arrest, prosecution and a criminal record.

Amongst the stimulant groups of NPS there has been an observable trend of new products emerging, establishing a market, and then being prohibited—often following a burst of high profile media around their risks. BZP was the first notable example in the UK, growing in popularity around 2004–06 before being prohibited for sale (but not importation and use) under the Medicines Act in 2007 and then prohibited outright under the Misuse of Drugs Act in 2009.

Mephedrone emerged rapidly during 2009–10, arguably, to some extent filling the void in the "legal high" market created by the BZP ban. Mephedrone was then prohibited under the Misuse of Drugs Act in late 2010. Following this ban a large number[4] of other synthetic stimulants have subsequently emerged onto the market.

The market is effectively unregulated, creating a series of risks:

— *There no quality controls.* Whilst the quality (in terms of purity) of BZP and mephedrone before their respective bans, appears to have been quite high and reliable, more recently quality of legal NPS seems to have become more variable Recent research[5] based on analysis of text purchases (published in July 2012) suggested that many of the substance being sold online as "legal highs" contained substances other than those advertised, often including prohibited substances. Studies have suggested that some users now accept the unpredictability of what they are consuming—referring to what is sometimes called *"bubble"*, an unspecified/unidentified white powder that will have some level of psychoactive effect.[6]

— Because these products cannot be sold for human consumption they are sold for other purposes—such as "*research chemicals"*, *"bath salts"* or *"plant food"*. This means concerning content, dosage, and risk/harm reduction information.

— *There are no age controls for purchase.* Whilst most "head shop" sales have some (often inadequate) voluntary age controls in place, online sales have little or none—meaning these products are effectively available to anyone able to purchase online. For younger or novice users the unregulated legality—when viewed alongside strict prohibitions on other drugs—may give the inaccurate impression that the legal status and availability implies relative safety.[7] There is some evidence that as well providing a substitute for illegal drugs some NPS have been gateways to initiation of some younger first time drugs users.

The rapidly changing nature of the NPS market creates additional challenges for the police—who are unable to identify substance; forensic services—who have to test for them; emergency services—who have difficulty identifying what substances an individual in an emergency situation may have taken, and drug service providers—who have little information on how to deal with problematic use of such drugs, assuming they can be identified.

Discussion Points

— The "legal" NPS market has largely emerged in response to demand for the effect the drugs provide in the context of historic prohibitions on such products. When legal products arrive that compare favourably to their illegal counterparts in terms of effect, risk,[8] quality and price—it is unsurprising that they become popular, and to some extent displace some illegal drugs. This phenomenon, and the specific challenges created by the rapid emergence of multiple NPS with unknown risk profiles occurs largely because of the lack of legal availability of more familiar and well understood drugs such as cannabis, ecstasy/MDMA, cocaine and amphetamines.

— The emergence of NPS can therefore be seen as driven primarily by the prohibitionist legal environment. There would have been, for example, no demand or market opportunity for products like *"Spice"* (one of the popular brand names for—now prohibited—synthetic cannabis products) if cannabis were legally available. Whilst demand remains for a particular drug (or drug effect), the profit opportunity this creates means that the market will always find a way to meet it—whether legal or illegal.

— Just as the emergence of NPS are an unintended consequence of historic prohibitions, so prohibiting a particular NPS can then have significant unintended consequences. Especially when demand for a given substance has been established, a ban is likely to have one or more of the following impacts:

(a) Create a void in the legal NPS market into which one or more new substance will move (the net health impacts of which are impossible to predict).

(b) Divert users back to the illegal substances the NPS are likely to have been a substitute for (exposing users to the risk of the illegal market and criminalisation over and above the risks of the drug use).

(c) Lead to the emergence of criminal market for the formerly legal NPS—in which it is likely that the quality (in terms of purity and reliability) of the product decreases and the cost increases.

Illustrative of this is that all of these impacts have been observed to some extent in the wake of the 2010 mephedrone ban.

What can be done?

New powers now exist to establish a 12 month ban on importation and sale of drugs following advice from the ACMD—to allow for an appraisal of risks, and decide on what course to take (notably, possession of these "banned" drugs is not criminalised).

Whilst the ACMD are well qualified to provide a risk assessment (at least with what limited evidence is available) the problem they face is translating this analysis into effective policy recommendations given the lack of options available to them. Currently the options, once any temporary import and sale ban expires, are limited to either an outright ban under the MDA, or unregulated legal free for all. As this briefing makes clear, both scenarios are highly problematic.

There is an urgent need to explore options that occupy the middle ground between blanket prohibition and unregulated free market. These could allow regulatory tools be deployed that offer a degree of control over products, vendors, and availability.

Some limited potential exists for using trading standards legislation or medicines legislation,[9] but neither are adequate in the long term—what is needed is dedicated legislation and a regulatory model, custom made for the purpose of controlling non medical use of potentially risky psychoactive drugs. International law (the UN drug conventions) has been a barrier to exploration of such models for currently illegal drugs—but no such barrier exists for NPS. As such they provide an opportunity to explore regulatory alternatives to the obvious failings and counterproductive nature of blanket prohibitions.

Clearly no substance should be allowed into any commercial market without at least a basic level of risk evaluation so a default prohibition on commercial sale of any new NPS is justified. However, such bans on emerging products will only be effective if there is a regulated outlet of other products that can meet pre-existing demand. Without some form of legally regulated supply the problems outlined above will inevitably continue, and in all likelihood get worse. Some form of regulated availability does not, of course, preclude increased investment in evidence based prevention and risk education that targets vulnerable populations—indeed, such interventions should form part of any drug policy.

In the longer term any regulated models for legal availability of NPS (as happened in New Zealand for BZP) are likely to create a problematic inconsistency between legal and illegal drugs—not least in terms of perception of risk. There is a need to explore models of regulation for all currently illegal drugs as well to create a level playing field—the rationale for which is explored in more detail in Transform's previous submission.

Prescription Drugs

The non-medical use of prescription drugs is also primarily demand driven and is unlikely to be substantially reduced unless alternative supply routes that meet demand are established, or demand can be reduced in the longer term. The ready availability of certain drugs, such as benzodiazepines, opiates, and amphetamines is a by-product of their extensive medical use. A strong argument can be made that many are either overprescribed, or that prescribing controls are inadequate. Increasing restrictions may appear an obvious solution, but there may again be unintended consequences in terms of displacing users to higher risk illegal drugs. Recent experiences in the US of an increase in heroin use following clampdowns on availability of some prescription opiates are illustrative of this risk.[10] The pragmatic solution would involve regulated supply of drugs that meets demand for non medical use in the short term, combined with longer term efforts to reduce demand.

As with NPS the choice is: unregulated legal markets, regulated legal markets or illegal markets controlled by criminal entrepreneurs; there must be no pretence that drugs can be eliminated altogether.

Recommendation

Detailed examination of options for regulation of NPS may be beyond the scope of this inquiry. However, the committee should recommend that such options be explored by the appropriate body. Reference can be

made to the Impact Assessment of options for NPS currently being undertaken by the European Commission, as well as work undertaken by UKDPC/Demos, and the experiences of New Zealand in regulating sales of BZP.

Further reading

- Novel psychoactive substances report. ACMD (2011): http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/acmdnps2011?view=Binary
- Winstock, A, Wilkins C "Legal highs The challenge of new psychoactive substances" Transnational Institute 2011: http://www.tni.org/sites/www.tni.org/files/download/dlr16.pdf
- "Taking drugs seriously: a Demos and UKDPC report on legal highs" UKDPC/Demos 2011:http://85.13.242.12/publication/demos-ukdpc-legal-highs/

References

1. Available online here: http://www.tdpf.org.uk/Transform_Drugs_Blueprint.pdf

2. Available online here http://www.tdpf.org.uk/Transform-HASC-submission-2012.pdf

3. Whilst some pharmaceutical preparations have psychedelic properties, most of the "legal" psychedelics market is dried plant products, notably including dried fly agaric mushrooms and dried peyote cactus. Neither are actually "novel" having been consumed for thousands of years.

4. Estimates suggesting as many as 40 last year. http://www.guardian.co.uk/society/2011/oct/25/legal-highs-automatically-banned

5. Ayers, T, Bond, J. *"A chemical analysis examining the pharmacology of novel psychoactive substances freely available over the internet and their impact on public (ill)health. Legal highs or illegal highs?"* BMJ Open 2012, Vol 2, Issue 4. http://bmjopen.bmj.com/content/2/4/e000977.full

6. Measham, F, Moore, K, Østergaard, J. Mephedrone, "*Bubble" and unidentified white powders: the contested identities of synthetic "legal highs"* Drugs and Alcohol Today VOL. 11 NO. 3 2011, pp 137–146, http://bit.ly/PPy5vv

7. Sheridan, J, Butler, R. *"They're legal so they're safe, right?" What did the legal status of BZP-party pills mean to young people in New Zealand?* International Journal of Drug Policy, Volume 21, Issue 1, January 2010, Pages 77–81.

8. In the absence of any formal evaluation, health risks are largely unknown, leaving knowledge on short and medium term risks to be established in an *ad hoc*, inadequate and dangerous fashion by experimental users and early adopters.

9. See *"Taking drugs seriously: a Demos and UKDPC report on legal highs"* UKDPC 2011 http://85.13.242.12/publication/demos-ukdpc-legal-highs/

10. Cicero, T *et al*. "Effect of Abuse-Deterrent Formulation of OxyContin" New England Journal of Medicine 2012; 367:187–189July 12, 2012 http://www.nejm.org/doi/full/10.1056/NEJMc1204141

September 2012

Written evidence submitted by Adam Langer (DP134)

Essential Points

1. What drug services actually treat is being misrepresented and needs to be theoretically clarified by independent qualified experts.
2. The information database of many of the incumbent service providers does not bear up to informed scrutiny, yet is being presented to those with political power as factually accurate.
3. Many of the employees of current service providers do not believe in the working practices they are forced to adopt, yet this voice is not being heard.
4. The inputs that lead to long term recovery from drug dependence are theoretically definable in terms clear enough for politicians to fully understand.
5. The managers and employees of both DAATs and service providers often lack the training and experience for what they do. Many are assuming they can forgo the specialist trainings that relate to working with addicts on the basis that backgrounds in social work, probation and mental health are adequate.
6. Replacement prescribing culture has become distorted, seemingly to plug the hole created by shortfalls of recovery capital within incumbent service providers.
7. The criminal justice system is in need of fundamental reform in terms of the way it addresses dependency within the prison/probation population.
8. NICE guidelines need to be followed.

Brief Introduction of Adam Langer

Background

Born 1964, London. Recreational and then dependent crack and heroin drug user. Experienced both community and residential drug treatment. Abstinent since 1999.

Relevant Training

Advanced Diploma in Integrated Humanistic Counselling (BACP accredited) 2005.

Relevant experience

Administrator for Outside Edge Theatre Company in London. Run by people in recovery from drug/alcohol dependence. Has produced professionally written and performed participatory theatre within treatment centres, community projects, and prisons for the past 10 years.

Counsellor at "Off the Record". Charitable youth counselling service in London.

Counsellor at Lampton Court Residential Drug Treatment Centre in Devon.

Senior Key Worker for Bethany Project, Barnstaple. Supported Housing service for homeless people with drug and alcohol dependency issues.

Spent the last two years advocating for better drug and alcohol services for Devon.

Professional supervisor: Ursula Carter (UKCP).

Experienced a total of 18 months addiction focused participatory group therapy.

Attended a variety of mutual aid organisations for 14 years (more than 5,000 hours of witnessing the testimony of other addicts), including representing Devon, Cornwall, and the Channel Islands for the largest addiction focused mutual aid organisation at their National committee level.

Factual Information for Improvements to Drug/Alcohol Treatment Services

A brief look at terminology

1. There appear to be a variety of highly subjective representations of what services are actually treating. Though an uncomfortable place to start, a glance at terminology and meaning seems important.

2. "Dependency" and "Addiction" both imply an impaired faculty for choice. Dependency seems to be a statement of circumstance rather than a diagnosis. It begs the question "dependent on drugs/alcohol to do what"?

3. "Addiction" seems to hold two interesting dynamics. The first is its etymological root. Past meanings include "yielding to", "sacrifice", "sell out", "betray", and "devotion". Its literal composition, holds, "ad"—to, "diction"—language.

Putting these together; Clients of drug and alcohol services appear to have yielded to, sacrificed themselves to, devoted themselves to a relationship with artificial chemicals rather than their bodies own natural chemistry which they have betrayed (I don't particularly like these words, but they are the etymological roots listed and seem useful here). They have also stopped expressing themselves in the direction of, "to", their needs, choosing the direction of artificial chemicals instead. They have become "flat affect", only expressing emotion in extreme passive-aggressive outbursts. By drowning out the body chemistry that is their emotional content, they have ceased to be motivated to express themselves in accordance with this natural self care system. They do not feel the chemistry of guilt or love even if it exists powerfully within them, so act in ways that hurt the people that matter most, leading to rejection, social exclusion and often homelessness. Thus the distinction between "an addict" and a "non addict" is the compulsive patterning to avoid experiencing the body's own wisdom.

4. My own experience of clients has led to the belief that dependency is on self medicating overwhelmingly difficult/painful internal phenomena. Behaviour, though apparently choiceful to begin with, has become compulsive to the point that even when primary relationships, and personal health and liberty are being destroyed, the client does not stop. The pain being medicated can be physical, emotional, or psychological, and only at the point when the fear of phenomena such as death become so dominant within awareness that artificial chemicals won't drown them out, does the willingness to seek help and engage in a process of change becomes possible. This is the stage of "action" within the cycle of awareness, and the state that most clients present.

5. Many service providers respond to this healthy anxiety and readiness for change with fear. They choose overcautious replacement prescribing regimes as a means of short term harm reduction without appearing to understand the consequences of this in terms of medium/long term harm, or the damage to a recovery process.

6. Many years ago I attended a lecture about the nature of emotion. It described emotions as "E"—the energy of, "MOTION"—action. The lecturer described how thoughts on their own do not lead to actions. It is

the emotional relationship with phenomena that motivates actions. When a client's emotional experience is dominated with mood altering chemicals (including replacement therapies), they do not experience the necessary anxiety needed to motivate self care.

7. Causes: Some people believe that there is an addictive gene, others that addiction is related to trauma, and some hold spiritual beliefs that explain addiction as something of that domain. Using an informal disease model (not a conventional medical disease), avoids the problem of trying to define something that is experienced so subjectively. Current treatment options are not reliant on a particular causal root.

8. As a trained counsellor I was taught to trust the "Self Actualising Process" of the client. This concept, born of the Person Centred model of psychotherapy holds that all people are meeting their needs as well as they can within their frame of reference. When given the chance to express and explore their frame of reference more fully their self awareness grows and they make more self enhancing choices based on their better grasp of their circumstances. Whilst there are many models of psychotherapy, most support this dynamic as the fundamental foundation of the therapeutic process.

9. What is strikingly consistent with the clients of community drug and alcohol services is the client's unwillingness to experience their frame of reference, "their world" in an authentic way. Whilst everyone has parts of themselves that they fear to acknowledge (existential givens), those people who have become locked into self destructive patterns of drug and alcohol use experience a sort of extreme panic at the thought of experiencing their lives in an authentic way. This panic is, to my mind, still part of their Self Actualising Process. I guess we have all witnessed, in films if not in our own lives, people who in a state of panic, run in front of cars, over cliffs, say the worst thing at exactly the wrong time etc. These people's internal realities are experiencing a fear similar to that of impending death even when their external world clearly doesn't fit this. It appears to be the central challenge of drug and alcohol service provision to find affordable ways of helping clients to bridge the gap between their internal and external worlds. This "is" the recovery process. Clients need to re-establish relationships of trust with the outside world so that when difficult internal experiences arise for them, they meet their needs, reaching out for help rather than just trying to drown out their body's messages.

10. Current providers have accumulated a huge and ever increasing number of clients who are dependent on replacement prescriptions. Devon DAAT has stated "The Methadone trail in Devon is huge". Clients begin trainings and work whilst still on replacement prescriptions. This traps them in a position of either maintaining their replacement prescription or facing the psychotherapeutically unsupported and traumatic movement into authentic experiencing whilst trying to maintain work or education commitments. Unsurprisingly, overwhelm, relapse, and a new replacement prescription is the most common outcome.

11. There are two processes that seem to achieve the needed bridge of trust between internal and external worlds mentioned above. Both are specific types of relationship.

1. A psychotherapeutic relationship.
2. A peer mentor relationship.

12. In a psychotherapeutic relationship the therapist has developed the skills to provide a relationship that holds heightened awareness of the client's world so here-and-now phenomenon are explored or avoided according to a fine sensitivity to what the client can handle being with. The therapist has the personal development to avoid polluting the relationship with personal stuff that would be unhelpful, differing to the client's experience. Pacing the highlighting of incongruencies within client disclosures also requires deep insight and sensitivity. Many tools employed by psychotherapists are also used in MI (Motivational interviewing), however, MI trainings are very short, just a few days. A psychotherapist will have undertaken at least two years training that included work on their own issues. Psychotherapy is a fine art with the self as the tool of the work.

13. There seems to be an unfortunate pattern with drug workers endeavouring to key work using MI. Even with psychotherapeutic training, it is extremely difficult to develop a therapeutic alliance with a client who is using mood altering chemicals. For someone who only has a brief MI training, it is not possible to create a therapeutically viable relationship. As clients fail to make progress, the worker has to find a way of maintaining a sense of validity to their endeavours. This requires a sort of cynicism about the client and their recovery, and a disengagement from the underlying vulnerability of the client to avoid acknowledging the skill shortfall within the professional. Once this has happened a co-dependent relationship emerges, with the member of staff seeing the client as failing in their recovery process rather than recognising the shortcomings within their abilities and treatment system being employed. The professional and client move into exchanging positions of "Victim, Rescuer, and Persecutor", the classic co-dependent triangle. Once co-dependency is in place the therapeutic process is blocked. When a project has a treatment philosophy based on MI, it seems the whole organisation becomes entrenched in co-dependency. Management act as unqualified pseudo-therapeutic supervisors of front line staff. They support and justify what their staff do to defend a reality too unpalatable for everyone to acknowledge as near valueless and often doing harm.

14. Design of this kind of flawed system of treatment seems to be the result of not respecting the need for specialist training and experience. In Devon, neither the DAAT nor management of commissioned services have any specialists qualified in the treatment of addiction within service design teams. Backgrounds in probation, mental health and social work are assumed to be sufficient, as if the specialist trainings that exist

are an unnecessary luxury. Over-reliance on guidance from incumbent commissioned service staff by DAAT management holds a conflict of interest that has no safe guards, and leads to skewed representations of data that support maintenance of the status quo.

15. Within a peer mentor relationship, it is empathic identification that creates the trust to bridge the gap between internal and external reality. Clients experience someone who has used drugs and alcohol in a similar way to them but who has managed to stop. This represents a believable and safe bridge for them to also cross. Where the peer shares that they can accept awareness of, move through and then beyond uncomfortable internal experience, clients realises they can too. Shared historical experience also helps facilitate trust and empathy.

16. It is these relational aspects of client experience that are not being adequately met. Clients do not engage with services because they feel too scared of what experiencing their worlds authentically will feel like. They sabotage their own treatment plans.

FIVE KEY AREAS FOR IMPROVEMENT/SAVINGS

1. Cutting back the CBT workshops offered before clients detox (excluding harm reduction).
2. Redesign of replacement prescribing culture.
3. Underuse of the mutual aid organisations.
4. Redesign of criminal justice system's sentencing and treatment regimes.
5. Better use of Tier 4 budget.

17. The rationale for this is described above.

18. Current prescribing policy is incoherent and ineffective. Replacement Therapies are accumulating clients suspended in chemical limbo. With only nine residential rehab places for drug users and only 17 for Alcohol each year for the whole of Devon (£200,000 total budget), most of the thousands of registered clients remain in community treatment for years, making little or no progress. The supported housing projects have to manage extremely chaotic people. Virtually no one breaks free from dependency, and community spirit has been sapped.

19. The first change to prescribing policy is distinction between "harm reduction" and "recovery" prescribing.

20. A client's human rights might include "choice to remain on a replacement prescription". If not upheld, client overdose could be argued as resulting from clinical negligence. Until proven both ethical and viable, long term prescribing should remain an option.

21. Clients who choose long term prescribing should be key worked from a harm reduction and health monitoring perspective.

22. Clients choosing recovery should be stabilised and ready to begin their detox within the "12 week effective drug treatment" window. If clients have dual diagnosis issues these should be addressed through appropriate prescribing within this time. If a client is too chaotic or has such antisocial behaviour that this proves unachievable, they should be presented (accompanied) by key workers to mental health services and a short term solution agreed. If not possible, a mental health section order should be recommended. Leaving unstable clients within communities costs a fortune to police, hospitals, social services and others. It deepens client feelings of despair and alienation, and damages communities.

23. In most circumstance, clients will be clean and have completed treatment including any aftercare, within 26 weeks of first presenting, providing huge savings.

24. NICE guidelines state that "All treatment professionals should routinely provide information on self help groups; these will normally be 12 Step, for example Narcotics Anonymous, Cocaine Anonymous". It also recommends that key workers accompany interested clients to their first meeting. This is not being followed. With services utilising the mutual aid groups, many of their clients will establish lives in recovery without needing expensive long term community or residential treatment.

25. The criminal justice system seems to be a place of huge wastage. What is needed is not currently achievable as many elements require legislative changes by central government. I've including them as the only way to arrive at a coherent system is stake holders grasping how their actions affect partner agencies.

26. In principle, someone found guilty of drug/alcohol related crime, should be required to address their dependency issues. Clients who consent to undertaking a detox and attending an intensive therapeutic program within the prison system (eg Rapt) should then by made eligible for unusually early release (25% of sentence?) on probation orders requiring regular testing, attendance of mutual aid groups (12 Step groups run a chit system for verification) and abstinence. This will create huge savings and see many prisoners achieving socially harmonious patterns of life rather than the huge rates of repeat offending that currently exist.

27. Clients who have just committed drug related crime but refuse drug treatment should be denied probation as they are choosing to stay in patterns that will in all likelihood lead to reoffending on release.

28. Drug rehabilitation requirements should include attendance of mutual aid groups for the reasons described earlier in this document regarding life style changes and a movement away from old using peers to new recovery peers.

29. The clients I see going through the prison system have all been maintained on replacement prescriptions. They immediately relapse into the same patterns they were in before their last arrest. Money spent on policing, judiciary and prison services has all achieved nothing for the community or for the client, other than a holiday in the company of people also entrenched unhealthy patterns of behaviour.

30. Sentences cannot currently specify which prison someone is to go to. This needs to be changed. Someone sentenced for a drug related crime should be sentenced to attend a prison with a therapeutic drug treatment regime.

31. Quasi residential services using the Supported Housing sector for accommodation can offer the same standards of intensive psychotherapeutic treatment journey for about a third of the cost of most residential Tier 4 services. They also create excellent recovery capital for Tier 3 services. Action on Addiction's SHARP projects exemplify good practice.

32. These might be fundable solely through savings from Tier 3 budgets, which would be an ideal. If this proved possible, the Tier 4 budget could be used to focus on meeting the needs of dual diagnosis clients who are not stable enough to be treated within the community.

January 2011

Written evidence submitted by RehabGrads (DP141)

SUMMARY

This submission, from the RehabGrads, provides evidence that it is possible to recover from addiction and alcoholism and to live a life free from all mood altering substances illicit and prescribed, including alcohol.

This submission draws attention to the fact that the term "recovery", within the field of addiction, has been hijacked by the harm reduction movement to enable the culture of substitute prescribing to become embedded in our substance misuse treatment system. This submission describes what the term "recovery" means, its history and proof that recovery from addiction is possible and accessible through residential rehabilitation.

Accompanied by a "Addiction Treatment Truths" factsheet, this submission draws attention to the danger of presenting harm reduction as a solution to addiction as opposed to a tool to be used on the path to abstinent recovery.

Recommendations discussed include:

- Promoting abstinent recovery within the substance misuse treatment system.
- Residential rehabilitation should be a readily accessible option for any addict or alcoholic who seeks its.
- That immediate action needs to be taken to address the rate of closures within the residential rehabilitation marketplace.

1. In response the closure of 32 residential rehabilitation facilities across the UK in the preceding 24 months, the RehabGrads were formed on 14 July 2010 at a meeting of the Concordat—a collective of 46 residential rehabilitation centres across the United Kingdom.

2. As the graduates of residential rehabilitation programmes, now leading a life free from all mood altering chemicals, including alcohol, our purpose is to demonstrate that recovery from addiction is possible and that it can be achieved through attending residential rehabilitation.

3. In five short months we have organised ourselves nationally, regionally and locally as a nationwide volunteer network able to advocate for recovery and for residential rehabilitation. We seek to break down the stigma surrounding addiction and alcoholism.

4. The RehabGrads are now represented on The Recovery Group (RGUK), The Recovery Partnership and lastly the Residential Rehabilitation Expert Group. RGUK is a group of the leading minds in addiction treatment in the UK. Represented at this group amongst others are DrugScope, Addaction, The Concordat (a collective of 40 residential rehabilitation centres), Turning Point and BAC O'Connor. We debate current policy, its implementation and ongoing strategies to bring current drugs treatment policy into being. The Recovery Partnership and the Residential Rehabilitation Expert Group, both chaired by David Burrowes MP, are informal policy advisory groups which feedback deliberations directly to Oliver Letwin and the Inter Ministerial Advisory group for substance misuse treatment. Whilst we collectively have a significant voice drug treatment policy implementation is still led by the NTA and its policy is still centred around and focused on harm reduction. This is unacceptable.

5. It is important to understand the word "recovery" in respect to addiction and alcoholism.

6. The term recovery was first used by Alcoholics Anonymous in 1934 to describe entering into a life of total abstinence from alcohol, in essence to "recover" from alcoholism. Further adopted by Narcotics Anonymous and Cocaine Anonymous the term, within the realms of addiction, is used to describe leading a life free from ALL mood altering substances—illicit, legal or prescribed—including alcohol.

7. The "treatment" system in the United Kingdom is STILL centred around harm reduction ie substitute prescribing. It continues to be so despite the 2010 Drugs Strategy being focused in abstinence and recovery. Our members have all experienced this treatment system from periods ranging from one to 10 years, told that the best we could hope for was to "stabilise" our chaotic using through substitute prescribing. Once given the opportunity of recovery via residential rehabilitation we have become productive members of society. We have collected hundreds of "life stories" describing life before rehabilitation, during rehabilitation and after rehabilitation.

8. Consistent in all these stories is the problem one faces when entering into the treatment system. Substance misuse workers have been educated that prescribing substitutes is THE solution. It is virtually impossible to be referred and then funded into residential rehabilitation despite the success of such facilities.

9. Susbstitute prescribing as a solution leaves the addict in a desperate state—tied to the demeaning daily 'pick up' from the chemist, more often than not then needing to pick up the street drugs still needed to satisfy the untreated addict mind and left, in the worst case scenario completely unable to work or to function. Giving methadone, an opiate, to a heroin addict is akin to giving an alcoholic a daily drink to stop the shakes … its DOES NOT SOLVE THE PROBLEM. We know because we have been there.

In short the current treatment system in the UK is keeping addicts and alcoholics locked in addiction. Referrals to residential rehab were down by more than a third last year again. This is nothing short of criminal.

10. As the RehabGrads with a volunteer membership of thousands we are the demonstration of what happens when offered a chance of genuine recovery. Many of us accessed residential rehabilitation through family funding having been systematically denied the opportunity by treatment service providers and treatment commissioners. We are campaigning to ensure that the state delivers on its promise to grant addicts and alcoholics in desperate need of residential rehabilitation the opportunity to access it. The average addict or alcoholic never meets anyone in recovery as treatment services, steeped in harm reduction, do not enable service users the opportunity to attend abstinence groups or meetings. This keeps the service users 'sick', the service workers gainfully employed achieving nothing and society is left with an every growing number of people entering treatment and never coming back.

11. The only source of "facts" about the success of the treatment system come from NDTMS (see attached "Addiction Treatment Truths" factsheet). In 2010 NO ONE was recorded as leaving treatment abstinent from anything other than illicit opiates and crack cocaine, 75% of the 200,000 in treatment were on prescription (mainly methadone) of whom 49% had been so for more than five years and only 2% had been referred to residential rehabilitation.

12. Research carried out by the Concordat in 2011 demonstrated that the average cost to society of an addict in the year leading up to entering residential rehabilitation is £85,000—this is based on GP visits, criminal justice and police expenditure, NHS funded detox, prescriptions. An episode in residential rehabilitation, for six months, costs on average £14,000. Drug users who go to residential rehab are seven times more likely to be drug-free after three years than those who go to methadone clinics. (Drugs Outcomes Research Study in Scotland—The Centre for Drug Misuse Research, University of Glasgow).

13. A recent survey (soon to be published) of services users in Birmingham shows that 10% of those service users would like the opportunity to go to residential rehabilitation. A second survey (soon to be published) of service users in the Wirral shows that 50% of service users do not want to be on prescribed substitute medication but are unable to access a pathway to achieve it.

14. Despite the 2010 Drug Strategy having "recovery" and abstinence as key elements of the strategy, referrals into residential rehabilitation are down by over a third from five years ago. In the same period of time the national treatment budget had doubled.

15. In light of all these points and in further reference to the attached "Addiction Treatment Truths" factsheet it cannot be claimed harm reduction "treatment" works as a solution to addiction. It can be seen as vital part of the treatment system IF it is seen as a stepping stone on the journey into recovery—a life free from all mood altering chemicals, illicit or prescribed

Conclusion

16. It is clear that the current "treatment" system neither provides nor promotes adequate pathways into abstinent recovery, despite the 2010 Drugs Strategy having recovery at its core.

17. Service users are being denied the opportunity to recover, being kept locked in a co-dependant relationship with treatment service providers and the situation is getting worse and worse.

18. Residential Rehabilitation DOES provide an exceptional pathway into abstinent recovery, however it is an extremely underused resource and the industry faces significant challenges in 2012 and beyond. Unless direct action is taken within Government then more residential rehabilitation centres WILL close and the huge depth of experienced addiction therapists will be lost.

19. The cost to society as a whole cannot be underestimated, both financially and socially if the 2010 Drugs Strategy is not implemented as it was intended to be.

20. Significant work needs to be done with treatment service providers to educate service workers, and service users, about true abstinent recovery and when it is right to refer to residential rehabilitation.

21. The RehabGrads are working extremely hard to demonstrate that abstinent recovery works, that it is achievable and that making proper use of residential rehabilitation facilities is vital to creating a vibrant, healthy and socially beneficial recovery community in the United Kingdom. To achieve this we have forged working relationships with the big treatment providers, like Addaction, and are proposing to offer a nationwide network of Recovery Champions to treatment providers and service users, to guide service users on their journey into abstinent recovery. We are developing a nationwide addiction prevention "Schools" project with the Amy Winehouse Foundation, to carry our message and experience to parents and schoolchildren alike to break down the stigma around addiction.

22. Recovery from drugs and alcohol abuse is possible, we are the active and real life demonstration of that fact and we will work tirelessly to achieve our goals.

January 2012

Addiction Treatment Truths

(2010 figures, National Treatment Agency)

- 204,473 "in contact" with treatment services (100%);
- 75% on prescription (mainly methadone);
- 49% on scripts alone with NO other intervention or support;
- 19% of those on scripts have been for *more* than five years;
- Methadone consumption not supervised after three weeks;
- 5% inpatient detoxification * *see note*;
- 2% (or less) residential rehab (of unknown length and at an all time low)* *see note*;
- 0% leave treatment abstinent and sober (no records taken) NDTMS treatment discharge figures refer only to "freedom" from illicit opiate or crack use, not from opiate substitutes, alcohol, cannabis or other illicit drugs**;**
- £730 million spent annually on this "treatment" system;
- £3,800 for each addict "in treatment";
- £300 per addict per annum methadone dispensing costs;
- £1.4–£1.7 billion spent on benefits of those in treatment (without child care costs) *see Breaking the Habit CPS 2011* http://www.cps.org.uk/cps_catalog2/Breaking_the_Habit.html
- average cost to society of an addict or alcoholic in active addiction, in the year leading up to admission into residential rehabilitation £85,000—including costs for hospital detox, police and criminal justice, GP visits, prescriptions. Does not include benefits. (Research carried out the The Concordat 2011);
- average weekly abstinence based rehab costs £550 per week—less if housing and other benefits used to contribute to cost;
- approximately 3,200 beds in England and Wales;
- rehab referrals down by over a third from five years ago (it was nearly 6,000 then);
- on average 1 in 3 of those people referred to residential rehab go on to receive state funding and successful admission into rehab; and
- drug users who go to residential rehab are seven times more likely to be drug-free after three years than those who go to methadone clinics. (Drugs Outcomes Research Study in Scotland—The Centre for Drug Misuse Research, University of Glasgow).

* These figures from the most recent NDTMS report *(Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2010—31 March 2011)* taken from table 3.2.2 may be inflated as they do not tally with another table 3.2.1 on the same Page (12) that reports only 3,845 Inpatient detoxification "pathways" last year which would be less than 2%. This requires further investigation—possibly a parliamentary question. Similarly there is a discrepancy between two tables regarding the residential rehab figs which would make RR figs 1.2%.

Written evidence submitted by Peter Hitchens (DP155)

THE WRONG END OF THE TELESCOPE

Why all inquiries into drugs miss the point

Submission to the Home Affairs Committee by Peter Hitchens, journalist and author of *"The Abolition of Britain"* (1999), *"A Brief History of Crime"* (2003) and of the forthcoming *"The War We Never Fought—Britain's non-existent war on drugs"*.

My simple point is that there is a national misconception, in politics, the academy and the media, that Britain's drug laws are repressive and harsh, that a "War on Drugs" is taking place and that many baleful results follow from this misguided prohibition. The truth is rather different. Despite a smokescreen of militant rhetoric, British governments, together with the police and the courts, have pursued an increasingly permissive attitude towards drugs, especially towards the most commonly used drug, cannabis, for four decades.

Whatever problems we face, a war against drugs cannot possibly be the cause of them, for there is no such war.

This truth is clearly visible on the public record, and hides in plain sight, ignored and disregarded in inquiry after inquiry, debate after debate. I am engaged in a history of this strange process, and I hope the brief selection of facts and quotations below will give some idea of the point I wish to make to the Committee.

In October 1973, Lord Hailsham, then the Lord Chancellor of a Conservative Government, instructed Magistrates in England and Wales to stop sending people to prison for possession of cannabis.

He told a meeting of the Magistrates' Association that they should not "dive off the deep end" when confronted with cases of possession of cannabis. Correctly interpreting the 1971 Misuse of Drugs Act's main provision, he said Parliament had drawn a distinction between possessors and traffickers. Magistrates should therefore treat users of what he called "soft drugs" with "becoming moderation". They should and take care over ascertaining the background. It would be quite different when large parcels of cannabis were discovered, when a deterrent sentence would be justified.

Hailsham advised the magistrates to distinguish between what he termed "retail and wholesale trade", and between transactions among neighbours "in the way of social intercourse" and transactions where money changed hands—expressing the curious belief that such neighbourly transactions did not involve money. He advised them "Do not lose your heads as judges because the drug is new to your experience and has a sinister ring". In the same speech he helped the transformation of the illegal drug user from culpable criminal to pitiable victim by insisting that "the addict must be treated as a human being".

He wound up his declaration of peace by saying "Don't let your prejudice, if you have one, against the offence, lead you to deal unduly harshly with the offender". (*The Times*, 13 October 1973, p 3 column a)

He gave this speech just as the 1971 Misuse of Drugs Act was about to come into force. This Act was the consequence of the 1969 Wootton Report, the prototype of every subsequent inquiry into drugs in this country.

It is widely believed that the Wootton Report called for Cannabis legalisation and was denounced and rejected by the then Home Secretary, Jim Callaghan. In fact it did not call for any such thing. And—though Mr Callaghan did indeed denounce the report in Parliament—most of its provisions, much desired by the powerful and influential establishment pro-Cannabis lobby which had taken out a famous advertisement in the Times, were in fact incorporated by Mr Callaghan into a planned Misuse of Drugs Bill in 1970. This fell, thanks to the 1970 General Election. But so important was it considered that the incoming Conservative Government immediately revived the Bill, in identical form, and it was quickly passed through all its stages with more or less bipartisan support (The then William Deedes being rather keener on it than James Callaghan). Mr Callaghan's Cabinet defeat on this issue is recorded in the Crossman Diaries (Jonathan Cape, London 1979, One Volume edition, p 613) and in Cabinet papers (CC70, 10th Conclusions, pp 10–11). It took place on Thursday 26 February 1970.

The crucial changes were the separation of cannabis from heroin, Cocaine and LSD, and its treatment as a supposedly "softer" drug, and the establishment of the rule that trafficking should in future be treated more seriously than possession. The absolute offence of allowing drugs to be used on one's premises was also to be abolished. A permanent committee was also to keep the law under perpetual review, as it still does in the shape of the Advisory Council on the Misuse of Drugs. This arrangement has not generally led to the tightening of the law. But it is not just the law itself that is changing. It is the way in which it is enforced.

Next, in 1976, the maximum penalty for cannabis possession was once again reduced by half to three months—one month less than the maximum proposed in the Wootton Report.

"In 1979 the Advisory Council on the Misuse of Drugs (the statutory successor to the Advisory Committee) proposed further reforms whose effect would be to remove the remaining powers of the courts to sentence offenders to imprisonment. These proposals were reiterated in a second expert Report on Cannabis, in 1982. The response of the Thatcher government was to move in the direction of decriminalisation by introducing cautioning and compounding (small on the spot fines for smuggling). By the beginning of the 1990s, the majority of cannabis offenders were cautioned and thus escaped without a criminal conviction. Cases which

do reach the courts normally result in discharges or small fines. Sentencing guidelines prevent imprisonment of minor offenders."

"When *The Times* finally came out for legalisation of cannabis, on the 25th anniversary of the Soma advertisement, the leading article said, correctly that "the law against cannabis is all but unenforced." (Stephen Abrams, The Wootton Report, 2007).

"The situation in 90s Britain is that sentences such as those passed on Hoppy [John Hopkins, leading counterculture figure in 1960s London, sentenced to nine months in prison for cannabis possession, June 1967] or Keith [Richards, sentenced, also in 1967, to one year for allowing premises to be used for consumption of drugs, later overturned on appeal by the lord Chief Justice] are virtually unknown unless large scale dealing is involved or the sentence is concurrent with another, more serious charge and has been used to make the other charge stick … the members of Baroness Wootton's committee must be thanked for changes in the law that have kept thousands out of jail" ("*Many Years From Now*", a biography of Paul McCartney, Barry Miles, Secker and Warburg, 1997).

"Cannabis has been a decriminalised drug for some time now. Although still illegal, somebody found by police in possession of a small amount for their own use will probably just get away with a caution these days. There is no record taken, no evidence that anything has occurred." (John O'Connor, former head of Scotland yard Flying Squad, article in *The Daily Express* 15 February 1994).

And then. Who said this?: "Well, it's worth saying that of the offences against the Misuse of Drugs Act—these are very round figures as I don't have them to hand—of the 120,000 offences against the Misuse of Drugs Act every year, 90% of those which are dealt with are possession offences and three-quarters of those are cannabis possession offences. Now *over half of those cannabis possession offences are cautions* (my italics) but it is worth remembering that a caution does bring with it an entry as a criminal record."

And "The police have been very sensible in many ways about their approach to policing the Misuse of Drugs Act. I think without their massive use of discretion, it would have ground to a halt."

Later still, she says "At the moment, until our law changes, we have after all for personal use—in theory on the statute book—five years potential imprisonment for a simple possession of cannabis. Now that, I think I am accurate in saying, is more harsh than almost any other country in Europe. *I am not aware that there has ever been a prison sentence of anything approaching that for the simple possession of cannabis. In fact, the average length of a custodial sentence for any possession, including heroin and cocaine, is four months at the moment whereas for heroin and cocaine you could get seven years in theory. So there is a huge gap. One of the good things about the Home Secretary's—as it was stated—possible intention is that it will close the gap between what the law says and what it does.*"(My italics).

(Dame Ruth Runciman, Chair of the Police Foundation Independent Inquiry into Drugs, 1997–2000, speaking to a BBC News Talking Point Forum, 25 October 2001)

We should also include a word here from Baroness Wootton herself, in a letter she wrote to *The Times* in March 1977, responding to an article by Ronald Butt saying that Mr Callaghan had rejected her report. She said: She wrote: "Why, I wonder, has Mr Ronald Butt chosen this moment (March 17) to give thanks to Mr Callaghan for his rejection, when Home Secretary eight years ago, of the allegedly pernicious recommendations of what has become known as the Wootton Committee on Cannabis?"

"Is Mr Butt unaware of all that has happened since then?" While conceding that cannabis may possibly have long-term risks comparable to those of tobacco, she proclaimed "There has been a great change in the climate of Western opinion about the moderate use of cannabis and the proper scope of legislative action in relation to this".

"Most remarkable of all is Mr Butt's failure to notice that Mr Callaghan himself is moving with the times. The Government of which he is the head has just presented to Parliament a Criminal Law Bill which would halve, by a reduction from six months to three, the maximum sentence which a magistrates' court can impose for possession of cannabis."

"Contrary to what is widely believed, neither my committee nor I have ever advocated the legalisation of cannabis. But the Government's new proposal would bring the penalty for summary conviction of possession actually *below* (Lady Wootton's italics) the level recommended by the infamous Wootton Committee. (Letter to *The Times* from Baroness Woottton of Abinger, published 21 March 1977)".

And finally, "By 2009, cannabis possession was even more decriminalised than it had been in 1994. In that year (the latest for which I have been able to obtain these very hard-to-find figures) 162,610 cannabis cases were handled by police in England and Wales. Of these, 19,137 cases were dealt with through police "Cautions", which expire after three months and need not normally be declared to employers—a way of dealing with cannabis which dates back to 1991. 11,492 resulted in penalty Notices for Disorder, an on-the-spot rebuke which generally results in no punishment of any kind, which are recorded indefinitely. A mere 22,478 cases actually ended in court and many of them did so because they were only one of several charges against the defendant. The outcome of several thousand more arrests was simply not recorded and cannot be traced, an extraordinary fact in a modern, computerised country.

But the most significant and interesting figure was that 86,953 were dealt with by a procedure known as a "cannabis warning". This is a curious anomaly. Though it is recommended as the preferred response by the Association of Chief Police Officers of England and Wales (ACPO), it has no legal status.

It is not recorded centrally. A person could receive such a warning in several different jurisdictions, without the information being shared. It does not create a criminal record. No Act of Parliament mentions it. How did this highly significant legal change come about? I asked several government departments and the ACPO. They were unable to give me a clear answer." (extract from Manuscript of my own forthcoming book, "*The War We Never Fought*").

I would be more than happy to go into this at greater length and greater detail, and to answer questions on it.

February 2012

Written evidence submitted by the Home Office (DP157)

THE GOVERNMENT'S DRUGS STRATEGY

1. We make no apology for the fact that people caught with drugs are punished under the law; based on the potential harms to themselves and wider society and sending a clear message that using drugs is unacceptable. However, alongside this we are focusing much effort on promoting and supporting their recovery. Those who are addicted to drugs must be reintegrated fully into society. Statutory bodies and partner organisations are now incentivised to support a drug user to live a productive, drug-free life, taking into account all the needs of the person to achieve and sustain that. Positive outcomes for the individual and wider society are the key motivating factors for our drug policy.

2. The Drug Strategy 2010, "Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life" set out the Government's fundamentally different approach to tackling drugs as key causes of societal harm, including crime, family breakdown and poverty. The strategy raised ambitions to offer every support for people to choose recovery as an achievable way out of drug dependence.

3. The strategy also set out a radical shift in power to local areas. Through the introduction of Police and Crime Commissioners (PCCs), the reform of the NHS and the creation of Public Health England (PHE), the power to direct action will move to the local level. At the national level, the National Crime Agency (NCA) will co-ordinate enforcement efforts on organised crime and bring a sharper focus to national and international efforts to reduce the supply of drugs.

PROGRESS ON THE DRUG STRATEGY

4. The drug strategy was launched in December 2010. The scale of reform is unprecedented and to achieve real change for substance misusers requires action across government. Progress on the strategy is driven forward by an Inter-Ministerial Group (IMG), led by the Home Office Minister and comprising Ministers from all of the key departments responsible for delivering the strategy. The IMG includes the Department of Work and Pensions, the Department of Communities and Local Government, the Department of Health, the Cabinet Office, the Ministry of Justice and the Department for Education. This IMG meets monthly and is supported in its work by a cross-government senior officials group. The IMG is currently reviewing progress on the strategy one year on and will be launching a review and refresh of the strategy in April 2012.

5. The drugs strategy does not have numerous targets that could drive perverse behaviours in the delivery system. Rather we will be accountable to the public for a drugs strategy that has strong and safe communities at its heart with two overarching aims to:

(a) reduce illicit and other harmful drug use; and

(b) increase the numbers recovering from their dependence.

6. Whilst it is too early one year in to the strategy to judge final delivery we are seeing positive signs that drugs use is continuing to fall and more people are exiting treatment free from drug dependence.

7. England and Wales has around the lowest recorded level of drug use in the adult population since measurement began in 1996. Individuals reporting use of any drug in the last year fell significantly from 11.1% in 1996 to 8.8% in 2010–11, as did use of any stimulant drug from 4.4% to 3.5%. There was also a substantial fall in the use of cannabis from 9.5% in 1996 to 6.8% in 2010–11.

8. This scale of reduction is also mirrored in younger adults aged 16–24 where there have been significant reductions between 1996 and 2010–11 in the use of any drug, any class A drug and any stimulant drug as well as in specific drug types. The use of cannabis in the last year for example reduced from 26% to 17.1% over this time period.[165] The prevalence of drug use among 11 to 15 year olds has also declined since 2001. In

[165] Smith, K & Flatley, J (Eds) (2011) Drug Misuse Declared: Findings from the 2010–11 British Crime Survey. Home Office Statistical Bulletin 12/11. London: Home Office www.homeoffice.gov.uk/publications/science-research-statistics/research statistics/crimeresearch/hosb1211/hosb1211?view=Binary

2010, 18% of pupils reported that they had ever taken drugs and 12% said they had taken drugs in the last year, compared with 29% and 20% in 2001.[166]

9. There were an estimated 306,000 opiate and/or crack cocaine drug users in England in 2009–10.[167] This is a significant reduction from 321,229 in 2008–09. There are also strong signs that young people are not starting to use heroin and crack cocaine to the same degree as previous generations with significant drops in the number of heroin and/or crack cocaine users under the age of 35.

10. The previous Government's drugs strategy measured activity rather than outcomes and the current strategy is delivering results. The numbers successfully completing treatment free of dependence increased by 18% in 2010–11 to 27,969, and National Treatment Agency (NTA) figures for the first six months of 2011–12 suggest this improvement is being sustained.

11. Drug treatment is now available to anyone who needs it in England, and 96% of clients start treatment within three weeks of referral. The number of adults newly entering treatment for heroin and crack has fallen by 10,000 in two years (from 62,963 to 52,933). The reduction is fastest in younger age groups, with the number of 18–24 year-old heroin and crack users newly entering treatment halving over five years (from 11,309 in 2005–06 to 5,532 in 2010–11).[168] We believe this is due to less demand for services rather than a lack of access to services—the average wait for treatment is now only five days. We will continue to monitor these trends over the life of the strategy.

12. Important actions have been driven forward across government, including:

(a) Establishing eight drug recovery Payment by Results (PbR) pilots ensuring providers are incentivised to support people to be free of dependence where appropriate, rather than being paid to keep people in substitution treatment indefinitely.

(b) New legislation that enables us to rapidly place temporary class drug orders when new substances are identified that cause us sufficient concern so that we can protect people from harm and prosecute the dealers.

(c) Established a Forensic Early Warning System to identify new psychoactive substances that are being introduced to the UK drugs market.

(d) Re-launched the Frank website to provide advice for all people who come into contact with drugs.

(e) Planning for the implementation of Police and Crime Commissioners, Public Health England and the National Crime Agency

13. These are important and tangible outcomes demonstrating our commitment to driving change throughout the life of the strategy.

Fiscal responsible policy and cost effective policy

14. We have good evidence of the cost effectiveness of drug treatment. The Home Office Drug Treatment Outcomes Research Study found that for every £1 spent, an estimated £2.50 was saved and treatment was found to be cost-beneficial in 80% of cases.[169] Cost-benefit analysis of young people's drug and alcohol treatment also suggests positive results with a benefit of between £4.66 and £8.38 for every £1 spent.[170]

15. In some areas of the strategy, particularly those where it is difficult to establish a meaningful counterfactual or where there is little existing evidence (eg in the new areas around building recovery and reducing supply), work has started to build up the evidence of impact and cost-effectiveness. For example, the Home Office is conducting research to understand the impact that the reduced supply of heroin in the UK has had on users on a range of criminal justice and health outcomes.

16. We are currently developing an evaluation framework which will improve our ability to assess the value for money effectiveness of the drugs strategy and its component policies and programmes.

[166] Fuller, E (2011) *Smoking, drinking and drug use among young people in England in 2010*. London: NHS Information Centre for Health and Social Care
www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Smoking%20drinking%20drug%20use%202010/Smoking_drinking_and_drug_use_among_young_people_in_England_2010_Full_report.pdf

[167] Hay, G, Gannon, M, Casey, J and Millar, T (2011) National and regional estimates of the prevalence of opiate and/or crack cocaine use 2009–10: a summary of key findings. London: National Treatment Agency.
www.nta.nhs.uk/uploads/prevalencesummary0910.pdf

[168] National Treatment Agency (2011) Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2010 to 31March 2011. London: Department of Health/National Treatment Agency.
www.nta.nhs.uk/uploads/statisticsfromndtms201011vol1thenumbers.pdf

[169] Andrew Jones, Michael Donmall, Tim Millar, Alison Moody, Samantha Weston, Tracy Anderson, Matthew Gittins, Varunie Abeywardana and John D'Souza (2009) *The Drug Treatment Outcomes Research Study (DTORS): Final Outcomes Report 3rd Edition*. Home Office Research Report 24.
http://webarchive.nationalarchives.gov.uk/20110218135832/rds.homeoffice.gov.uk/rds/pdfs09/horr24c.pdf

[170] Frontier Economics (2011) *Specialist drug and alcohol services for young people—a cost benefit analysis*. Research Report DFE-RR087.
www.education.gov.uk/publications/eOrderingDownload/DFE-RR087.pdf

Policy grounded in science, health and human rights; and the independence and quality of expert advice given

17. As part of the development of the strategy we drew on a range of expert advice, research, evaluation and public consultation. We are committed to ensuring our research is up to date and informs ongoing policies as we implement the strategy. To this end we have an inter-departmental Drug Strategy Research Group which brings together analysts from relevant departments, research councils and the Advisory Council on the Misuse of Drugs (ACMD) to ensure better coordination of drugs research across government.

18. The Advisory Council on the Misuse of Drugs plays a key role in accessing and evaluating a significant amount of research to inform our policy development. In 2010 Sir David Omand completed a review of the Advisory Council on the Misuse of Drugs (ACMD).[171] The review concluded that the ACMD *"represents an essential authoritative cost-effective source of scientific advice on the classification of substances"* and *"….has been effective within the resources made available in fulfilling its statutory remit of providing independent advice on the harms caused by the misuse of drugs"*. We have implemented recommendations for Government to set out its work priorities for the ACMD on an annual basis, developed and published a joint Working Protocol, and provided additional secretariat resources from the Department of Health to support the ACMD's work.

19. The Government also ensures that expert independent advice from the drugs sector informs policy. In May, William Butler, chair of the Substance Misuse Skills Consortium, the chief executive of Drugscope, Martin Barnes, and Noreen Oliver, the chair of Recovery Group UK formed the Recovery Partnership. The Partnership's aim is to act as a critical friend to government by acting as a conduit for views from the sector on the implementation of the Drug Strategy. All three organisations are umbrella organisations and are therefore able to provide a good cross section of views from the frontline. However, this group will not replace engagement with wider stakeholders. The Partnership has already produced a sector view for Ministers on housing issues and payment by results approaches.

20. The EMCDDA (the European Monitoring Centre for Drugs and Drug Addiction) is (rightly) held up by the World Health Organisation as a shining example of a regional monitoring centre which benefits individual Member States, the EU as a whole and the wider international community. The UK is represented on its management board and finance sub-committee by a Department of Health official in order to provide assurance that its activities assist in the delivery of UK priorities and that funding is being used effectively.

21. Since its establishment in 1993, the EMCDDA has developed a wide and impressive range of instruments which it has used to collect information about the drug situation across Europe and encourage the collection and reporting in more comparable formats. The EMCDDA compiles an annual report on the state of the drug problem in Europe which collates information from across the region and provides a narrative of changes in drug use and associated harms across the region, as well as information on regional averages and trends.

22. This work has been assisted by a network of National Focal Points (also referred to as the "Reitox network") who act as national partners to the EMCDDA. The UK Focal Point is based at the Department of Health and submits a wide range of data to the EMCDDA each year as well as an extensive annual report. With a long involvement in interventions in the field of drug misuse, a large research community and long data series the UK has also contributed much expertise to the work of the EMCDDA since its inception.

23. The UK therefore has access to a vast range of information on the drugs situation, best practice, interventions, policies and laws which is of great help in the development and formulation of its own policies and interventions.

Criteria used for measurement

24. We are currently developing an evaluation framework for the strategy that provides a structure to: facilitate a common understanding of the programmes which contribute to delivering the commitments in the strategy; understand the existing evidence base; assess the impact of these programmes, and; identify the potential evidence gaps. This will be the first time that the Government has developed an overarching evaluation framework for its drugs strategy and this work will enable more robust assessments to be made of the fiscal and outcome effectiveness of the strategy.

25. At a local level we are ensuring that the incentive systems are effective for local commissioners and service providers to improve outcomes. We will not do this by introducing a myriad of indicators and targets and imposing them on local partners as the previous government did. Rather we are facilitating new, locally owned, outcome-based incentives and measurement methods. We have worked with eight payment by result (PBR) pilot areas to co-design outcome-based commissioning models focusing on reducing re-offending, improving health and wellbeing and achieving freedom from dependence. PBR outcome measures have been developed with local commissioners who will be setting tariffs that reflect local needs and priorities. We aim to expand outcome-based commissioning models to include all the elements (such as housing) that we know are important to sustainable recovery. The PBR pilots will be fully evaluated.

[171] Report of the 2010 NDPB Review of the Advisory Council on the Misuse of Drugs By Sir David Omand December http://webarchive.nationalarchives.gov.uk/+/http://www.homeoffice.gov.uk/publications/alcoholdrugs/drugs/acmd1/2010-ndpb-review-acmd?view=Binary

Drug-related policing and expenditure

26. Enforcement and reducing the supply of drugs is a fundamental part of our drug strategy. Illegal drug use causes serious impact to communities through drug related violence, anti social behaviour, acquisitive crime including burglary and robbery, knife and firearms crime and other criminal activities. These crimes are driven by the activities of suppliers, dealers and by users sustaining their habit.

27. Reductions in police funding over the Spending Review period are challenging but manageable. The urgent need to take action to address our budget deficit is clear from events across the world. We are cutting bureaucracy for the police so they can get out from behind their desks and on to the front line. By working more efficiently and driving out unnecessary costs savings can be found whilst protecting frontline services.

28. The case for local investment in reducing drug-related offending is clear. Offenders who use heroin, cocaine or crack cocaine are estimated to commit between a third and half of all acquisitive crime. In 2010–11, the Government provided £125 million to local areas to support them in delivering drug interventions as part of the Drug Interventions Programme (DIP) in order to tackle drug-related offending. DIP is estimated to help prevent around 680,000 crimes per year (though this number may be smaller if some individuals would have sought treatment anyway). Research showed that of the Class A drug misusers coming into contact with DIP, around half had a 79% fall in offending during the following six months.

29. The introduction of Police and Crime Commissioners (PCCs) will make forces truly accountable to the communities they serve, ensuring Chief Constables target their resources properly to where they are needed. This will provide genuine democratic accountability for the decisions and priorities that are set locally, with communities able to influence the activity that they want the police to take in response to local circumstances. Innovations such as crime maps provide transparency to communities, so that meaningful challenge can take place. From October 2011 drug offences (covering possession, supply and production) have been available on street-level crime maps on the 'police.uk' website giving the public greater transparency on the impact of these crimes locally.

30. As well as a local policing issue, drugs are a key factor in national and multinational crime, with over 50% of identified organised crime groups impacting on the UK being involved in trafficking illegal drugs. Criminals involved in drugs trafficking are also associated with firearms, robbery, handling stolen goods, extortion and vehicle crime. The supply of most drugs is controlled by organised crime groups. These groups do not respect international boundaries and span various police force boundaries in their activities, which can present challenges for any given police force. From November 2012 Chief Constables and PCCs will have a statutory responsibility to have regard to the Strategic Policing Requirement, including the need to have sufficient capabilities to contribute to the Government's Organised Crime Strategy. This will help ensure that tackling cross police force-area drug-related organised crime is also a priority for police forces and PCCs. Drugs are a key priority within the Organised Crime Strategy and within the UK Threat Assessment. Two Threat Reduction Boards co-ordinate domestic and international efforts on the organised crime drugs threat.

31. The National Crime Agency (NCA) will be a powerful crime fighting agency to enhance our ability to counter the threat from organised crime. The NCA will set the strategic priorities for the policing at and beyond our borders, enabling coordinated, intelligence-led action to be taken against those seeking to import drugs to the UK. The NCA will work with a wide range of partners, including other law enforcement agencies and government departments, the intelligence agencies, wider public and private sectors and partners overseas, bringing greater coherence to the reach and coverage of law enforcement efforts against organised crime.

32. We are not waiting until the introduction of the National Crime Agency to drive improvements in the way the police tackle organised crime, or indeed other national threats that cross police force boundaries. Keith Bristow—a senior Chief Constable with a track record of success in law enforcement—has been in post since December as Director General of the NCA. Driving early operational progress, including at the border, is a priority ahead of the Agency being formally established in 2013. We have issued a shadow Strategic Policing Requirement, setting out the Home Secretary's view of the national threats to which Chief Constables and Police and Crime Commissioners will have to have regard. The Organised Crime Coordination Centre is now up and running, providing, for the first time, a complete map of organised crime groups to drive better national coordination of law enforcement efforts.

Extent to which public health considerations should play a leading role

33. Our response to the harms from drugs draws on health, education and criminal justice responses to protect the public and support individuals. The best way to prevent the harms from drugs is to stop people taking drugs in the first place and to encourage and support those who do towards abstinence. This is the ultimate goal of this government. However, we recognise that complete abstinence remains a significant challenge to achieve so we are working to reduce the harms of those that are addicted to drugs and support them to recover. Programmes such as the provision of clean needles and swabs help to reduce infections of blood-borne diseases and other dangers associated with the misuse of drugs.

34. "Substitute prescribing" continues to have a role in the treatment of heroin dependence in stabilising drug use and supporting detoxification. However, too many people currently do not move beyond what should

be a first step to recovery free from dependence. Our strategy focuses on supporting all those in treatment to achieve recovery.

35. Public health and criminal justice have common aims in relation to drug misuse. For example 30% of new presentations into treatment were referred by the criminal justice system (CJS) in England and Wales in 2010–11. Previous research has shown that CJS referrals have similar levels of treatment retention, improved health outcomes and crime reduction as non-CJS referrals. It has also shown that a third of those referred from the CJS stated they would not have entered treatment at that time without the pressure resulting from their arrest.

36. The treatment of offenders with addictions is an area of significant focus for us. There is a risk that offenders can fall through a gap between leaving prison and accessing treatment in the community. Identifying the need and then providing individual-focused support that will follow a person from prison into the community is key. Integrated offender management systems are now running across England and Wales bringing together a range of agencies to promote sustained recovery for drug misusing offenders. The National Offender Management Service (NOMS) is also piloting drug recovery wings in prisons which place a strong emphasis on connecting short-sentenced prisoners with community based services to ensure better continuity of treatment and care. The first tranche of drug recovery wings were launched last June, and a second tranche, which will include at least two women's prisons and a Young Offenders' Institution will be implemented from April this year. As well as supporting the recovery of prisoners with substance addiction, NOMS is working to tackle the supply of drugs in prisons; this includes working closely with the Home Office to pilot mobile phone blocking technology. Further details of NOMS activity in support of the drug strategy are covered in their own submission of written evidence to the committee.

The relationship between drug and alcohol abuse

37. Many drug users have a complex range of issues to deal with which often includes alcohol addiction. The Drug Treatment Outcomes Research Study[172] found that found that 24% of individuals seeking drug treatment reported problematic use of alcohol. Many treatment providers also tell us that alcohol addiction is common in the opiate and crack-cocaine using group with which they work.

38. For the first time, our drugs strategy also considers alcohol dependence, recognising the link between drug addiction and alcohol use. We have recently asked the ACMD Recovery Committee for further advice on the subject of alcohol dependency and poly-substance misuse.

39. Although significant differences exist in the drug and alcohol legal and policy environments, treatment and recovery of dual users or single substance users have similarities. This is recognised in our strategy and the recovery strand explicitly addresses the provision of treatment and services for recovery from alcohol addiction. The soon-to-be-launched alcohol strategy will re-enforce this message, and our focus on long-term sustainable recovery is the aim of treatment for all people with addictions.

40. We are committed to removing any remaining barriers that may prevent local treatment providers delivering the support that people addicted to multiple substances need. The removal of central control, giving PCCs and Health and Wellbeing Boards greater control of budgets locally to make decisions in response to local need, will enable increased flexibility. Service provision will be tailored at a local level, achieving efficiencies and delivering the best possible joint services in response to local need.

Impact of the transfer of functions from the National Treatment Agency to Public Health England and impact on treatment

41. The Government announced in July 2010 that the NTA will end as a separate organisation by April 2013 and its functions are to transfer to Public Health England (PHE).

42. Currently commissioning of services at a local level is too fragmented meaning that opportunities for efficient and joined up interventions which would benefit the service user can be missed. PHE will provide opportunities not only to better link the commissioning of treatment for drug and alcohol dependency, but also to join up services (and outcomes for service users) with wider local health priorities. Commissioners will be better able to commission and pay for a service that meets the full needs of an individual to help them recover, rather than solely a specific activity that they hold the budget for.

The comparative harm of legal and illegal drugs and the availability of legal highs and the challenges with adapting the legal framework

43. The Government takes advice from the ACMD on the harms—both individual and societal—from drugs and uses this to inform our policy and legislation.

44. So-called "legal highs" are a priority for the Government and we have made clear progress on tackling this complex issue. We have adapted our existing legal framework to respond rapidly to the emergence of new

[172] Jones, A, Weston, S, Moody, A, Millar, T, Dollin, L, Anderson, T and Donmall. M (2007) *The Drug Treatment Outcomes Research Study (DTORS): baseline report. Appendices.* Home Office Research Report 03 http://webarchive.nationalarchives.gov.uk/20110218135832/rds.homeoffice.gov.uk/rds/pdfs07/horr03append.pdf

substances through the introduction of a new power to invoke a temporary class drug order which will make the importing and supply of a drug illegal. We have also introduced legislation, based on ACMD's advice, that covers not just the one particular substance, but the whole family of related substances (for example the cathinones and synthetic cannabinoids) which removes an easy work-around for the producers. We are now able to rapidly respond to advice that is provided to us by the ACMD in order to protect the public. SOCA (Serious Organised Crime Agency), as part of a wider initiative to disrupt criminal activity, has taken action against UK-based websites that offered mephedrone or naphyrone for sale following their classification as Class B drugs in April and July 2010 respectively. In 2010–11 over 120 websites were closed down as a result of SOCA action.

45. We have developed the Forensic Early Warning System (FEWS) which has enabled us to proactively detect in real time these new toxic substances. In its first year, the FEWS has undertaken a number of activities—including test purchasing, the testing of amnesty bins at five music festivals and testing police seizures and we are closely monitoring the substances identified.

46. We have established a Drugs Early Warning System (DEWS) that links local healthcare partners (including GPs and accident and emergency wards), the police (at local and national levels), central bodies (including the Department of Health, the ACMD and the Health Protection Agency) among various other partners with a 10 central focal point where information is gathered and then shared with the other partners. This is an information sharing system that ensures trends relating to new psychoactive substances are rapidly identified and disseminated to partners nationally so that appropriate action can be taken. The focal point is also the key information exchange point with wider EU systems, enabling us to benefit quickly from our neighbours' experiences.

47. We recognise that a purely legislative response is not the only answer with tackling any drug. Other elements are needed as part of a strategic response to reduce demand and tackle supply. We are working closely with other departments and agencies to ensure that we utilise the significant public protection infrastructure and legislative frameworks that already exist on the open sale of substances.

48. Education is important, not least to educate potential users of the very real medical dangers of these so-called "legal highs", many of which are toxic chemicals which can cause permanent health damage. Providing people with information will be an increasing focus for us going ahead.

The links between drugs, terrorism and organised crime

49. Links are apparent between the drugs trade, organised crime and terrorism. The most obvious examples are the organised crime groups that control much of the import and sale of heroin and cocaine. Organised criminals have a hugely damaging impact across the entire supply chain, exploiting farmers, corrupting democratic institutions in source and transit countries and of course supplying dangerous drugs to the consumer market. The violence associated with organised crime gangs is also significant. Organised crime does not recognise national, international or jurisdictional boundaries. But, while it is a global problem, its effects are felt in communities across the country, from significant social and personal harm, through to financial costs to the taxpayer, businesses and the government.

50. The links between the drugs trade and terrorism are most apparent in (but not confined to) Afghanistan (where the United Nations Office on Drugs and Crime estimates that the insurgency derives approximately $150 million per annum from Afghan narcotics) and in Colombia (where criminal groups continue to support terrorist and paramilitary groups such as the FARC). There is also evidence of the profits from the transit of drugs in the West African region being used to fund terrorist groups such as Al Qaeda in the Islamic Maghreb (AQIM).

UK support to its global partners

51. The UK works actively bilaterally and in multilateral fora to promote and support activity that reduces the harms caused by drugs across the world. Europe is primarily a consumer market for heroin and cocaine and so a key responsibility for us is to reduce the demand for drugs from our population. Data trends are positive in this area, and we are seeing a reduction in users of opiates, crack cocaine and powder cocaine.

52. Our responsibility to the global community is however greater than just reducing the demand for drugs from the UK. We are working actively in support of 11 international conventions and agreements to reduce the global drug trade, driving forward opportunities for action and influence and working bilaterally with a number of countries to build capacity, support policy development and implement effective controls that are mutually beneficial to the global community. Our work in Afghanistan through the military, in the Caribbean through SOCA and diplomatically in the EU are examples of our commitment.

53. The UK continues to work closely with partners in the EU and more widely to disrupt drug trafficking routes. Such upstream efforts form part of the "golden thread" of law enforcement in the UK—the connectivity from local, neighbourhood policing through to international work—and allows end-to end disruption of organised crime groups. SOCA works closely with intelligence and law enforcement agencies both in the UK and overseas, as well as government departments, agencies and the private and third sector to disrupt this market. Further details on this are set out in the SOCA submission to this inquiry. The UK actively participates

in the EU effort against drugs through the EU Drugs Strategy. We also a key player in and major funder of the UN Office on Drugs and Crime to support their counter narcotic efforts.

54. In the international arena, the UK has also engaged competent authorities within source countries and sought to leverage action against the threat, including legislative changes. For example, China has increased its controls of on-line sales of precursors and made mephedrone a controlled substance, while India has introduced controls for the manufacture and export of Ketamine.

Whether detailed consideration ought to be given to alternative ways of tackling the drugs dilemma

55. The UK is keen to learn from experience and expertise in the area of drug policy. We are clear though that drugs cause significant harm and therefore it is our responsibility to both reduce demand and restrict supply. The case for decriminalisation or liberalisation of drugs fails to recognise the complexity of the problem and gives insufficient regard to the harms that drugs pose to the individual or society. It neither addresses the risk factors which lead individuals to drugs misuse, nor the misery, cost and lost opportunities that dependence causes individuals, their families and the wider community.

56. The nature of the drug problem, criminal justice and health responses differ in each country. Additionally data on prevalence and usage across countries are not always comparable and caution must be taken on the sometimes selective use of data to judge the comparative success or not of the approaches in different countries. It is more appropriate to look at trends within individual countries than comparisons across. There is no clear evidence to suggest that where alternative approaches to the legal status of drugs have been used these have led to a reduction in the number of people using drugs. The European Monitoring Centre for Drugs and Drug Addiction examined the relationship between penalties and 12 cannabis use and found that no simple association can be observed between legal changes and cannabis use prevalence.[173]

February 2012

Supplementary written evidence submitted by the Home Office [DP157a]

LETTER FROM LORD HENLEY, MINISTER OF STATE FOR CRIME PREVENTION AND ANTI-SOCIAL BEHAVIOUR REDUCTION, HOME OFFICE, TO THE CHAIR OF THE COMMITTEE, 1 SEPTEMBER 2012

I am responding to your letter of 26 July regarding an update on the 2002 Home Affairs Select Committee report's recommendations; and your letter of 28 August about the Drug Strategy Evaluation Framework and information on what percentage of the total Government expenditure on drug policy is provided by individual Government Departments.

This Government published its own drug strategy in December 2010 following a consultation in which over 1800 responses were received. Our strategy is vastly different to those previously, in particular our focus on full recovery for all individuals. The 2002 recommendations were addressed to a previous Government, not this Government, and focused on an old strategy and approach. I am therefore not in a position to update you on the progress of these recommendations.

The document setting out the approach to evaluating the 2010 Drug Strategy is currently going through quality assurance processes, including an independent peer review. We are aiming to publish the document by the end of November. The document will not contain any analysis or results but will rather set out how we intend to evaluate the Strategy. Further updates will be provided in the Drug Strategy Annual Reviews.

We do not have the proportion of investment in the Drug Strategy by individual Government departments. Work is ongoing, as part of the evaluation of the strategy, to estimate expenditure on different elements of drug policy across Government. However, this is a difficult undertaking as almost all of the activity is part of wider mainstreamed programmes. For example, the work of the police to reduce crime and bring offenders to justice; the work of the Department for Education to build resilience among young people to resist temptation and have the confidence to make sensible decisions; and the work of the Department of Health to invest in the health of young children through family nurse partnerships. All of these contribute both to the drug strategy but have much wider benefits too.

Lord Henley

September 2012

---

[173] European Monitoring Centre for Drugs and Drug Addiction (2011). The State of the Drugs Problem in Europe. Annual Report 2011. www.emcdda.europa.eu/publications/annual-report/2011

Written evidence submitted by the Association of Chief Police Officers [DP162]

This response has been provided by the Association of Chief Police Officers (ACPO) Drugs Committee. It addresses questions 4, 7, 10 and 11 posed by Home Affairs Select Committee (HASC).

Question 4: *Whether drug-related policing and expenditure is likely to decrease in line with police budgets and what impact this may have*

Police drugs budgets

In the majority of Forces, specific drug related policing budgets do not exist. Rather, enforcement activity against drugs is embedded within the core policing budget and distributed across different areas of police activity. For example:

> *Neighbourhood Policing*: Local policing teams will address issues such as preventative patrols near schools, tackling local drugs dealing (eg crack houses) and working with partners such as the local authority to address issues such as the disposal of drugs paraphernalia in public places.
>
> *Incident Response officers*: They deal with behaviours on the street which prompt calls to police a number of which are alcohol and drugs related. Of particular concern are those involving persons suffering from mental illness which can, in turn, involve drugs.
>
> *Serious Crime teams*: The majority of police forces have dedicated teams of officers targeting serious and organised criminality at force level and those involved in cross border activity. Evidence from ACPO's Crime Group Mapping indicates that overall some 50% of Organised Crime Groups are involved in illicit drugs. It is such criminality which requires forces increasingly to work closely with other police forces and enforcement partners such as the Serious Organised Crime Agency (SOCA), HM Revenue and Customs and the UK Border Agency.
>
> A very small number of forces have dedicated Drugs Units. In these cases, then there is naturally the ability closely to monitor the impact of reduced budgets on police activity.
>
> *Proactive offender management*: As a result of the known links between drugs misuse and offending behaviour, a good deal of work is undertaken by police and other partners to address the underlying issues more effectively. The limitations of putting low level drugs users before the Courts (the "revolving door" of Justice) is recognised and acknowledged. Programmes such as Integrated Offender Management and the Home Office sponsored Drug Interventions Programme are intended to address this aspect of the drugs misuse more effectively and with a degree of longer term success.

Comprehensive Spending Review (CSR): budget reductions

In common with other areas of the public sector, police budgets are being reduced. Whilst the headline figure is that of a 20% reduction this relates, in fact, to the Home Office grant the percentage of which varies between forces. Whilst debates about the actual scale of the reductions may continue the fact is that police budgets are being reduced and Chief Officers and Police Authorities have a duty to take steps to reduce costs over the four year CSR budget period so as to remain within budget.

In the majority of forces, the reductions are being made across all areas of police activity albeit with a focus initially on so called "back office" functions. The fact remains that reductions cannot be effected without having an impact on aspects of operational policing.

Impact of budget reductions on drugs related policing

General background: Because police related activity is distributed and embedded within so many aspects of policing, it is not possible accurately to assess the overall impact of the current budget reductions.

Helpfully, during 2011 the UK Drug Policy Commission (UKDPC) undertook research entitled "Drug enforcement in an age of austerity".[174]

ACPO was supportive of this work and provided the UKDPC with access to all forces. It should be borne in mind, however, that the findings were a snapshot of force responses and are largely perceptions of those involved in drugs enforcement about the impact of cuts to their force budgets. It also made no attempt to gain information from other areas of operational policing activity with which drugs enforcement could be compared.

[174] The key findings from a survey of police forces in England can be found at: www.ukdpc.org.uk/resources/Drug_related_enforcement.pdf

In preparing this response for the HASC additional enquiries with forces have been made, over and above those of the UKDPC. It was not possible to determine whether such expenditure has been or will be more adversely affected than other areas of policing activity. Given the extent of budget reductions, however, enquires confirmed that reductions impacting upon drugs enforcement will be made within most forces with the following potential impacts:

Operational policing: Forces are striving to minimise the impact of budget reductions on operational policing but the fact remains that reductions of this magnitude cannot be delivered solely by reducing "the back office" or through greater collaboration or efficiency savings albeit each has a contribution to make.

In response to CSR reductions, police forces are systematically reviewing all aspects of service delivery in order to identify where budget reductions can be made. For the reasons set out above, because enforcement of drugs is undertaken in a variety of ways, it is inevitable that capacity will be reduced proportionally when such reductions are implemented. In a limited number of cases, specific operational capability is removed altogether such as when some forces cease to maintain a permanent "test purchase" unit which involved the use of long term undercover officers.

It is too early to determine the impact of these collective capability reductions particularly on issues such as acquisitive crime. The risk remains that the overall impact may lead to a modest increase in drugs-related activity and associated criminality in some areas.

The police service is equally mindful of the risks associated with the indirect impacts of current budget-driven reviews. If this continues for a period of time, there is the possibility that experience and skills in tackling aspects of drug-related criminality will be diminished and it can take time to retrain officers and to recover lost professional expertise, particularly in the most risky/specialist areas of enforcement activity such as Test Purchase.

Similarly, cut backs on holding or attending specialist conferences can lead, over time, to a reduction in the exchange of professional knowledge and the sharing of good practice. Again, these are issues which are hard to quantify and to cost.

What is evident is the fact that all forces are concentrating their efforts on reducing the threats posed by serious and organised crime, much of which involves drugs, whilst maintaining a less intrusive approach to offences involving simple possession. Here, pragmatic use is made of out of court disposals such as cautions or of local diversionary programmes involving referral to treatment centres.

Regarding serious and organised crime, there is good evidence of increasing collaborative work and regional activity amongst forces. All are seeking a strong and effective working relationship with the new National Crime Agency as the details of the organisation begin to emerge. The fact that the new Director of NCA is a former Chief Constable assists in forging this relationship.

Forensics activity: Another area which appears to be coming under increasing pressure is that of forensic budgets. Here the challenge is twofold. The Government's decision to close down the well established and well respected Forensic Science Service at relatively short notice with the requirement for the private sector to step into the breach was not without risk. A great deal of work was undertaken by ACPO and by forces to explore and agree alternative methods of service delivery and to the credit of the police service, the Home Office officials dealing with the issue and the industry this has been broadly achieved. The longer term implications on service delivery remain to be seen. There is an underlying concern that by replacing one supplier with several the police service may lose the benefits of a national perspective, of the exchange of intelligence and the development of good practice.

Regarding the impact of budget reductions, the picture is mixed. As a result of a tighter focus on efficiency, collaborative working and costs a clearer picture has been emerging on the cost-effectiveness of forensic examination and the link to outcomes in terms of prosecutions and convictions. Generally, the number of submissions has been reducing across the board and this is set to continue.

We believe that in tackling serious and organised crime then the impact is modest. When it comes to such issues as testing small quantities of "white powder" for personal possession the costs of forensic analysis are rarely seen as justified. The impact here is less operational and more on the loss of intelligence on what drugs are in circulation, on purity and on cutting agents.

Risks to partnership working: Financial pressure is being experienced across the public and voluntary sector and another medium to long term risk is that of reduced partnership working as agencies take steps to manage on reduced budgets.

Some of this relates to central funding initiatives such as the well respected Home Office funded Drug Interventions Programme (DIP). Since 2008–09 the budget has been progressively reduced. The budget for 2012–13 represents a 27% reduction on that former period.

More locally, as is apparent from the workings of Local Criminal Justice Boards, as other Criminal Justice agencies reconfigure to meet budget reductions there is an impact on

relationships (many levels of management are being merged and are thus no longer co-terminus with police force boundaries) and capacity is being reduced.

The impact upon the third (voluntary) sector is hard to measure but there is increasing anecdotal evidence that some effective local charities are reducing their work or, in the worst case, closing down as local funding from statutory agencies is reduced or terminated. Sadly, work with drug offenders and drug misusers lack the wider appeal of many other equally worthy charitable causes.

Proposed changes to the distribution of health budgets is equally a concern for the same reason. The treatment of those misusing or addicted to drugs is an important element of the Government's Drugs Strategy. Decisions on local priorities may not, in the longer term, reflect this fact.

There is an underlying concern in the police service that, as other agencies reduce or alter their involvement in partnership working, problems in respect of illicit drugs and the threat they pose to local communities will, by default, manifest themselves as a growing demand on the police.

Question 7: *The relationship between drug and alcohol abuse*

This is regarded as primarily a matter for public health professionals albeit the practical implications for policing are recognised and there are particular risks associated with "poly drug use" with which forces are all too familiar. There is strong anecdotal evidence from within the police service that young people often chose to mix alcohol with "recreational drugs". Police are also aware that misuse of alcohol and drugs by people socialising within the night-time economy is well documented. There are a number of academic papers which address the issue readily accessible via the Internet.

ACPO Drugs Committee deals specifically with illicit drugs and "legal highs". Colleagues overseeing the ACPO alcohol policy are better placed to provide a view on the dangers and policing issues associated with alcohol.

For our part, we share the concerns of health professionals at the inherent dangers of people, often young adults, mixing alcohol with other drugs be they illicit, legal highs or prescription. Mixed drug use can affect behaviour, occasionally resulting in violence and the possibility of assault and serious injury to other.

More pressing are the dangers of self-inflicted harm and of the risks to people receiving treatment by paramedics or, having been arrested, being held in custody facilities by police. A significant number of deaths in police custody involve drug and alcohol misuse. It should be remembered that such deaths are a professional risk to police officers and police staff whose actions come under investigation by the Independent Police Complaints Commission (IPCC) who oversee all resulting investigations.

We consider that this is an issue which requires further research and publicity. It should also feature within the Government's Drug Strategy the first element of which deals with prevention/education. Indeed, the Home Office directly links its work on drugs and alcohol to reflect the reality of the link on the streets.

Question 10: *The availability of "legal highs" and the challenges associated with adapting the legal framework to deal with new substances*

Availability

Whilst the appropriateness of the term "legal highs" is being challenged, this is the expression adopted by the Committee and will thus be used here. Regarding availability, the situation is unclear not least because the term as used by the public and the press covers such a wide and diverse set of substances.

In general there is a paucity of information on the availability of legal highs not just in the UK but within Europe and beyond. The largest data-set in the UK is captured by the Forensic Early Warning System (FEWS) Project managed by the Centre for Applied Science and Technology (CAST) and sponsored by the Home Office Drug and Alcohol Unit. ACPO forces make a major contribution towards the project with the primary customer for the data being the Advisory Council on the Misuse of Drugs (ACMD). The Home Office is thus best placed to provide the Committee with information on availability.

The feedback from police forces is that legal highs are readily available across the country and there is considerable uncertainty, some would say confusion, as to the nature and status of such substances and the risks associated with their use. There is also strong anecdotal evidence of poly-drug use. It must be assumed that this ready availability will continue for the foreseeable future.

Adapting the legal framework

ACPO Drugs Committee is of the opinion that these substances present the most significant challenge to existing legislation and the Government's Drug Strategy. Given that a central element of the latter relates to enforcement, they also represent a new and significant challenge to those agencies charged with tackling illicit drugs and protecting our communities.

Law enforcement agencies have well established methods for tackling the criminality associated with "conventional" illicit drugs such as heroin, cocaine and cannabis. How effective these methods are in the long run is a matter for others to debate. Over time, the police service has developed a proportionate response focussing its main effort on tackling the criminals involved in drug trafficking and drug dealing and taking a less harsh "deterrent/diversion" approach to instances of personal possession.

These established approaches are not well geared to meet the challenges presented by legal highs. The problems are threefold:

— The speed with which new substances are being produced and made available.

— The use of the inter-net and retail outlets such as Head Shops to supply these substances.

— The use of social networking to spread news about such substances and to promote their use. Instances have been seen of party invitations circulating on smart-phones including an embedded internet link to a supplier of legal highs.

There is also the matter, of course, of the choices that young people make as to what use they make of the wide range of substances they have access to including alcohol, prescription drugs, legal highs and illicit drugs.

Individually, any of the three elements above would present a challenge to the Government and law enforcement agencies. Taken together, that challenge is substantial and we have little practical experience on which to draw. A key question for the Government to determine is the extent to which legislation can realistically be used to address active choices being made by (predominantly young) people and to tackle the undoubted harms caused by the misuse of substances taken essentially for pleasure.

Law Enforcement challenges

From an early stage, the Chair of ACPO Drugs Committee was of the opinion that the solution to the particular challenges of legal highs did not lie in adding inexorably to the list of illicit substances. The practical implications for police officers on the street at 3.00 am dealing with a young person in possession of a substance bought on the internet, the nature of which they themselves are unsure, are self-evident.

The Committee are of the opinion that new approaches must be explored and considered to meet such a new challenge.

Whilst broadly welcoming the introduction of Temporary Banning Orders (as an alternative to classifying the substances as illicit) this was never seen as a long-term solution. The problem remains of what the Home Office will do at the end of the temporary period and taking account of the advice provided by ACMD. The strong likelihood is that the substance will be made illegal. The alternative, of course, is that the substance is in effect identified as a Home Office approved legal high. This option is unlikely to appeal.

For the reasons previously outlined, the police will continue to focus their energies on serious criminality and take a less robust enforcement approach on matters relating to personal possession. The recently published guidelines from the Sentencing Council tend to endorse this approach. The combination of budget pressure and substantial and ongoing changes to the provision of forensic services means that it is most unlikely that unidentified substances such as legal highs will be sent off for analysis. Consequently information with regards to these substances and potential intelligence will not be routinely available.

The practical problems are predictable. Operational officers report that some Head Shops appear to exploit the letter of the law by deliberately mislabelling substances and misrepresenting their use and purpose. They are labelled variously as plant food, bath salts, pond cleaner, room odorises or "research" chemicals. They continue this pretence by adding the warning—"Not for Human Consumption", which is designed primarily to protect them from the Medicines Act and Food Labelling Regulations.

Exploring a new approach

The Government's Drug Strategy includes a preventive/education element and it is this area which is considered worth exploring more comprehensively. For example, ACPO would accept that Head Shop proprietors may not know exactly what the chemical ingredients of the substances they are selling are, but in our view they do know exactly what they are intended for eg to be consumed by users to mimic the stimulant effects of an illicit drug, eg Cocaine, Ecstasy or Amphetamine. Why else would a user pay £20 per gram for plant food?

Consideration should, therefore, be given to the Head Shop owner being made accountable for all the products they sell and to be potentially liable for any subsequent harm or injury they may cause to a purchaser or user of the product. In general they are unlicensed, although some forces have worked in partnership with Local Authorities (regarding bye-laws) and Trading Standards departments (regarding consumer legislation) in an attempt to bring some form of control to this area of business. ACPO would support moves to close these "loopholes" by drafting similar legislation as that which controls Sex Shops, Betting offices and other Licensed Premises.

There is also an increasingly strongly held view that young people should be held more responsible for the choices they themselves make when it comes to taking unknown substances or mixing drink and drugs. This

links directly to the wider information/education aspect of the Drugs Strategy and the potential for public health information to be seen as a legitimate element of responding to the harms presented by legal highs rather than ceaselessly reaching for the legislative/regulatory solution.

Question 11: *The links between drugs, organised crime and terrorism*

This is a matter upon which SOCA and officials from the Home Office dealing with Organised Crime are best placed to offer advice to the Committee.

From the ACPO Drugs perspective, there is considerable evidence, anecdotal and otherwise, to indicate clear and substantial links between organised crime and drugs. The links between Drugs and Terrorist activity is less clear albeit there is a history of terrorists using illicit drugs as a means of generating income.

Evidence of organised criminal activity has emerged from ACPO's innovative development of the Organised Crime Group (OCG) mapping process. Data indicates that around 50% of all OCGs are involved in drugs and 80% of the most harmful groups are involved in drugs predominantly in importation/supply of class A Drugs. This data was being updated towards the end of January 2012. This information and associated intelligence is now being utilised to inform law enforcement at national, regional and local level.

Complementing the Home Office's Organised Crime Strategy, the Integrated Operating Model, developed by colleagues in ACPO Crime Business Area, is being used to facilitate better joint working. Together, these form a firm foundation upon which the new National Crime Agency (NCA) will be able to build.

February 2012

Written evidence submitted by the Advisory Council on the Misuse of Drugs (ACMD) (DP170)

The Advisory Council on the Misuse of Drugs (ACMD) makes recommendations to Government on the control of dangerous or otherwise harmful drugs, including classification and scheduling under the Misuse of Drugs Act 1971 and its Regulations. It considers any substance which is being, or appears to be, misused and of which is having, or appears to be capable of having harmful, effects sufficient to cause a social problem.

The ACMD also carries out in-depth inquiries into aspects of drug use that are causing particular concern in the UK, with the aim of producing considered reports for both policy makers and practitioners.[175]

The extent to which the Government's 2010 drug strategy is a "fiscally responsible policy with strategies grounded in science, health, security and human rights" in line with the recent recommendation by the Global Commission on Drug Policy.

The Government's drug strategy is largely grounded in science, health, security and human rights

KEY POINTS

The ACMD consider that the use of evidence should be at the forefront of considerations. This is reliant on robust research and evaluation being undertaken. The shrinking public sector and current financial austerity measures will have an impact on drug strategies, and the Government should recognise and look to mitigate for this.

The benefit of prevention initiatives for children, and with families, to prevent substance misuse should be recognised. Effort should be placed to ensure appropriate links are made between the individual, their networks within the setting of schools and families and how services can best be targeted to unlock cross cutting opportunities to improve outcomes. The key is the timeliness of the intervention.

The Government should continue to look to the evidence base and its advisers for guiding it through difficult decisions around measures to deal with substance misuse.

EVIDENCE

— An evidence-based approach is advocated for delivery of the 2010 Drug Strategy, as evidenced by the extra investment and prioritisation of evidence-based drug treatment (via the Pooled Treatment Budget) particularly since 2002.

The criteria used by the Government to measure the efficacy of its drug policies

KEY POINTS

In principle, the ACMD supports the move to measuring drug policy by sound outcomes and cost-effectiveness. The ACMD recognise that there is much to do to get to a position where there are outcome measures and cost-effectiveness measures for all the three main strands of the drug strategy: the drug strategy

[175] All ACMD reports, minutes and membership information is available at: www.homeoffice.gov.uk/agencies-public-bodies/acmd/

includes some key measures for reducing drug use, and increasing the numbers recovering from their dependence—the ACMD recommend the development of measures for the supply reduction strand.

To effectively deliver the strategy the ACMD consider that there needs to be a better understanding and ability to measure social value, particularly at the local level.

One of the overarching aims of the drug strategy is to "increase the numbers recovering from their dependence". Although the "ultimate goal" is to enable people to become free of dependence, the strategy states that recovery "is an individual person-centred journey as opposed to an end state"—this is important, as it recognises that recovery includes much more than abstinence.

Too narrow a focus may have unintended consequences for those in treatment with the most complex needs, who may not be able to achieve recovery easily, quickly or at all.

EVIDENCE

— Drug treatment has proven benefits for those whilst undergoing treatment, not just those who can overcome their dependency and recommend this is fully taken into account.

— Payment by results commissioning for drug and alcohol treatment is in its very early stages. The ACMD, through its Recovery Committee, will be providing further advice to Government on this issue.

The independence and quality of expert advice which is being given to the government

KEY POINT

The Government benefits from independent expert advice on highly emotive issues such as drug use and misuse. The use of independent expert bodies should be maintained and encouraged. The Government could enhance the quality of this advice by ensuring that independent research and evaluation is systematically commissioned on all aspects of the national drug strategy.

EVIDENCE

— The independence of the ACMD is specifically set out in the Misuse of Drugs Act 1971 and a Working Protocol, agreed between the ACMD and the Home Secretary.[176] The ACMD has high expectations that this document will form the basis for the continued provision of advice and sets out the Government's commitment to evidence- based policy making.

— *The Omand Report* (2011) found the ACMD to be "effective, excellent value for money, and an authoritative source of advice".

— It is important that recommendations of expert bodies are properly considered to best inform the development of a better UK evidence-base to develop drug policy.

— The relative investment in evaluation and research does not match, nor is it proportionate to, the large public investment in drug demand reduction and supply reduction activities.

— The piloting and independent evaluation of new approaches may enable later implementation if interventions are found to be successful.

Whether drug-related policing and expenditure is likely to decrease in line with police budgets and what impact this may have

KEY POINTS

The introduction of police and crime commissioners and potential disinvestment in the substance misuse agenda needs to be monitored, particularly in the context of the current constraints on (or reductions in) police budgets.

It will be important for the Drug Interventions Programme to be continued as it has been successful at referring drug users into treatment and reducing crime.

In times of recession and financial austerity, recent research by RAND (Research ANd Development) (2011) indicates that in the general population levels of substance use (drugs and alcohol) tend to go down. However, the experience of some communities during the recessions in the 1980's and early 1990s highlights concern about the potential impact of youth unemployment on levels and patterns of drug and alcohol misuse amongst young people and young adults (particularly problem drug use). An increase in youth and young adult unemployment may be accompanied by an increase in young people dealing drugs to generate income.

[176] The protocol is available at: www.homeoffice.gov.uk/agencies-public-bodies/acmd/

EVIDENCE

— The Home Office Research Report 2 *The Drug Interventions Programme* (DIP): addressing drug use and offending through "Tough Choices" 2007 reports an overall drop in offending by a cohort of 7,727 of 26% following DIP identification and that levels of retention in treatment for DIP entrants equalled those of non-criminal justice route entrants to treatment. The Home Office (website) reports that, in 2009–10, the Drug Interventions Programme helped to manage over 57,000 people into drug treatment and recovery services.

— RAND report, 2011.

The cost effectiveness of different policies to reduce drug usage

KEY POINT

While some International evidence suggests that drug policy appears to have limited impact on the overall level of drug use (Professor Reuter *et al* (2007) review for UK Drug Policy Commission (UKDPC), policy responses (such as investment in drug treatment) can address the harms associated with drug use. The authors of the UKDPC study argue that drug use is more influenced by wider social, economic and cultural factors.

In summary: there is poor evidence that drug use is impacted on by drug education, some evidence (although conflicting) about the cost effectiveness of prevention activities and a strong evidence-based about the cost effectiveness of drug treatment (particularly for heroin and/or crack cocaine dependency). There is little evidence on the overall cost-effectiveness of supply activities. The evidence base for the effective treatment of problems associated with new psychoactive substances is less strong, but is developing.

DRUG USE

English school and crime survey data shows that the metric of "all drug use" peaked in 2004 and has since fallen to levels similar to those recorded in1996. However, Class A drug use has remained relatively stable, although cocaine use amongst 16 to 24 year olds has increased, and there has been an emergence of the use of other psychoactive drugs including mephedrone, ketamine and GBL (gamma butyrolactone).

Research provides little evidence to show that drug education of itself reduces drug use, although it can delay any start of drug use.

PROBLEM DRUG USE

There is strong evidence that drug treatment is cost-effective and can reduce and cease drug use. Furthermore, recent research evidence demonstrates that the number of problem heroin and crack users has recently reduced.[177] This group has been prioritised by recent drug treatment policy and the NTA argue that this reduction is linked to an increase in drug treatment capacity, treatment "penetration" and an increase in people successfully completing drug treatment, although a cause-and-effect relationship has not yet been established. There is also evidence that injecting drug use is reducing all across the UK and Europe (excluding steroid use).

There is a time lag in the collection of official data on those presenting for treatment. The experience of some treatment services, for example in Swansea the north west of England, suggests a recent increase in injecting heroin use. It is not possible for the ACMD to confirm such reports or verify whether there is evidence of an upward trend—the National Treatment Agency may be best placed to investigate this.

The ACMD recommend the Government invest more in the commissioning of independent research to establish the effectiveness and cost—effectiveness of different aspects of drug policy.

EVIDENCE

— Drug Misuse Declared: British Crime Survey 2010–11, Home Office Statistical Bulletin December 2011.

— Smoking, drinking and drug use amongst young people in England 2010, Health and Social.

— Care Information Centre 2011.

— Prevalence Problem Drug Users in England, Hay *et al*, University of Glasgow 2011.

[177] Whilst the most recent national data shows a fall, there is a time lag in collection of such data. The most recent front line view in the North West is that injecting heroin use is increasing in the last couple of months, confirming the fears of many drugs workers that pushing people into rapid detox may be counter productive. This has been reported in the NW by several sources including drug workers in criminal justice and NHS services, as well as third sector. It could be a NW regional phenomenon or it could be that the NW sees it first because it has the highest drug use outside London and it has some of the areas of greatest deprivation so will feel the recession first and deepest. However, there appear to be regional differences as in London data from the front-line, capture-recapture and the NTA indicating a general drop in injecting among heroin users, with the remaining injectors having greater need.

The extent to which public health considerations should play a leading role in developing drugs policy

KEY POINTS

Public health considerations are of vital importance in drug policy due to the association between drug misuse and, for example, sexual health, blood borne viruses, smoking, poor diet and unhealthy lifestyles.

England has an excellent track record in the implementation of ground-breaking interventions (including needle exchange and methadone maintenance programmes) which have resulted in one of Europe's lowest rate of HIV amongst injecting drugs users (6%). Investment in such public health interventions needs to be maintained.

The ACMD recommends that public health should be placed on an equal footing with the legislative and criminal justice elements in influencing drug policy—particularly reducing demand and promoting recovery.

The introduction of the new public health service and the transfer of the functions of the NTA into Public Health England are broadly welcomed. The responsibilities of Health and Wellbeing Boards and directors of public health provide the opportunity to better integrate health, public health and social care. The transfer of responsibility to local authorities for drug and alcohol treatment also has the potential to improve the commissioning of (and partnership working between) treatment and related recovery services (eg access to housing). The ACMD is however, aware of the potential competing demands on local public health service budgets, particularly with the planned removal of the "ring-fence" for the "pooled treatment budget". The risk of disinvestment in drug and alcohol services (and the capacity to support the aims of the drug strategy) merits the introduction of specific safeguards for the funding for drug and alcohol treatment, including consideration of transitional protection. Public Health England will play a key role in supporting local authorities in providing accessible, high quality and evidence-based treatment services. Future trends in epidemiology of drug use; prevalence and incidence of drug-related morbidity levels; and drug mortality data will need to be closely monitored.

National and local policy and commissioning fora will also need to consider community safety and crime prevention and reduction concerns, particularly given the transfer of treatment funding from the Ministry of Justice. Evidence is strong that drug interventions including diversion and treatment of drug misusing offenders is cost effective and reduces crime and so community safety and interventions with offenders remain an important consideration of local and national drug policy. Future trends in epidemiology of drug use; prevalence and incidence of drug-related morbidity levels; and drug mortality data will need to be closely monitored. At present, in fact, most drug and alcohol treatment services in several areas in England are not any longer part of the NHS and this may be seen as a potential disinvestment in the substance misuse agenda. Public health professionals may require investment in training to ensure competence in substance misuse.

Police and Crime Commissioners will have an obvious interest in the important role that local drug and alcohol services play in addressing crime and re-offending. Although criminal justice system representatives can be invited to participate in Health and Wellbeing Boards, we understand that there is currently no statutory obligation for them to be involved or consulted. There will be a need to ensure co-ordination (and potentially shared funding and commissioning) for overlapping.

Measures in the Health and Social Care Bill will impact on the commissioning of drug and alcohol treatment in prisons and the integration between prison and community based provision. The ACMD welcomed proposals in the criminal justice Green Paper (*Breaking the cycle*, 2011) to improve drug and alcohol treatment in prisons and to explore the development of more "intensive" and "secure" community based treatment as a further alternative to a custodial sentence. We also welcomed the commitment to improve treatment and other support for women offenders with drug and alcohol problems. As yet, it is unclear how the NHS Commissioning Board (which will oversee prison based treatment) will work with community based services and the responsibilities of Health and Wellbeing Boards.

The new commissioning environment (eg Police and Crime Commissioners, the public health service and the NHS Commissioning Board) will also impact on work with prolific and priority offenders (PPOs), many of whom will have a history of drug or alcohol misuse and/or mental health problems. The role of treatment and health interventions (in prisons and the community) is key to strategies to tackle and reduce re-offending.

Consideration should be given to the reported growth in problematic use of prescribed medications for pain relief, anxiety and depression and sleep disturbance. The ACMD is concerned about the misuse of prescription medicines, and plans to undertake an in-depth review of this topic during the next three year period.

In the recent past, workforce development has been focussed on increasing access to drug treatment, reducing waiting times, harm minimisation and maintenance treatment. The aim has been to create a cadre of generalists and GPs with Special Interests to deliver safe opiate substitution treatment in primary care. To deliver this there needs to be a refresh in how, in the recovery orientated approach, we engage primary care to meet the needs of substance misusers. It is important to transform to a deliver recovery orientated drug treatment agenda with greater emphasis on prevention and social reintegration.

EVIDENCE

— British Crime Survey 2010–11 indicates drugs users are also likely to be frequent consumers of alcohol and smoke cigarettes.

— In relation to Blood Borne Viruses (BBV), Health Protection Agency: (Shooting Up: 2008) cite injecting drug use as a cause in 90% of Hepatitis C cases, 34% of Hepatitis B, and 6% HIV (Also see ACMDs report on the Primary Prevention of Hepatitis C among injecting drug users, 2009).[178]

— The Home Office Research Report 2 *The Drug Interventions Programme* (DIP): addressing drug use and offending through "Tough Choices" 2007 reports an overall drop in offending by a cohort of 7,727 of 26% following DIP identification.

— The Green Paper Evidence Report—*Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders* quotes the success of the Drug Treatment Alternative-to-Prison programme in New York (National Institute of Drug Abuse (2003) Crossing the Bridge: An Evaluation of the Drug Treatment Alternative to Prison Programme.

The relationship between drug and alcohol abuse

KEY POINT

There is an important, but under-utilised, evidence base on the relationship between drug and problem alcohol use. This can better inform policy responses, not least with the introduction of the new public health service and the opportunity to better integrate drug and alcohol prevention and treatment.

Evidence tells us most drug users drink (many to hazardous or harmful levels). Alcohol misuse is over-represented amongst those in drug treatment. Evidence (eg the *National Treatment Outcome Research Study (NTORS*),1996) suggests that many drug users in treatment swop a drug addiction for an alcohol addiction. While many older alcohol misusers have not used drugs, there is increasing evidence of polysubstance misuse among young people.

Drug and alcohol demand reduction interventions can learn from each other. There is a large evidence-base on alcohol misuse and a developing evidence-base on substance misuse addiction. The ACMD Recovery Committee plans to utilise this evidence-base in its work and recommends this wealth of information is used to inform the development of both drug and alcohol policy and the two are better aligned.

EVIDENCE

— National Treatment Outcome Research Study (1996).

— Drug Misuse Declared: British Crime Survey 2010–11, Home Office Statistical Bulletin December 2011.

— Smoking, drinking and drug use amongst young people in England 2010, Health and Social Care Information centre 2011.

— Prevalence Problem Drug Users in England, Hay *et al*, University of Glasgow 2011.

— National Drug Treatment Monitoring Statistics (NDTMS): annual NTA publications by NTA.

— DH Alcohol Payment by results pilot.

The comparative harm and cost of legal and illegal drugs

The relationship between drug and alcohol misuse

The relationship between drug and alcohol use is an important issue that needs to be better understood. At the request of the Interministerial Group on Drugs the ACMD Recovery Committee will include reviews of evidence-based approaches to the treatment of alcohol dependence, as well as dependence on illegal and new psychoactive drugs.

The ACMD is also presently considering polysubstance use and will report its findings later this year. The report will consider key polysubstance using groups, prevalence and patterns, social and physical harms and treatment issues, as well as the relationship between alcohol use and polysubstance use.

The impact of the transfer of functions of the National Treatment Agency for Substance Misuse to Public Health England and how this will affect the provision of treatment

KEY POINT

It is not possible at this stage to predict the impact of the transfer of functions of the NTA into Public Health England (PHE) and how this will affect provision. It is recommended that monitoring and evaluation strategies are put in place to ensure that negative un-intended consequences can be identified early and changes made if necessary.

[178] www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/acmd1/acmdhepcreport2

The core functions of the NTA have been: oversight of the pooled treatment budget (PTB); oversight of national data systems, including NDTMS; "delivery assurance" of local areas of local priorities (and previously national priorities); and policy champions on drug treatment in local areas, in regions and nationally—across and within government departments and professional bodies. We hope that PHE takes forward all these core functions.

It is important to distinguish the role of PHE (as a national agency) should and can play, and the responsibilities of the new local public health service. *The Healthy lives, healthy people: update and way forward document* (published July 2011) includes drug and alcohol services among 17 potential responsibilities for Health and Wellbeing Boards, including will have a wide range of smoking cessation, sexual health, obesity, education around healthy lifestyles and prevention of "unhealthy lifestyles". The recently published Public Health Outcomes Framework has 66 local indicators—only three of these are specifically for drugs and alcohol. Up to half of the local public health budgets will represent the amount currently spent on drug and alcohol treatment services, around £1 billion a year.

The ACMD shares the concerns expressed by others—including DrugScope; the Recovery Partnership; the UKDPC; the Royal College of Psychiatrists and provider agencies—about the risk of local disinvestment in drug treatment. In addition to the competing demands on funding, the removal of the drug treatment "ring-fence" and the context of cuts in overall local authority funding, drug users (as highlighted by the UKDPC work on drug use and stigma), are a stigmatised population who can be perceived as "undeserving". The risk of disinvestment is underlined, for example, by the impact of the removal of the ring-fence for central government funding for the Supporting People programme—in the current financial year, some local authorities have reduced Supporting People funding by over 50%. Despite government funding for young people's drug and alcohol treatment being maintained in cash terms, there is evidence of significant reductions in service provision in some areas.

Other changes are also occurring which should be monitored for potentially negative consequences, including changes in local commissioning and partnership structures and the "localism agenda", with greater power given to local systems to decide local priorities.

There is an opportunity to align the skills, competencies and social norms activities required to promote a healthy family and personal life in respect of all the wider determinants of health as part of the transition to public health. Focus should be aligned with not only specialist services, but those gateway services with workers who can support individuals with their recovery journey and social reintegration.

The availability of novel psychoactive substances and the challenges associated with adapting the legal framework to deal with these new substances

KEY POINT

Drug use trends in the UK are changing. Young people in particular are experimenting with and using a wider range of illegal and legal substances as illustrated by the British Crime Survey, schools surveys, club surveys and other surveys including Mixmag survey (see ACMD report below for references).

In a recent report the ACMD consider that novel psychoactive substances sometimes known as "legal highs"[179] can pose serious health risks and can contain harmful and illegal substances. The ACMD is clear that action should be taken to combat the unregulated sale, supply and consequent harms of the growing market in these substances. In its report, the ACMD recommends a range of supply restriction and demand reduction activities which take into account legal highs. Evidence indicates that the legal framework alone will not stem the tide of novel psychoactive substances among young adults in England.

EVIDENCE

— ACMD Report.[180]

The links between drugs, organised crime and terrorism

The United Nations estimates that the most powerful international organised crime syndicates each accumulate in the region of $1.5 billion a year. The international drugs market alone is estimated to be worth £200 billion.

At the lower levels, drugs feature in organised dealing within open markets and amongst "gangs" and other groups, alongside a range of criminality and anti-social behaviour. Such activity can blight an area and can be extremely difficult to eradicate. "Turf wars" between gangs and disputes between criminals over drugs matters, can result in serious violence, shootings and homicide.

The links between the effects of concentrated drugs/crime problems and acquisitive crime are well known but the combination of night-time economy, alcohol and readily available Class A drugs, sourced through organised supply chains, has a direct bearing on general levels of violent crime and disorder. For example,

[179] Psychoactive drugs which are not prohibited by the United Nations Single Convention on Narcotic Drugs or by the Misuse of Drugs Act 1971, and which people in the UK are seeking for intoxicant use.

[180] www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/acmdnps2011

parts of central London suffer from a high incidence of serious violence, despite a continuous enforcement focus on users and lower-level dealers.

There is evidence that significant undercover operations into organised crime and drug supply generally, and in distinct geographical areas, can make a marked and prolonged difference, albeit there can be continued pressure from new supply sources to return things to the previous norm. It has been found that such approaches are best supported by co-ordinated intervention, with treatment agencies, taking the opportunity of enforcement led supply shortgages, to divert increasing numbers into treatment programmes.

The Home Office's Organised Crime Strategy estimates the overall cost to the UK from organised crime as between £20 billion to £40 billion a year and that there are around 38,000 individuals, operating as part of around 6,000 criminal gangs. Those organised criminals have a global reach and a local presence. About half of all organised criminals are involved in the illegal drugs trade—which, in turn, fuels a huge amount of acquisitive crime.

Twenty-five to 30 tonnes of adulterated and unadulterated cocaine annually is needed to meet demand for the UK cocaine powder and crack markets. A tonne of cocaine at import could, depending on purity, equate to between seven and 14 million street deals of cocaine at £20 to £40 per deal. 18–23 tonnes of adulterated and unadulterated heroin are imported annually to supply the UK market. A tonne of heroin at import could, depending on purity equate to between three and six million street deals of heroin at £10 to £20 per deal. The increased use of "cutting agents" for bulking drugs, in particular cocaine, maximises the profit margins for organised crime.

Much progress has been made in terms of our knowledge about the threats to this country from terrorism and organised crime. However, more analysis needs to be done as to whether these threats are converging and, if they are, what this means for the safety and security of the UK and the efficiency of our combined effort.

Money is central to the needs and objectives of organised criminals and terrorists. The financial requirements of most UK based terrorist cells are modest by comparison with organised crime. The drugs trade is a known source of funding for terrorist and insurgent groups in different parts of the world.

Evidence

— Home Office—Organised Crime Strategy.

— Personal communication—SOCA (Serious Organised Crime Agency) ACMD member and Police and former Police ACMD members.

Whether the UK is supporting its global partners effectively and what changes may occur with the introduction of the National Crime Agency

Key Point

The UK is actively involved in the European Union (EU) and United Nations (UN) drug policy forums and through collaboration with the European Monitoring Centre on Drug Dependence Agency (EMCCDA). The ACMD welcomes these collaborations and continued involvements in both arenas.

The EMCDDA (2009) seminal review of drug policy, commissioned by the EU to inform its position at the United Nations in 2009, highlighted conclusions that can be drawn from research and experience over the last 10 years to support rational policy making:

— It has not been possible to stifle the flow of drugs in to and around the European Union, either through action in source countries, or interdiction.

— It has not been possible to reduce demand for drugs through the arrest and punishment of users.

— Attempts to eradicate drug markets can have significant adverse consequences on health and social problems.

— Drug dependence treatment strategies can effectively reduce crime and other social problems.

— Harm reduction strategies can effectively reduce drug related public health problems such as HIV and overdoses.

These findings, plus the evidence of UK effectiveness of supply side activities in reducing drug use, lead us to an uncomfortable position that introduction of the National Crime Agency may not have any impact on drug use. The ACMD recommends that supply reduction activities of the National Crime Agency are researched to try and establish an evidence-base around what is effective and cost effective in this area.

Whether detailed consideration ought to be given to alternative ways of tackling the drugs dilemma, as recommended by the Select Committee in 2002 (The Government's Drugs Policy: Is It Working?, HC 318, 2001–02) and the Justice Committee's 2010 Report on justice reinvestment (Cutting crime: the case for justice reinvestment, HC 94, 2009–10)

KEY POINT

Criminal Justice interventions which involve young adult drug users gaining a criminal record or a custodial sentence may not be the best use of public resources, given the "life limiting effect" or negative impact this may have on a young adults future employment and life prospects.

The majority of drug users are late teenagers or young adults, living in urban areas with men being twice as likely to use as women. The 2010–11 British crime survey showed that levels of ANY drug use are higher amongst the 16 to 19 year olds (23%), with levels of Class A drug use highest amongst 20–24 year olds (8.2%). Men are also twice as likely to use drugs as women.

In the *British Crime Survey 2011* respondents were asked where they acquired their drugs, over half (53%) of drug users said the obtained them from a friend or member of their family, over a fifth (21.4%) from someone else they knew and 21.8% said they got them from a dealer.

Young adults (particularly young urban and Black Minority and Ethnic (BME) men) are disproportionately impacted upon by criminal justice drug interventions. Their lives may be negatively impacted by being caught in the criminal justice system for simple possession offences, drug dealing amongst "friends" etc causing a disproportionate, negative impact on their lives.

DIVERSION

In responding to the Government's drug strategy consultation in 2010 the ACMD considered the question, "Do you think the criminal justice system should do anything differently when dealing with drug misusing offenders?" The ACMD believes that there are further opportunities to be more creative in dealing with those who have committed an offence by possession of drugs for personal use (in cases where there were no additional criminal offences). The ACMD considers that such approaches might be more effective in reducing drug-related harms to individuals and society, reduce repeat offending and reduce the costs to the criminal justice system.

The ACMD propose potential diversion into drug education/awareness courses (similar to those for speeding drivers) or possibly other, more creative civil punishments eg temporary loss of a driving licence.

The ACMD recognise that such a diversion proposal would require extensive consultation with education and treatment agencies and support from the police, probation and criminal justice stakeholders before this could be formalised but there is evidence of considerable support for such diversion measures already eg ACPO.

The ACMDs proposal is in the context of an awareness that a proportion of offenders—primarily for possession of cannabis—are already dealt with by way of a Police caution issued on the basis of the offender's admission of guilt of a criminal offence. The ACMD consider that some form of drug education/awareness/ treatment might better reduce drug-related harms than increased penetration into the criminal justice system. The ACMD state that if there were other trigger offences (eg theft, burglary etc.) then the appropriate criminal justice procedures and sentences would normally apply, which could include community sentences and imprisonment. In June 2011, the ACMD responded to the Sentencing Guideline Council's Consultation on Drug Offences Guidelines in similar vein.

The ACMD is aware that, subsequent to its submission, it has been incorrectly suggested by some that this was a proposal for decriminalisation. The ACMD was, and still is, clear that its suggestions relate to the discretionary diversion of certain offenders from further penetration into the Criminal Justice System, diverting them into an alternative community- based intervention that may be more effective and more cost effective. This is not decriminalisation because the ACMD consider that the possession of drugs is a criminal offence and should remain a criminal offence.

February 2012

Supplementary written evidence submitted by the Advisory Council on the Misuse of Drugs (DP170a)

My colleagues and I welcomed the opportunity to provide evidence to the Home Affairs Committee on behalf of the Advisory Council on the Misuse of Drugs (ACMD) on the 19 June 2012.

Towards the end of the session Mrs Fullbrook asked a question around the decriminalisation or legalisation of "recreational drugs". Her question was "what would the world would look like if the Government decrimalised or legalised recreational drugs?". The short answer was provided by my colleague (Ms Dale-Perera): "it is impossible to say".

The ACMD finds no strong evidence to persuade it that there should be support for a change to legalisation or decriminalisation (please see the paper "A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalization of illicit drugs" by Hughes and Steven, 2012 published in Harm Reduction Digest 44). However, the ACMD does consider that there is scope for the diversion of drug offenders, within the current framework. I therefore attach a memorandum from the ACMD that fully sets out its position on the issue.

Professor Les Iversen

July 2012

HOME AFFAIRS SELECT COMMITTEE INQUIRY: DRUGS, EVIDENCE SESSION—RESPONSE TO QUESTIONS

1. The ACMD has considered the question, "Do you think the criminal justice system should do anything differently when dealing with drug misusing offenders?" The ACMD considers that there are further opportunities to be more creative in dealing with those who have committed an offence by possession of drugs for personal use (in cases where there were no additional criminal offences). The ACMD consider that such approaches might be more effective in reducing drug-related harms to individuals and society, reduce repeat offending and reduce the costs to the criminal justice system.

2. The ACMD proposes that for drug offenders there is opportunity for diversion into drug education/awareness courses (similar to those for speeding drivers) or possibly other, more creative civil punishments (eg temporary loss of a driving licence).

3. The ACMD is aware that a proportion of offenders—primarily for cannabis—are already dealt with by way of a Police caution. The ACMD consider that some form of drug education/awareness/treatment might better reduce drug-related harms. The ACMD note that if there are other trigger offences (eg theft, burglary etc.) then the usual criminal justice procedures would normally apply. In June 2011, the ACMD responded to the Sentencing Guideline Council's Consultation on Drug Offences Guidelines in similar vein.

4. The ACMD is aware that, subsequent to its submission, it has been suggested by some that this was a proposal for decriminalisation. The ACMD was, and still is, clear that its suggestions relate to the diversion of certain offenders from the Criminal Justice System into an alternative intervention that may be more effective and more cost effective. This *is not* decriminalisation; the ACMD consider that the possession of drugs should remain a criminal offence. The offer of diversion to offenders is at the discretion of the Police and CPS and must be fully agreed/accepted by offenders—who should always have the option of having their case heard in a criminal court.

5. The ACMD recognise that such a proposal would require consultation with education and treatment agencies and support from the police, probation and criminal justice agencies.

July 2012

Written evidence submitted by Russell Brand (DP181)

Russell Brand is a well-known comedian and British actor, whose life in the public eye is well documented. Following on from the death of his friend Amy Winehouse last year at the age of 27; the same age Russell beat his addiction, his desire to speak out and be a driving force behind his passion for "recovery" has been augmented. Russell has a unique perspective on drug addiction—he has been an addict, been through detox and rehab, has been in recovery for nine years and works with other addicts through being a Patron at the drug charity Focus 12. (The same charity that saved him from his drug and alcohol addiction.)

Russell wrote an incredibly moving piece in *The Guardian* on 24 July 2011 (which has been added below), that was also published in *The Daily Mail*. The piece was both heartfelt and revealing, and touched many people and was seen as a response that went far beyond the many outpourings of grief following that tragic event. As a result of this Russell has been commissioned to make a programme for the BBC and Sport Relief looking into the subject of addiction, and how society views it, understands it, legislates and makes policies around it, and ultimately what the best way to recover from it is. This search will lead him to speak to experts and addicts alike, and hopefully help us get a real understanding of the root causes of it.

As such, Russell is very keen to present what he believes are some of the underlying problems to do with drug and alcohol addiction in this country and tackle some of the issues the Home Affairs Select Committee is dealing with. He is very keen to research, and use the findings of this documentary to present scientific, fact based and first hand evidence of how the government's 2010 drug strategy is actually working on the ground. He is adamant that Amy's life should not have been wasted in vain and that it can be a catalyst and force for change and good policy making in this country.

In particular Russell would like to talk about and present evidence, tackling the inquiries remit on:

1. The extent to which the Government's 2010 drug strategy is a "fiscally responsible policy with strategies grounded in science, health, security and human rights" in line with the recent recommendation by the Global Commission on Drug Policy—By finding out firsthand what is happening on the ground, Russell will be talking to experts both scientific and non scientific, charities and addicts themselves. Through this Russell will be able to present first hand and objective evidence of how the government's policies are affecting people who are dealing with drugs, addicts and the enforcement of it.
2. The extent to which public health considerations should play a leading role in developing drugs policy—Russell is a big believer in the idea that drug dependency is much more of a mental health issue than it is an issue of criminality. In his view and according to official statistics, we spend far more money locking people up than it costs to treat them in the first place. Especially considering when you look at early intervention, the NTA (National Treatment Agency) estimates that for every £1 we spend on treatment society receives £9.50 back.
3. The relationship between drug and alcohol abuse—Russell can argue this point from a very personal standpoint. He believes the two are inextricably linked and that a holistic, abstinence-led based approach is the best way forward for this. He has plenty of evidence from heroin recovered addicts, who say that they are glad that they aren't alcoholics as in this society it would be impossible to escape the temptation. Again the evidence from the documentary and first hand users will prove invaluable in this respect.
4. The impact of the transfer of functions of the National Treatment Agency for Substance Misuse to Public Health England and how this will affect the provision of treatment—This is another avenue that the documentary and Russell's research is certainly be looking at. Whilst speaking to members of both organisations and charities, and treatment centres affected by the change Russell will learn and understand what pressures, changes, advantages and disadvantages.
5. Whether detailed consideration ought to be given to alternative ways of tackling the drugs dilemma, as recommended by the Select Committee in 2002—Russell wants to really analyse and look into whether it is possible to look at decriminalisation of drugs. Not Legalisation, as a deterrent in his view is still necessary, but not simply locking up users, and abusers of drugs. Especially considering the drug and alcohol problems already rife within the prison system, getting hold of this problem, and treating people in a holistic and individual way, can clearly be of benefit to society, in his opinion. Russell would like to expand this argument, again using evidence gathered from the film as well as research, and put this question to the enquiry.

February 2012

Russell Brand's Article on Addiction following the Death of Amy Winehouse

When you love someone who suffers from the disease of addiction you await the phone call. There will be a phone call. The sincere hope is that the call will be from the addict themselves, telling you they've had enough, that they're ready to stop, ready to try something new. Of course though, you fear the other call, the sad nocturnal chime from a friend or relative telling you it's too late, she's gone.

Frustratingly it's not a call you can ever make it must be received. It is impossible to intervene.

I've known Amy Winehouse for years. When I first met her around Camden she was just some twit in a pink satin jacket shuffling round bars with mutual friends, most of whom were in cool indie bands or peripheral Camden figures Withnail-ing their way through life on impotent charisma.

Carl Barât told me that Winehouse (which I usually called her and got a kick out of cos it's kind of funny to call a girl by her surname) was a jazz singer, which struck me as a bizarrely anomalous in that crowd. To me with my limited musical knowledge this information placed Amy beyond an invisible boundary of relevance: "Jazz singer? She must be some kind of eccentric," I thought. I chatted to her anyway though, she was after all, a girl, and she was sweet and peculiar but most of all vulnerable.

I was myself at that time barely out of rehab and was thirstily seeking less complicated women so I barely reflected on the now glaringly obvious fact that Winehouse and I shared an affliction, the disease of addiction. All addicts, regardless of the substance or their social status share a consistent and obvious symptom; they're not quite present when you talk to them. They communicate to you through a barely discernible but unignorable veil. Whether a homeless smack head troubling you for 50p for a cup of tea or a coked-up, pinstriped exec foaming off about his speedboat, there is a toxic aura that prevents connection. They have about them the air of elsewhere, that they're looking through you to somewhere else they'd rather be. And of course they are. The priority of any addict is to anaesthetise the pain of living to ease the passage of the day with some purchased relief.

From time to time I'd bump into Amy she had good banter so we could chat a bit and have a laugh, she was a character but that world was riddled with half-cut, doped-up chancers, I was one of them, even in early recovery I was kept afloat only by clinging to the bodies of strangers so Winehouse, but for her gentle quirks didn't especially register.

Then she became massively famous and I was pleased to see her acknowledged but mostly baffled because I'd not experienced her work. This not being the 1950s, I wondered how a jazz singer had achieved such cultural prominence. I wasn't curious enough to do anything so extreme as listen to her music or go to one of her gigs, I was becoming famous myself at the time and that was an all consuming experience. It was only by chance that I attended a Paul Weller gig at the Roundhouse that I ever saw her live.

I arrived late and as I made my way to the audience through the plastic smiles and plastic cups I heard the rolling, wondrous resonance of a female vocal. Entering the space I saw Amy on stage with Weller and his band; and then the awe. The awe that envelops when witnessing a genius. From her oddly dainty presence that voice, a voice that seemed not to come from her but from somewhere beyond even Billie and Ella, from the font of all greatness. A voice that was filled with such power and pain that it was at once entirely human yet laced with the divine. My ears, my mouth, my heart and mind all instantly opened. Winehouse. Winehouse? Winehouse! That twerp, all eyeliner and lager dithering up Chalk Farm Road under a back-combed barnet, the lips that I'd only seen clenching a fishwife fag and dribbling curses now a portal for this holy sound.

So now I knew. She wasn't just some hapless wannabe, yet another pissed-up nit who was never gonna make it, nor was she even a ten-a-penny-chanteuse enjoying her fifteen minutes. She was a fucking genius.

Shallow fool that I am, I now regarded her in a different light, the light that blazed down from heaven when she sang. That lit her up now and a new phase in our friendship began. She came on a few of my TV and radio shows, I still saw her about but now attended to her with a little more interest. Publicly though, Amy increasingly became defined by her addiction. Our media though is more interested in tragedy than talent, so the ink began to defect from praising her gift to chronicling her downfall. The destructive personal relationships, the blood-soaked ballet slippers, the aborted shows, that YouTube madness with the baby mice. In the public perception this ephemeral tittle-tattle replaced her timeless talent. This and her manner in our occasional meetings brought home to me the severity of her condition.

Addiction is a serious disease; it will end with jail, mental institutions or death. I was 27 years old when through the friendship and help of Chip Somers of the treatment centre Focus 12 I found recovery. Through Focus I was introduced to support fellowships for alcoholics and drug addicts that are very easy to find and open to anybody with a desire to stop drinking and without which I would not be alive.

Now Amy Winehouse is dead, like many others whose unnecessary deaths have been retrospectively romanticised, at 27 years old. Whether this tragedy was preventable or not is now irrelevant. It is not preventable today. We have lost a beautiful and talented woman to this disease. Not all addicts have Amy's incredible talent. Or Kurt's or Jimi's or Janis's. Some people just get the affliction. All we can do is adapt the way we view this condition, not as a crime or a romantic affectation but as a disease that will kill.

We need to review the way society treats addicts, not as criminals but as sick people in need of care. We need to look at the way our government funds rehabilitation. It is cheaper to rehabilitate an addict than to send them to prison, so criminalisation doesn't even make economic sense. Not all of us know someone with the incredible talent that Amy had but we all know drunks and junkies and they all need help and the help is out there. All they have to do is pick up the phone and make the call. Or not. Either way, there will be a phone call.

Written evidence submitted by the Ministry of Justice (DP185)

We are writing in response to the Committee's call for written evidence in relation to its recently announced Drugs Inquiry.

The attached memorandum sets out the approach to reducing both the supply of and demand for drugs in prisons in England and Wales. It supplements evidence already submitted to the Committee from the Home Office and is in anticipation that the Committee may develop interest in these areas through the course of the Inquiry, particularly given the commitments in relation to prisons contained in the Government's 2010 Drug Strategy.

Should the Committee require further evidence on this or any other prison related matter we would be glad to provide it.

Introduction

This Memorandum is by way of supplement to the Home Office memorandum on the Government's Drug Strategy and is intended to bring particular focus to prisons drugs issues.

Operating context of prisons

There are 135 prisons in England and Wales with a combined population of around 85,000. Prisons are busy places, with a high turnover in population. Nationally we receive 135,000 new prisoners and undertake around 800,000 prisoner movements annually.

Each prison is in effect a micro community. In a single day a prison with a capacity of 1,000 can receive 50 new prisoners, 300 visitors, 3,000 items of post, 44 vehicles and its prisoners can make 5,000 minutes of telephone calls.

Many offenders arrive at prison with a significant social deficit, including:

— 70% report drug misuse prior to prison;
— 51% report drug dependency;
— 35% admit injecting behaviour;
— 36% report heavy drinking; and
— 16% are alcohol dependant.

Potentially, this creates a significant demand for drugs and a challenge in providing appropriate levels of treatment.

In response our strategy is twofold—to work with prisoners to reduce their demand for drugs, and to deploy a flexible range of measures to reduce the supply of drugs into prisons. Each element is mutually re-enforcing.

Supply Reduction

Supply of drugs can involve individuals smuggling comparatively small quantities to increasing involvement of organised criminals seeking to smuggle larger quantities using more sophisticated methods. The main smuggling routes include:

— social visits;
— mail;
— new receptions;
— staff; and
— perimeter "throw-overs".

Prisons deploy a comprehensive and flexible range of measures to reduce the supply of drugs into prisons based on a local assessment of risk. The measures include:

— local searching strategies;
— drug detection dogs;
— social visits security measures, including sanctions against prisoners/visitors;
— intelligence gathering and exchange with police; and
— mandatory drug testing.

A key element is the exchange of intelligence with law enforcement agencies. Prison intelligence officers from local police forces are attached to every prison in England and Wales play a vital role in this process.

"Project Mercury" a secure IT based intelligence system, will enable the electronic sharing of intelligence between prisons and nationally, and will improve National Offender Management Service's (NOMS') ability to assess the threat to prison security locally, regionally and nationally, including drugs. This will be rolled out in 2012.

A further innovation in line with the Governments Green Paper "Breaking the cycle" will be to increase in the number of drug free wings. A new model is being developed and will shortly be piloted in six prisons. The wings aim to offer a safe, secure and drug free environment to prisoners stable and motivated to lead a drug free life.

Manifestations of Drug Supply in Prison

Mobile phones pose a specific and increased risk to prisoners being able to communicate and conduct criminal business with the outside world.

NOMS' strategy to tackle mobile phones is to minimise the number entering prison, to find those that have entered, and to disrupt those that cannot be found. Prisons have access to technology such as signal detectors, BOSS Chairs and metal detecting equipment.

We have also been trialling mobile phone signal denial technology in a small number of prisons. Our experience has confirmed that denying signals in prisons is not a quick, simple or cheap option. The use of signal denial technology is highly technically challenging, given the nature of the different fabric and layouts of prisons and the need to identify technology that is effective at denying signals within prisons without adversely affecting signals outside the prison. There is no off-the-shelf solution and bespoke technology must be procured. NOMS is working closely with partners across government to evaluate possible solutions.

As part of our efforts to disrupt mobile phone signals we will shortly be distributing around the prison estate around 300 short range portable mobile phone blockers.

We have also strengthened the law. It is now an offence to convey into prison a mobile phone or a component part of a mobile phone or to transmit an unauthorised wireless communication within prison for simultaneous reception outside of prison. In addition, it will soon be an offence to possess a mobile phone or component part in prison.

NOMS has a culture that values integrity and the vast majority of our staff are professional, honest and hardworking. Regrettably however there will be instances where staff undertake corrupt activity, such as supplying drugs and mobile phones to prisoners. By nature, any covert activity is difficult to quantify. No organisation can determine with any degree of precision the number of corrupt staff operating at any given time.

We have in place a National Corruption Prevention Unit and a network of local and regional corruption prevention managers gathering and acting upon corruption—related intelligence and pursuing corrupt staff through the criminal courts and internal disciplinary procedures. We have revised training for new staff on recognising and acting upon corrupt and corrupting behaviours in prison. We work closely with the police, reinforced by a memorandum of understanding, which encourages police to investigate allegations of corruption.

It is estimated that around 55% of organised crime activity in the community relates to drugs. We work closely with the Serious Organised Crime Agency to disrupt the activities of organised criminals whilst in prison. This helps also to reduce the supply of drugs into prisons.

Treatment

Reshaping drug treatment and interventions in prisons is at the heart of the Government's intention to develop a treatment system focussed on recovery that helps more people to be free of their dependence, work-ready and with somewhere to live. NOMS is working with health services and other partners to move towards a fully integrated recovery focused system that supports continuity of treatment across custody and community.

Drug Recovery Wings

An important element to this is the piloting of Drug Recovery Wings (DRW) focused on abstinence, being drug-free and connecting offenders with community drug recovery services on release. As with drug free wings, DRWs aim to provide a drug-free environment. DRWs will have a greater emphasis on the provision of treatment and support and in building links back into the community.

In June 2011 drug recovery wings were launched as a pilot in five prisons: Manchester, Holme House, High Down, Bristol and Brixton. These initial pilots are focussed primarily on drug and alcohol misusing offenders sentenced to between three and 12 months in custody where there is limited time available in prison to complete treatment interventions. However, prisons also have the flexibility to design their models appropriate to their offender population and include some offenders who are serving over 12 months. Some of these will already be working towards recovery and will become recovery champions to promote the ethos of recovery and support on the wing.

The initial pilots will run for at least 18 months (until December 2012). An implementation study has begun and an interim report will be available in July 2012.

The Department of Health is also undertaking an independent evaluation of Drug Recovery Wings which will commence in Autumn 2012.

We are committed to implementing a second tranche of five prisons which will include at least two women's prisons (New Hall and Askham Grange) and a Young Offenders Institution from April this year. This will allow us to explore the complexities of testing recovery wings in other prisons.

Integrated provision

From April 2011 the Department of Health assumed responsibility for funding and commissioning drug and alcohol treatment in all prisons and the community in England. Subject to parliamentary approval, the responsibility for commissioning substance misuse treatment services for people in prison and other places of prescribed detention will lie with the National Health Service Commissioning Board, under an agreement between the Secretary of State for Health and the NHS Commissioning Board. In the community local authorities will be responsible for commissioning drug treatment services in the new public health system, bringing together treatment provision and the wide range of local services that help promote and sustain recovery. These changes present a unique opportunity to move to a fully integrated, locally commissioned recovery-orientated system that meets the health needs of offenders and plays a key role in protecting communities from drug related harms and re-offending, as recommended by the independent review of prison drug treatment chaired by Lord Patel of Bradford.

NOMS Treatment Framework

NOMS has in place a drug treatment framework designed to meet the needs of low, moderate and severe drug misusers within the prison population—irrespective of age, gender or ethnicity—including the many

that spend a comparatively short time in prison. The framework comprises: clinical treatment; psychosocial interventions; case management; and throughcare services.

Evaluation

Evaluating "what works" in relation to tackling the demand and supply of drugs in prisons is complex as many factors impact on both supply and treatment and it is difficult to differentiate cause and effect.

The new initiatives we are testing such as Drug Recovery Wings and Drug Free Wings are underpinned by evaluation and practice sharing.

We evaluate many of our technical interventions such as BOSS chairs, drug testing methods, and mobile phone signal detectors, to be sure that they perform to specification.

A large multi-site independent evaluation of Integrated Drug Treatment System (IDTS) will be completed in 2012. Among other outcomes, the evaluation will measure the impact of IDTS on re-offending rates, suicide in prison custody, and drug-related death following release.

The overall measure of our success is the proportion of prisoners testing positive under the random mandatory drug testing programme. In 1996–97 24.4% of prisoners tested positive. In 2010–11 the figure was 7.1%, representing a 71% decline in the proportion of prisoners testing positive.

References

1. Hollin, C, Palmer, E, McGuire, J, Hounsome, J, Hatcher, R, Bilby, C and Clark C (2004) Pathfinder Programmes in the Probation Service: A Retrospective Analysis. Home Office Online Report, 66. London: Home Office.

2. Hollis, V (2007). Reconviction analysis of programme data using Interim Accredited Programme Software (IAPS). Unpublished report, Ministry of Justice.

February 2012

Written evidence submitted by the Royal College of General Practitioners (DP201)

Thank you for your letter on the 25 October following the House of Commons Home Affairs Select Committee oral evidence session I attended earlier this year.

The College welcomes the opportunity to provide you with more evidence as needed, and I have answered your questions below.

> *I am writing to you in regards to the NICE clinical guidelines which list methadone as the preferred opium substitution treatment.*

Please note opioid is the correct term to use in this context rather than opium.

> *I understand buprenorphine is a viable alternative, particularly when it is combined with naloxone—what is the rationale for the preference of methadone?*

Naloxone is added such that it renders it impossible to inject or snort buprenorphine as the naloxone becomes active when taken in this route and neutralises the effects of the buprenorphine. In UK we don't need to use suboxone paradoxically because of the ready supply of heroin—buprenorphine injected or snorted is in essence used, where heroin is in short supply, as an alternative to heroin. There is no need to use suboxone in UK—so we use buprenorphine without the naloxone.

Regarding the use of methadone versus buprenorphine, NICE guidelines says that in the absence of evidence for choosing one over the other—let the patient choose. See NICE detox guidelines CG52 Drug misuse—opioid detoxification. Available online at http://publications.nice.org.uk/drug-misuse-opioid-detoxification-cg52/key-priorities-for-implementation

The following section from the NICE Drug misuse—methadone and buprenorphine appraisal may also be worth noting:

> *4.3.8 Taking all these factors into account, the Committee concluded that the decision about which drug to use should be made on a case by case basis and should consider a number of clinical and patient factors, including the person's history of opioid dependence, their commitment to a particular long-term management strategy and an estimate of the risks and benefits made by the responsible clinician in consultation with the person. However, the Committee was mindful that methadone is cheaper than buprenorphine and therefore concluded that, if both drugs are equally suitable for a person, methadone should be prescribed as first choice.*

Source: (NICE TA 114, available online at http://www.nice.org.uk/ta114).

From the perspective of the GP, patient choice and preference will be taken into account first and foremost.

Your second question asked:

> *In your experience what percentage of those on OST would be prescribed methadone and what percentage would be prescribed buprenorphine in the form of subutex or suboxone?*

In my experience around 90% choose methadone. 1% on suboxone and around 9% buprenorphine alone.

Professor Clare Gerada
Chair of Council
Royal College of General Practitioners

November 2012

Written evidence submitted by Professor John Strang [DP202]

I think you will find that the NICE Technology Appraisal (TA114, if I recall correctly) concluded that both methadone and buprenorphine had good evidence-bases to support their use in maintenance OST treatments (acknowledging the greater, longer-term evidence-base of methadone, and the more recent gathering of the buprenorphine evidence-base), and that it was the lower price of methadone that primarily led to the conclusion that, if no other factor indicated one or the other, then methadone should be used. But my recall is that this is the basis of any hierarchy. So both are considered viable—but, if no other reason to choose between one or the other, then choose the cheaper one.

This is also broadly similar to the conclusions from a substantial number of Cochrane reviews of bupreorphine and methadone, authoritative international scientific reviews to which the NICE Technology Appraisal itself refers.

Note that the NICE consideration was of buprenorphine as a mono-product (ie not with naloxone added) but then also remember that the naloxone does not have any therapeutic chemical effect and is added as a harm-triggering additive to deter any intravenous abuse.

The pharmaceutical companies have subsequently introduced and promoted a combined buprenorphine-nalxone variant (Suboxone), but also you should be aware that I believe the combination product has recently been withdrawn from use in the US following concerns about an unexpected association with deaths. You should explore this area yourself if you want further detail as I do not have available first-hand information.

If you are interested in the percentages prescribed as methadone versus buprenorphine, then, as far as I am aware, these data are not routinely collected in a way that gives you this answer, which is a real failing and should be corrected. However, on the basis of some English national data extractions and calculations which I and colleagues undertook a couple of years ago, we identified that, after its introduction in 1999, the proportion of OST as buprenorphine had steadily increased up to about 15% by 2005, but that it had remained steady at this proportion (about 15%) thereafter. (This study led to our attached BMJ paper on the reduced proportions of deaths per million doses of methadone, at which time we collected and analysed the buprenorphine data also, but were not able to analyse them meaningfully as the death data were not as robust as we wished: the method is as described in this paper, with buprenorphine prescription data added).

It is a great shame that these amounts and proportions between methadone versus buprenorphine versus other less commonly-used OST treatments are not routinely analysed. We have previously done so, but such research tracking is now impossible to get funded. The task is fairly easy, probably only about £50k per annum, and potentially yields strong useful information about national and regional changing practice, and any association with different problems or benefits etc. We have done this work previously when research opportunity arose and so we know it can be done—but it is now nearly eight years since the last national community pharmacy survey, despite the high yield from the previous surveys.

The ratio between buprenorphine and methadone is approximately 1:6, but this varies considerably in different parts of the country, partly for reasons of clinical preference or judgement, I suspect, partly as a result of promotion of the pharmaceutical companies probably, and also because of legacy of concerns from earlier intravenous abuse of analgesic buprenorphine (eg especially across Scotland in the 1980s) so that it is much less likely to be prescribed as OST today.

For some effort to disentangle reasons for prescribing buprenorphine versus methadone, see our paper published in 2009 exploring patient and clinical perspectives and their influence in the South London sample (Ridge *et al*, JSAT, 2009—attached[181]).

November 2012

---

[181] Not printed.

Conference held in Portcullis House on Monday 10 September 2012

The Committee held an international conference on drugs at Westminster on 10 September 2012. The following transcript of the plenary session was reported to the House as written evidence on 3 December 2012

Members of the Home Affairs Committee present:

Keith Vaz (Chair)

Nicola Blackwood
Dr Julian Huppert
Alun Michael
Bridget Phillipson
Mark Reckless

Q1 Chair: Good morning, participants and parliamentarians. I welcome you most warmly to this international conference that has been called by the Home Affairs Select Committee. I begin by introducing the members of the Committee who are here today: Dr Julian Huppert, Mr Mark Reckless, Bridget Phillipson, Nicola Blackwood and Alun Michael. They represent different constituencies across the United Kingdom. This Home Affairs Committee was constituted in 2010. For those of you not familiar with our Committee system, its purpose has been to scrutinise the actions of the Home Office, and to make recommendations about areas of policy.

In particular, I thank Dr Julian Huppert, the Member of Parliament for Cambridge, for suggesting that we have this inquiry into drugs, supported fully by other members of the Committee. The last time the Select Committee looked at the issue of drugs was 10 years ago, when the Prime Minister was, in fact, a member of our Committee, so the Committee felt that a decade later, it was probably timely to look at the subject again.

I thank everyone for coming here today. Some of you have travelled many miles in the United Kingdom; some have travelled many thousands of miles. In particular, I welcome the head of the Colombian National Police, General León, who has travelled from Bogotá and arrived yesterday, and Dr Leal da Costa, the Portuguese Minister of Health, but all of you are most welcome. We have people here from the United States through to France, and from Brazil through to Yemen. That gives you an indication of how important and how dangerous the issue of drugs is.

The outcome of this conference will feed directly into our inquiry on drugs. We are very interested in your comments and your experience; because of the way in which the Select Committee system operates, it is just not possible to have everybody coming before us to give oral evidence to the Committee, which is why we were very pleased to see more than 200 submissions from individuals and organisations on this subject. I thank the Home Affairs Committee staff because they, along with us, have had to read the submissions and—I was going to say make sense of them, but they are all very sensible—try to decide which ones should carry weight and which ones should be included in our inquiry.

As well as having international speakers, we have some speakers today who will help us, in our workshops, to lead further discussions. I should say, in the traditional way of the British police, that everything you say will be taken down and used in evidence, not necessarily against you, but certainly to assist the Committee.

The use of drugs has existed for several thousand years. Traditional drug use was limited largely to special religious and social events, and to medical use. Opium and cannabis have long been used in Asia, and later in Africa and Europe. The same is true of the coca leaf, and of khat in countries such as the place of my birth, Aden in Yemen. However, in the last century, the use of drugs has become a growing and legitimate public health concern.

The first conference of the International Opium Commission was held in Shanghai in 1909; it was followed by the adoption of the international opium convention, signed at The Hague in January 1912. Three drug control conventions were adopted under the League of Nations in the inter-war period and, finally, the three United Nations drug control conventions were adopted in 1961, 1971 and 1988. Despite more than a century's work to stop the flow of drugs, we have at most stabilised rather than reduced the number of illicit drug users. Only two months ago, the UNODC released figures showing that the global number of illicit drug users is likely to grow by 25% by 2050 to 287.5 million. The bulk of the increase is expected to take place among the rapidly rising urban population of developing countries. This presents a new set of difficulties for those committed to the eradication of harmful drug use.

The harms that stem from drug use are not just the danger of addiction or its effect on physical health. In the United Kingdom alone, drug addicts commit between a third and a half of all acquisitive crime. Drugs are costing our health and justice service about £15.3 billion a year. While they are dangerous, the harms of drugs extend far beyond the addict in the consumer country, who is knowingly being sold a product that is contaminated with many adulterants. There are harms to farmers in the source country who have their crop destroyed because they are also growing coca leaf or opium. Three Andean countries, Colombia, Peru and Bolivia, are responsible for virtually all global coca leaf production—the raw material for cocaine. In 2010, coca was cultivated on 149,100 hectares in those three countries, an area roughly one and a half times the size of Hong Kong. There are harms to the political leadership in the transit countries, which cannot combat the drug traffickers because their national budget is dwarfed by the money available to those who smuggle illicit

drugs. The value of the global cocaine market is £543 billion, while Bolivia's national budget, for example, is only around £1.69 billion.

The harms of illicit drugs are varied and have dire consequences. It is estimated that more acres of the Colombian rain forest are cleared to plant coca leaf than are cleared for use in all farming. Despite the damage to their land, which the Committee witnessed first hand in Colombia, Andean farmers receive only 1% of the revenue from global cocaine sales, yet we are rarely able to discuss the environmental impact of drug use. In West Africa, we are seeing the emergence of the world's first narco-states, yet how often do we discuss the implications of drug use? All kinds of harms have occurred, but we are particularly concerned about the huge increase in addiction to prescription drugs, which we saw for ourselves when we visited Miami; that is something that we fear may happen in this country.

As we saw when the Home Secretary appeared before the Home Affairs Committee last Thursday, we are also very worried about the increase in legal highs. There are 41 new substances discovered every year in the United Kingdom to do with legal highs. In 2011, a new substance was discovered almost every week. Such substances, I am afraid, have unknown health effects. We have to deal with these problems and face them together.

At the end of the last Session of Parliament, the former Lord Chancellor, Ken Clarke, still a member of the Cabinet, told the Committee that he felt that we had lost the war on drugs. The Home Secretary, when she appeared before the Committee last Thursday, expressed a great deal of concern about the need to join up various parts of Government, not just in this country, but internationally. We cannot reach a solution on our own. That is why the Committee decided to hold this international conference. We have brought together representatives of Colombia, people from Guinea-Bissau in West Africa, the Health Minister from Portugal, and, of course, parliamentarians and other groups from the United Kingdom. I do not believe for one moment that we can solve this problem on our own. The only way to solve this problem is if we all work together.

I hope we have a very productive conference. The Select Committee does not have answers yet. We are still in the process of looking at the evidence. Very shortly, we will have a discussion as to our recommendations, and we hope to have a report ready—the first such report in 10 years—by Christmas this year. I hope that you will speak freely. No one is going to shout you down—this is not a session of the British Parliament. This is an opportunity for us really to hear what you have to say, and to learn, so we are keen to listen to you. I hope you will use this as an opportunity for taking this cause further.

I was very interested to hear from five parliamentarians who have come from Morocco just before we began our session. It is vital that those of us who are here as Members of Parliament continue this dialogue. Of course, in the end it is up to Government, but we in Parliament have a very important role to play in ensuring this happens.

Our first speaker is one of the most senior members in the Colombian Administration dealing with drugs. General León took office last year, and this is his first international visit as Director General. He has been in the Colombian police for over 30 years and has also studied in Paris and the United States of America. Members of the Committee went to Colombia, and we met many of the Colombian generals. General Pérez is here with us today. We actually went into the Colombian jungle. Some, of course, would have hoped that the Select Committee might have stayed there, but we came back. It was astonishing to see the very young men who had volunteered to go into the jungle to fight those who are involved in cocaine. This is the front line. It is not Leicester, London, Slough, Birmingham or Leeds; the front line in the fight against drugs in our country is what is happening in Colombia. We in Britain owe them a huge debt of gratitude for what they do. Ladies and gentlemen, please welcome General León, the head of the Colombian police.

Speaker: **Major-General León Riaño**, Director General of the Policía Nacional de Colombia.

Major-General León Riaño: *(Translation)* First, I would like to greet you all cordially on behalf of President Santos and the national police. I also thank you for inviting me to share the experience of Colombia's fight against drug dealing. For a decade, Colombia has been going through a very difficult situation, fighting against drug dealing. When engaging with international forums, other countries did not appreciate some of Colombia's comments, but today, Colombia is seen as a point of reference on an international scale for the success it has had in the fight against drug trafficking. Our President has shown that the experience gained over three decades of fighting against this problem is now available for all countries, so that the people of other countries can avoid the same spiralling downfall experienced by some of our compatriots in Colombia. For that reason, the Colombian experience is available for everyone.

Let me show you how the fight against drug trafficking has become a national policy. Ours is one of the most solid and consistent policies in fighting drug trafficking. More than 40 state members share in the strategy. The components of action include repression; prevention; social, economic, and political aspects; and issues to do with health and the environment. The integral anti-drug policy used by the Colombian states and developed by the national Government comes under the framework of a policy called "Prosperity for Everyone". Through the Ministry of Defence, the main objective is to reduce the production of narcotics.

Among the institutional imperatives is a definitive offensive against narco-trafficking, in which we are looking to eliminate areas of drug cultivation, strengthen the capacities of interdiction, and eradicate criminal bands and drug-trafficking organisations.

Major-General León Riaño

Today, the mega-tendency of the anti-trafficking policy, seen from our point of view, is talking about the end of the big cartels, because drug trafficking has been transferred to armed groups. The big drug cartels have been disbanded—the Medellín cartel in 1993, the Cali cartel in 1998, and the Norte del Valle cartel in 2003. Cartels dominated drug trafficking, from cultivation to export to foreign places. All this led to a rupture in drug trafficking within the country, which led to the hegemony of drug trafficking in Colombia and in the Mexican cartels. In this fight, we have identified 17 micro-trafficking groups and approximately 42,100 consumers within the country. As a result, various networks, including FARC, the National Liberation Army, and the criminal bands, have resulted.

Cultivation and potential production has been reduced by 61% between 2000 and 2011, from about 162,510 in 2000 to 63,762 in 2011. Again, there has been a reduction in the potential production from 695 tonnes in 2000 to 345 tonnes in 2011, and an increase in the rate of effectiveness of combating drugs from 36% to 56%. As a result we have seen a drug-terrorist symbiosis. The FARC and the ELN, like the main perpetrators of drug trafficking in Colombia, have left aside their ideological profile to move on to the consolidation of economic empires that will let them maintain their illicit activities. This drug-terrorist symbiosis leads to a new threat in cocaine trafficking for the state. These narco-terrorist groups such as the FARC, the ELN and the criminal bands maintain a strong influence over drug trafficking strategies where they capitalised drug cultivations as platforms for distributing drugs internationally.

We found that the FARC control 88% of the coca plantations in the country—approximately 56,233 hectares of the 63,762 hectares that have been identified. For example, in zone number 4 the FARC controls 22,379 hectares of coca plantations. Criminal bands control approximately 26,000 hectares and the ELN controls about 15,000 hectares. To follow the development of drug trafficking between south America and Europe we have identified three routes that leave from different points within south America and transit to the Caribbean islands, central America and Africa. We have also identified two new routes in the trafficking of drugs: the Suez Canal route and the Balkan peninsula route, the latter being through Turkey, Bulgaria, Romania and Italy. That has made the Governments implement a strategy against drug trafficking, developed by the national police. It joins up all the cycles of drug trafficking—production, trafficking, money laundering and export—so that the illicit trade is less lucrative for the delinquents and criminals.

The strategic components of the policy include prevention, eradication of illicit plantations, research and operations, and control of ports and airports. The prevention of the production and consumption of drugs tackles four aspects that you can see in this slide. It is directed through social programmes, sensitising the young, teachers and parents to prevent the consumption of drugs.

The eradication of illicit plantations includes a technical and controlled eradication of crops to ensure permanent eradication; a consolidation of areas, with reduced detrimental impact; an environmental management plan; and a look-out for complaints relating to aerial fumigation.

Today we eradicate in three ways. The first is through voluntary eradication by communities, especially in rural areas. The second is manual eradication by groups that have been hired by the police and the Government, and protected by the police. Finally there is aerial fumigation, controlled by the Ministry of Environment.

With regards to the interdiction, investigative processes and operations are used to break up criminal organisations. When President Santos was the Minister of Defence he created a system of national intelligence where the various forces put together their technological capacity and intelligence to find and capture and neutralise the heads of the different terrorist groups. Among the operations that took place is Operation Phoenix which enabled the neutralisation of Raúl Reyes, the main international link of FARC and the second in command of this drug terrorist group; the Jaque operation where some Americans who had been kidnapped were freed as well as Ingrid Betancourt, a former presidential candidate; and Operation Sodom, where Mono Jojoy, the main terrorist of our country was captured

In this slide we can see the reduction in the illegal crops: in 2000 it is 162,000 hectares and with a reduction of 61% last year ending in 63 hectares. It is the lowest rate in the last 16 years in our country, which confirms the success and the sustainability of the anti-drug policy in Colombia. Today we find a new phenomenon, replantation. This slide shows the percentages of replantation in each of these zones. Thanks to the operational control that we are implementing at the moment we can see the big reduction in replantation. We can summarise this in what you can see here of the support. Today we intend to increase the basis for fumigation with the point of identifying the cycle of production and that way eradicate the illegal crops more effectively.

These contingency strategies against replantation are in three categories: fumigation, manual clearance and social programmes. We have also noticed decreasing production of cocaine in Colombia. As I have shown, it has gone down from 695 tonnes to 350 tonnes today—a reduction of more than 50%.

Colombia has always sought co-responsibility. For that reason we always look for regional alliances, and we also have alliances outside our continent. Collaboration goes beyond simple co-operation, but it is imperative in order to reduce the production of drugs. For that reason, we appeal to international co-responsibility. Through teamwork with other police forces in the world, such as Europol, Ameripol, Interpol, and the American Association of Police Officers, we managed to capture more than 30 heads of drug trafficking at the first level. They had taken refuge in places in Ecuador, Cuba and Venezuela, escaping from the police and the authorities. The result was due to co-operation with police forces in other countries. Some 1,500 policemen from abroad have been trained in Colombia.

Major-General León Riaño

In conclusion, I would say that our country's position today in the fight against drug trafficking was expressed recently by President Santos in the international forum in Cartagena in Colombia, where he referred to legalisation as an alternative to research and study and as a policy that could be most effective in the fight against drug trafficking. At this time, our country continues to fight against this issue. Thank you.

Q2 Chair: Thank you very much. We now move on to our next speaker. Alex Stevens is professor of criminal justice at the University of Kent and the author of a number of important books on the subject of drugs. He is going to speak to us for about 10 minutes.

Speaker: **Dr Alex Stevens,** Professor of Criminal Justice, University of Kent.

Dr Stevens: Good morning. First of all, I would like to thank Mr Vaz and the other members of the Committee for this opportunity to talk to you about drug policy—my specialist subject. I am going to be talking today about Portugal and Sweden, and I imagine that this is because the examples of Portugal and Sweden are often given by opposing camps in the drug policy debate as countries that we should copy in order to solve all our drug problems, or at least see them substantially reduced. I am going to be talking today about the key features of those policies and about how the story has been told of the success or failure of those policies. I will then perhaps contrast some of the stories against the data that I am going to show you about trends since decriminalisation in Portugal and more recent trends in Sweden around drug use and drug-related harm. Finally, I want to expand the argument and make it a little more interesting, I hope, by arguing that it is not just about drug policy; we need to be thinking about other forms of policy when looking at drug policy outcomes.

I will now speak about the key features of the Portuguese policy. I imagine that we will hear more about that from Dr da Costa, so I will keep this brief. Portugal, as many of you know, decriminalised the possession of personal amounts of all illicit substances—not just cannabis—in 2001. Possessing less than 10 days' supply is now not a criminal offence, but it remains an administrative offence, so one can still be referred to what are known as committees for the dissuasion of addiction, which can impose fines, but normally provisionally suspend proceedings in the hope that one will not return. Dealers and traffickers continue to be prosecuted. Treatment and harm reduction have also been majorly expanded. For example, low-threshold methadone maintenance services were significantly expanded by investing in them after 2001. There have also been changes in broader social policy. The Socialist Government that introduced decriminalisation also introduced a guaranteed minimum income for levels of welfare support.

The narrative of success that has been given by, for example, Glenn Greenwald from the Cato Institute is that drug use has declined, drug deaths were reduced, and Portugal has a lower prevalence of drug use than other European countries. However, he did not place much emphasis in that story on the expansion in treatment, which I consider to be very important, or on the fact that there was an increase in reported lifetime drug use among adults in Portugal after 2001. He declared the policy a "resounding success". He has an opponent in this story: Dr Pinto Coelho, who has been a long-time opponent of the policy within Portugal, said that, on the contrary, drug use went up, drug deaths went up, drug-related homicides went up, Portugal has the highest rate of HIV among injecting drug users in Europe, and the policy was therefore a disastrous failure.

So there are two stories about the same objective reality. How do we disentangle this? As a researcher, I try to disentangle things by looking at what the data say, so let's have a look at some of the data. We have available to us a range of surveys done among young people. There are four different types of survey done at different ages of young people. You will see, however, that the general trend since decriminalisation has been a downward one among all the ages of school age. In front of the Home Affairs Committee last week, the Home Secretary mentioned this increase from 1995 to 2007, but she did not mention that the more recent trend is downwards. We also have evidence on drug-related deaths. This is a little bit confusing, because we have two indicators of drug-related death in Portugal. The grey line is based on the number of bodies where drugs are found in toxicological autopsies after the person has died. The black line is the more internationally recognised classification of drug-related death, where a physician declares that drugs had some role in the death. You will see that they both go down and then the grey line divergers go up. Dr Pinto Coelho is emphasising that line. The problem with that is that not only has the number of people found with drugs in their body when they have died gone up, the number of toxicological autopsies has gone up, so even if there had been no increase in drug-related deaths, there would have been an increase in the number of bodies found to have drugs in them. We therefore consider the black line to be a much more reliable indicator of an actual decrease in drug-related deaths in Portugal.

With regard to drug-related homicides, Dr Pinto Coelho's statement was based on a footnote in the United Nations Office on Drugs and Crime World Drug Report, which speculated that an increase in homicides after 2001 might have been drug-related. Even if it were drug-related, where there is no clear mechanism that it would be, we are now actually down to levels very similar to those before decriminalisation, so there does not seem to be any lasting effect of decriminalisation on homicides, let alone whether they are drug-related or not.

For me, the biggest story from Portugal is the dramatic decrease in levels of HIV infection among

injecting drug users—an extremely positive policy impact. The decline continued from 2008. The red bars on the graph had also continued further by 2010, according to the European Monitoring Centre for Drugs and Drug Addiction.

Let us move on to Sweden. In contrast to Portugal, which had an aim in its drug policy of bringing drug users into society and creating social solidarity, the main thrust of Swedish policy is to aim for a drug-free society. That has been the case since about 1969, when an activist called Nils Bejerot founded the Association for a Drug-Free Society, which was very successful in changing laws in Sweden and moving things in that direction. Sweden has had since the 1970s a very restrictive approach to drugs. The use of drugs is still criminalised in Sweden. Having drugs inside your body is a crime; it is not just possession of the substances. People who are arrested are very likely to face conviction, which is much less likely in Portugal and even in this country. They also have the opportunity to use compulsory treatment, to force people who don't want to be treated for their drug problem to go to treatment, even if they have committed no other crime.

In contrast to that restrictive story, by comparison with the UK, Sweden has a relatively lenient penal approach. Several offences under the Misuse of Drugs Act here carry much longer sentences than the maximum for a first drug offence of any type, even large-scale drug trafficking, in Sweden. The other element of the Swedish situation is that there is quite limited availability of harm-reduction services. There is not much needle exchange and very little methadone maintenance provision.

According to the United Nations Office on Drugs and Crime, the story was that countries get the drug problems they deserve. If you have a restrictive approach, you will end up with low levels of drug use, making a clear cause and effect link from the restrictive approach to the low levels of drug use that Sweden observes. Other people have made counter-arguments to that: Peter Cohen in Amsterdam and Pelle Olsson in Stockholm say that the conclusions are not supported by the evidence and that recent data show increasingly worrying tendencies in drug-related death and HIV. So let's again look at the data.

This is a graph from the United Nations Office on Drugs and Crime report, which proclaims the success of the Swedish drug policy since the 1970s in reducing drug use. One thing you will see is that Sweden did historically have very high rates of amphetamine use. You will see that there is a major reduction in the use of amphetamines. You will also see that that reduction took place before the restrictive policy happened. Therefore, the restrictive policy cannot be the cause of the effect of a significant reduction in drug problems.

There is a quite worrying tendency in Sweden towards an increase in drug-related deaths. Drug-related deaths are now the leading cause of death in Swedish cities, greater even than road traffic accidents among young men. There have also been worrying trends in HIV incidence among Swedish drug users. In 2006, an outbreak in Stockholm led to increasing surveillance, so the peak may be more to do with surveillance effects than such a dramatic increase in HIV, but there is still a worrying tendency for outbreaks of HIV in the absence of harm reduction services.

So far I have been looking at drug policies and what outcomes we might tie to an individual country's drug policy. I want to argue that it is more interesting to look elsewhere. For example, this morning General León talked about the importance of social policy and social programmes on the drug problems that countries experience. The graph shows on the vertical axis the prevalence of cannabis use among 15-year-olds—the type of cannabis use that we would most like to reduce as it appears to be the most damaging. On that axis, you have an index of welfare generosity—de-commodification; how much you can get services without access to the market and being able to pay for things. It is based on levels of unemployment benefit, sickness pay and pensions. We see a correlation between countries that have the least generous welfare states tending to have the highest rates of cannabis use among their population. There is also a correlation between the least generous welfare states having the highest rates of injected drug use. You will all know that correlation is not causation, but it is indicative of a relationship—a relationship that does not exist between the harshness of the enforcement of drug laws and prevalence of drug use. There is no consistent relationship across countries, as to countries with more or less harsh drug laws having consistent differences in the rate of drug use among their people or, indeed, of problematic drug use.

At least we can say from the conflicting evidence that decriminalisation in Portugal did not lead to the feared explosion in drug use. Therefore, many of the arguments put forward, for example by the Home Office, that we would expect to see a massive increase in drug use if we were to be more liberal in our drug policy are not supported by that example, at least. On the other hand, restrictive policies in Sweden did not cause the reduction in drug use. Something else was going on in Sweden that led to a reduction in quite high levels of amphetamine use, which have stayed low and stable since. But it was not about the restructured drug policy.

Treatment and harm reduction services appear to be associated internationally with reductions in HIV and drug-related deaths, but broader policies of welfare and imprisonment are a very important part of the story that is often omitted from analyses and political debate on what to do about our drug problems.

Thank you for the opportunity to give you this short run-through of some of the issues. If you want more information, it is available in the publications I have brought with me or by e-mailing me at my university e-mail address.

Chair: Thank you, Professor Stevens. We have a quick question from a member of the Committee who just happens to be your local MP.

Q3 Mark Reckless: You described Portugal and Sweden as if they were two poles in the debate. That there is a restrictive, harsher policy in Sweden, I would not question, but is it correct to portray Portugal as liberal or relaxed in its approach to drugs? One of the difficulties in the debate is that as soon as

Dr Alex Stevens

you say "decriminalisation" with respect to Portugal, people make the assumption that somehow drug use is tolerated within Portuguese society. That was not our impression on our visit. The dissuasion commissions that people are sent to seem, in many ways, to take stronger and greater action on drugs than perhaps our own criminal enforcement measures often do.

Dr Stevens: It is true to say that Portugal certainly has not shone the green light for drug users and said that everyone is free to use drugs. It still disapproves of it, but its attitude was that the criminalisation of drug users was driving a wedge between drug users and the rest of society that was not helpful in terms of integrating them into the treatment services they need. For example, treatment was seen as a better way to go than prison. Looking at the prison population in Portugal, on the graph in front of you, the blue line shows those imprisoned for drug offences. After decriminalisation, there was a significant decline in the number of people in prison for drug use, as you would expect. If imprisonment is an indicator of the harshness of drugs policy, then certainly that type of harshness reduced; at the same time, Portugal was able to integrate more problematic drug-users into treatment to create social solidarity.

Q4 Chair: That is very helpful. Thank you. We are now going on to our next panel. Could I say to Nicola Singleton and Angela Painter, whose biographical details are in the booklet, that you don't need to come to the lectern for this? What we would like is just five minutes from each of you on the issues that you cover. Nicola Singleton is the Director of Strategy and Research at UKDPC, and Angela Painter is the Chief Executive of Kenward drug treatment.

Speakers: **Nicola Singleton**, Director of Policy and Research, UK Drug Policy Commission, and **Angela Painter**, Chief Executive, Kenward Trust.

Nicola Singleton: Thank you very much for inviting me to talk briefly about payment by results. The UK Drug Policy Commission was set up to provide objective analysis of the evidence around drug policy. For those who don't know, we are an independent, charitably funded body. We are not part of the Government. We have considered payment by results as part of our wider work programme, so we included it in our evidence to the Committee. There is a lot that could be said about it, but I will try to be brief and concise.

Payment by results is intuitively very appealing. Who would not want to pay for good outcomes? Unfortunately, the evidence around the payment by results model is not as strong as people might think. The evidence suggests that where it works is where you have a single, very clear outcome, and you are quite clear about the interventions that will get you there, so that everybody is clear about what needs to be done, and about the outcome you are going to pay for. Unfortunately, recovery does not really tick those boxes. Recovery is recognised as a very complex and individual process. People start from different points. They have different resources themselves, and they may also have a different opinion of what recovery will mean to them. It is very hard to pay for recovery or to measure the recovery when you get to it.

There has been a good attempt, but you have ended up with nine separate outcomes as part of the payment by results recovery model. There are also a number of different complexity levels in recognising people's different starting points. This means that you have a very complex model to work out what has to be paid to people. That will come with a whole host of costs in administering the process. One also has to wonder how the incentive works. When you have so many different payments that will all carry tiny amounts of money, how do you feel incentivised to deliver? There are questions around that.

There is also a lot more opportunity for perverse incentives. This has been shown in quite a lot of attempts at payment by results in the past, and in the forerunners to the Work programme. It was the same with targets. People focus very much on these areas that are being paid for, and they may not take a very clear overall approach to people. I will not talk about the impact on providers because I think that is what Angela will talk about, but there are issues around the risks that are being put on to the providers. I suppose one of the main dangers that we see is that the focus on the payment by results recovery has led to an expectation that this is the only game in town, and that this is the most important way of achieving greater recovery.

It is important to recognise that there has been a sort of payment by results; there has been payment for better outcomes going on through the payment system. The way in which money has been allocated to areas has already been paying for improvements in delivery. There has been an improvement that has been ongoing for some time. There are lots of other important things that are being tried out in local areas that are not directly payment by results. The evidence suggests that a good way of improving recovery outcomes is to have better-linking services, with mutual aid and peer support, which need not cost anything at all. Getting better integration of services does not have to be done through a payment system. There are also lots of different ways in which people are working to improve recovery in their areas, perhaps through setting up social enterprises, which help to sustain recovery. That is perhaps the more difficult thing—not so much achieving it in the first place, but sustaining it afterwards. There is a big concern that all the focus is on payment by results, and we will not necessarily be learning from a lot of the other good things going on in our system already.

Q5 Chair: Thank you. May I ask Angela Painter to give us a brief overview?

Angela Painter: Good morning. It is good to be here and I thank the Committee for inviting me. There are

a couple of things that I want to make absolutely clear first. Kenward Trust is completely committed to the implementation of the drugs strategy. We are also committed to a whole person recovery model. We are committed to outcome-focused approaches, and we are keen to seek ways of offering efficiencies and value for money. What I want to share with you today is our particular experience of the introduction of the payment by results model in Kent and the impact on my organisation. I want to raise some cautions, like Nicola, around this particular implementation of the commissioning model within the drugs sector.

Kenward is a voluntary sector organisation. We provide residential recovery programmes. We are based in Kent, but we see individuals from around the country. We currently have a 100% occupancy rate in our main 31-bedded project, and a 98% occupancy rate in our other three projects. We provide aftercare and preventive and early intervention services for young people and adults in the community. We work with the homeless and offenders. Up until April this year, we also provided all the alcohol treatment services within West Kent and a significant amount of the drug treatment services. This was in a very high-performing DAT—drug and alcohol action team.

However, Kent DAT made the decision to decommission all the drugs and alcohol services, and they were successful in their bid to become a payment by results commissioner. We were quite excited by that, so we did a lot of work with all our stakeholders preparing for the tender. However, when we saw the financial modelling in the tender specification, our board had to take the very difficult decision that we could not sustain the financial risk involved in that particular model.

We were not alone. There were at least 20 provider organisations at the initial consultation event. My understanding is that only two large national providers eventually put in a bid, so the first point that I want to make is that in our experience, a payment by results model will exclude smaller voluntary sector providers that can provide innovative and quality services, and that will certainly have good local knowledge and good well-established relationships with all the variety of agencies that we know contribute to a successful outcome.

The second point I want to make is that I think the payment by results model is in danger of creating a huge bureaucracy involved in collecting payments. In my previous work in the NHS, I saw a similar thing happen. There is a danger of becoming target-driven, rather than outcome-focused. The biggest danger for me is that it changes the relationships that we know work towards successful outcomes. It can change the relationship between the recovery worker and the individual who is sat in front of them when they have a tariff attached to their head. It can change the relationship between a commissioner and provider when payment is involved. An extra bureaucracy of course has its own costs and its own inherent dangers.

My final point is that there is also a danger in this model. Where we know a fully integrated service that includes residential provision is of benefit to service users, there is a fear that where the budget for residential provision sits with the PBR provider, there may not be good engagement, and there may not be good, comprehensive use of that provision. We now know that such provision can really help those who have the most complex needs, such as dual diagnosis, and those who have entrenched offender behaviour and who will really benefit from a residential part of the whole pathway of care. Our experience so far in West Kent is that we have had one referral from the new PBR provider, and we would expect far, far more than that. That is the same story, I understand, as other residential providers in the seven other national pilot areas.

In conclusion, I think that there is huge opportunity, with the new evidence and research that we have, around what works for recovery. There is an opportunity to transform lives—the lives of individuals, families and communities—but at the moment I am not at all convinced that a payment by results commissioning model is the way to go. I think there is a danger that we may hit a target but miss the point.

Keith Vaz: Thank you very much. Are there any questions to any of the panellists so far? May I just start with the Committee?

Q6 Nicola Blackwood: One of the major concerns that has been raised with the Committee over treatment options and payment by results is the gaps between different areas of treatment, and between prisons and the community. I wondered whether the payment by results system takes that into account. I do not know whether that is perhaps one for Nicola Singleton, who has been doing the research.

Keith Vaz: I am sorry, this is like a very large dining table in a stately home. This is Parliament, so you don't expect things to be perfect, and I apologise.

Nicola Singleton: One of the outcomes for payment by results is an offending outcome. In theory, the payment by results model could incorporate it. There are other payment by results in the offending area, and one of the additional complexities is how these all marry together. At the moment, what they have done is to have them in different geographical areas so they do not overlap, but there isn't a coherent model for making these things fit together.

Q7 Nicola Blackwood: So although it is recognised that there is a problem of people falling through the gaps at that point, there is, as far as we can see, no mechanism to try to improve that within the payment by results system.

Nicola Singleton: The Peterborough payment by results is looking at that period of leaving prison, so there are payment by results pilots, but there are lots of them. Some areas may be looking at payment by results for recovery, but they are all very different. Basically, they are focusing mainly on the community treatment, but people come in and out, so they will be picking up people coming out of prison and they are considering how they do that. That is not ignored, but it is part of the additional complexity.

Q8 Dr Huppert: One of the live issues that we have had a lot of comment on—I think it was an issue in Portugal as well—was about what the aim ought to

be. To what extent should the aim be complete abstinence, and to what extent should it be to move people down the road from acquiring drugs on the street towards either injection or methadone maintenance, and then towards abstinence? How realistic do you think it is to have a drive just towards abstinence? Will that result in people being parked as too hard to treat and hence not financially worth looking at, and being left on the streets with street drugs?

Nicola Singleton: To be fair, the outcomes included in the payment by results recovery include interim payments to try to recognise that for some people, it will be a long time before they achieve the abstinence outcome. The problem is, how do you know what weight to put on different ones? People move through at different times. If you give a high weight to the interim outcomes, you do not incentivise the long-term outcome that you are hoping to achieve. If you do it the other way round, the reverse applies. If there had been a single outcome that was just abstinence, it would probably have resulted in a lot of cherry-picking. The question, "What have you achieved by introducing the interim outcomes?" is something that, as a provider, you take a punt on and hope that, randomly, it will work out in your favour.

Angela Painter: In my experience, there definitely is not one size that fits all. We need to find some way of looking at individualised care, and we must find a way to recognise stepped change. We are offering people tools to ensure the sustaining of recovery, and we must have a way to measure that.

Q9 Bridget Phillipson: I have a question for Alex Stevens; sorry I can't see you from down here, Alex. I have a couple of questions arising from your presentation.

The Committee has focused a lot on different ways of regulating drugs or otherwise. What I found quite interesting was what you talked about regarding the correlation between drug use and welfare policy, and how that links to decriminalisation and the other different approaches. Decriminalisation would not in itself address the underlying reasons why people begin using drugs. Looking at the different approaches in Portugal and Sweden, could you explain a little more about the reasons for the reduction in amphetamine use in Sweden? You said that restrictive policies did not give rise to that reduction, but I wonder what the reasons might have been.

Could you also comment more on Portugal? I found that some of the evidence you presented was a little mixed, in terms of the positive outcomes; I had expected to see slightly more positive outcomes from the Portuguese approach. I felt that the evidence was perhaps a little mixed. Will you comment on that?

Dr Stevens: On the first issue, it is absolutely right to focus on the underlying reasons of why people get into drug use and—perhaps even more so—why people get into problems with their drug use when most people who take drugs do not get into problems. A lot of that is about what other sociologists would call social dislocation—the fact that people do not have pathways to a meaningful existence, where they can create lives that are prosperous, wealthy and satisfying for them without getting into a problematic pattern of drug use. So there would be a mechanism, for example, whereby welfare gives people an opportunity to create those lives, because it gives them a platform on which they can base themselves when they are looking to create those lives. Imprisonment does the opposite. Imprisoning people takes them away from those opportunities. It reinforces their exclusion and deepens their stigmatisation.

One graph that I could show here is this one, which shows that there is not only a correlation between more generous welfare and lower drug problems, but a correlation between more imprisonment and higher drug problems. So there is some suggestion from the criminological literature that welfare and imprisonment operate in opposite directions, in terms of reducing the drug problem and other social problems.

If we extend that analysis to Sweden, it becomes speculative, because unfortunately, people were not doing research in the 1950s and 1960s, when amphetamine use was reducing in Sweden. You can see Sweden as a country that emerged from an extremely traumatic time in the second world war, when there were very high rates of amphetamine availability, partly due to the presence of armed forces that were provided with amphetamines. It became, over the post-war period, a very successful liberal democracy with a very generous welfare state, which has been very successful at integrating the aspirations of all its citizens. One might be able to link that to the reduction in drug use, but that would be very speculative.

Regarding Portugal, this slide shows the conclusion from the most recent article that we published, in which we weighed the two competing stories against each other—the narrative of success and of disastrous failure. While there has been selective use of the evidence on both sides to create a clear and unambiguous position, we think that the evidence is more nuanced, but generally positive, in that a reduction in HIV and death is an extremely positive outcome from a policy. The policy does not appear to have increased the levels of drug use to the levels that its opponents said it would. It has achieved the Portuguese Government's aim, which was to bring people back from the margins of society into institutions where the state can support them into productive and meaningful lives. Our analysis is that the Portuguese story of decriminalisation, allied with welfare reform and expanded health care, is one of success.

Q10 Chair: Thank you, Professor Stevens. Can we now move on to our next panel—Professor McKeganey, Jan Palmer, Gary Monaghan and Mark Johnson? I want to start by opening this up to the audience. When you speak, it would be great if you could make your points as succinctly as possible and put questions to the panellists; that would be very helpful, as that is why they are sitting there. In order to get down everyone's evidence, we need to know who you are. We are very keen to hear something new, rather than something that is being repeated. Apart from the Moroccan delegation, who are French

speakers, is there anybody here who speaks fluent French?

Dr Stevens: Yes.

Chair: Apart from our panellists. Okay, that's fine. I was just checking. Let us see if there is anyone from the audience who would like to say something. If you could say who you are and make your points within 60 seconds, that would be terrific.

Q11 ***Dr Eliot Ross Albers:*** I am the executive director at the International Network of People who Use Drugs. My question is really about PBR. It seems that PBR, and the recovery agenda generally, is disparaging methadone and putting it in an extremely negative light. I have myself been maintained for the last seven years on morphine. I do not see how good maintenance fits into the PBR framework. I really worry that people are going to be discouraged and not allowed to remain on maintenance when it works successfully for so many. Many of us do not wish to be put through recovery or abstinence programmes. We are quite happy with maintenance. I am worried that it is really not going to be delivered and will be discouraged. That is my point. It is not really a question.

Chair: Very helpful. We will park that, note it, and someone from the panel will come back and talk to you about that in a second.

Q12 ***Mat Southwell:*** I am an ex-NHS general manager. I was one of the people involved in East London responding to HIV. I now work in international development, taking the lessons of the now neglected British model out to the global environment. I also sit on the board of the United Nations AIDS programme as a civil society representative. We have recently been hearing from the Global Commission on HIV and the Law, which has really highlighted that when you criminalise and increase stigma and discrimination against the key populations affected by HIV—sex workers, gay men, drug users, and transgender people—you see an absolute increase in human rights abuses, and also a devastating impact on the response to HIV and on treatment uptake.

One of the things that we are increasingly doing—Europe and South America are leaders in this area—is starting to question how we can justify a drug control policy that drives up human rights abuses, contradicts the founding principles of the United Nations, and conflicts with the very programmes being run by UNAIDS. We are really starting to struggle with this. In this country, we would be horrified at abuses conducted against gay men, against women, and against transgender people, but we seem to not take the same approach when thinking about sex workers and drug users. The challenge in society, as the Olympics highlighted really well, is that we cannot leave people behind. We have to have a policy that is inclusive and does not just work to dogma, as the recovery model does, but recognises that drug use is highly complex and requires a range of different interventions. My question to the panel is: how can we justify human rights abuses against people like me who choose to use drugs?

Chair: We will come back to answering—at least I won't, but the panel will—those questions very shortly. May I recognise Caroline Lucas, MP from Brighton, who hosted the Committee on a recent visit to Brighton?

Q13 ***Caroline Lucas:*** Thank you very much. Congratulations on an excellent session. I am not normally a fan of cost-benefit analysis, because there are lots of flaws in it, but I wanted to ask whether there has ever been a proper, rigorous, economic impact assessment or cost-benefit analysis of different approaches to treating drugs. If some of the other arguments might not be persuasive, I believe an economic argument would show that, were you to treat drug addiction as a health issue rather than a criminal one, not only would there be many of the benefits that have already been spoken about today, but it would, I suspect, also be an awful lot cheaper. At a time when budgets are under pressure around the world, not just in Britain, I wonder whether that might be a persuasive part of the armoury to try to persuade Governments to move a little more progressively on this.

Q14 ***Dr Deborah Judge:*** I am a child and adolescent psychiatrist working in Bristol with young people with problems with addiction. My question is partly for Mark Johnson and Dr Alex Stevens, and it is about their thoughts on these complex trajectories that children are growing up with in this country, which lead into the end-stage of addictions. A point was raised earlier about the Colombian policy. Including social policy, education and approaches to children at a much, much earlier stage in the process is important, because the young people that I see do not need locking up for their addiction problems. In the UK, we lock up more young people than any other European country. Where are the solutions? I certainly have my own ideas about those solutions, but I want to hear from Mark and Alex Stevens.

Chair: Thank you. Can we take one more, and then we will move on?

Sheila Bird: I am from the Medical Research Council's biostatistics unit. My question is about PBR and the fact that there is no single protocol. Each of the pilot sites has its own definition of outcomes and tariffs, and the Department of Health is accordingly unable to produce or publicise the protocol by which payment by results will be evaluated. Can the panel say how they suggest the evaluation might proceed, when, in England and Wales, we do not count the dead properly? We do not know about drugs-related deaths until the coroner's inquest is completed, and the waiting time for completion is at least six months. These pilot studies are short-term, and they will not know authoritatively which of their clients has even died.

Chair: Thank you very much.

Q15 ***Derek Williamson:*** I am from Cannabis Law Reform. At the beginning of this meeting you described the effect of drugs in somewhat dark tones, talking about the harm that drugs are causing to society. Are we not in danger of confusing the effects

of drugs and the effects of drug law policy and prohibition? Is it not in fact true that the vast majority of drug use is totally non-problematic?

Q16 ***Peter Reynolds:*** I am also from Cannabis Law Reform and I am also the prospective parliamentary candidate in the Corby by-election. The point that my colleague Derek has just made is crucial. Prohibition always causes more harm than it prevents. Much of the discussion here, with respect to General León and people in the drugs support industry, is predicated on the idea of prohibition and the idea that it is something we must clamp down on. This process of clamping down is causing more harm. It is deeply depressing to hear the talk about the drug trade moving into terrorism. The reason the drug trade is moving into terrorism is because of the money involved. When you clamp down on something, the price goes up. When the price goes up criminals get involved. If you clamp down on it harder, the criminals become more violent. You clamp down on it harder, the price goes up again. It is an endless circle of destruction.

Chair: I hope I don't have to read out the list of all the other candidates in Corby in order to give them a fair hearing. I think we will take a final contribution and then we will come to the audience afterwards.

Q17 ***Huseyin Djemil:*** I am a freelance consultant in the drug and alcohol field. I have worked across treatment with individual charities, individual people or whole treatment systems. I have also worked with law enforcement and helped police forces to work better in terms of their ability to reduce supply into their area. I am an ex-criminal and also an ex-drug user in recovery. I was formerly the London area drug co-ordinator for all the London prisons and I have been in the field since 1986. Currently, I am seeing a gap within the Committee. I have followed the Committee and helped several people with their evidence but I have not heard much talk of commissioning.

An MP talked about a choice between abstinence and harm reduction. All of this policy talk has to be translated on the ground. What I see is a real gap in terms of commissioners' skills and commissioners' knowledge and their ability to translate what they believe the national policy to be in their locality. As a result we are getting 31 different flavours of drug policy locally. As someone who works in that commissioning space, I am often called in, whether it is to drug action teams or to service providers seeking to meet contractual targets, to clean up the mess of that wrong interpretation. So some comment on where commissioning fits is needed because that is where we translate the good practice and the high ideals into reality for an individual whose behaviour we are seeking to influence.

Speakers: **Professor Neil Mckeganey**, Founding Director, Centre for Drugs Misuse Research, **Jan Palmer**, retired author and lecturer on substance misuse, **Gary Monaghan**, Governor, HMP Pentonville, and **Mark Johnson**, User Voice, author, Visiting Associate of University of Durham and Probation Trust Board Member.

Q18 Chair: That is very helpful. Let us move on now to the second panel: Professor McKeganey is the head of drug research at Glasgow University. I think I pronounced your name wrongly. I don't speak Scottish.

Professor McKeganey: It is close enough.

Q19 Chair: Thank you. You are very polite.

Jan Palmer is an independent clinical substance misuse adviser. Gary Monaghan is the governor of Pentonville prison and Mark Johnson is the founder of User Voice. I want to start with a question to the governor of Pentonville. The Committee visited two prisons, yours and Brixton. Shortly after we visited your prison there was a breakout. I hope it was not connected in any way to the visit of the Home Affairs Committee and that you caught the person who escaped. What surprised us—I don't know why we were surprised, but we were—was the large amount of drugs that had ended up in prisons. We thought prison was an opportunity to get people off drugs but people went into prison with no association with drugs and came out having become addicted while inside. This is a big failure of the system. Why do you think this happening?

Gary Monaghan: I will talk about my own establishment. It is 170 years old and so I will start off with the physical factors within prisons. When it was built it was surrounded by fields. Substance misuse was not such a big issue. In an urban environment it is now totally surrounded by buildings. It is very difficult to stop supply into the jail because associates of prisoners inside constantly try to throw packages of drugs into the establishment. We consistently have to battle with preventing substances from coming into the jail. There is also the fact that people secrete items about themselves when they come in from court. They will bring them in when they get arrested by the police. They hold them on themselves, which we cannot get to. They bring drugs in themselves.

When the prison was built, visitors did not have physical contact with prisoners. We now have domestic, social and family visits. It is part of our trying to maintain their human rights, and part of our rehabilitation strategy. Unfortunately, sometimes some of those visitors will also bring drugs into the establishment. Sometimes we have members of staff who will bring substances into the jail as well. It is a battle for us, because the economy in a prison means that drugs in prison are worth several times the value out on the street. The more successful we are in terms of reducing the supply into the establishment, the higher the price of drugs.

In the past—I think things have changed quite dramatically now—we had very limited substance misuse programmes. Pentonville has the biggest substance misuse programme in the country. As a

result of that, we are helping to stop and deter people from starting to abuse substances while in custody, so I think the trend is being rapidly reversed over time. I am not going to say it does not happen, but because we have developed such an extensive approach towards substance misuse in custody, I think that the likelihood of somebody coming in without a habit already is quite reduced. We have support and drug-free wings—

Q20 Chair: It really is very odd that the one place you do not expect to see drugs is in our prisons. If you are going to break the cycle, is that not the best place to do it?

Gary Monaghan: It depends on the individual concerned. For some individuals it is not as straightforward as saying, "Put them in prison. That is the best place for them and that will resolve their issues." We have a high level of dual diagnosis—for example, substance misuse and mental health problems—so it becomes more complex. Prison might not be the best place to help such individuals. We have other individuals who may be creating a lot of damage in the community because of substance misuse, and maybe the best place for them is prison. It is a difficult and complex area. How we will deal with an individual very much depends on the individual we see in front of us.

Q21 Dr Huppert: I am interested in trying to get a handle on evidence of what happens. Some research has been done looking at what happens to people when they are exiting prison. I think the research is a few years old now. I say that with some nervousness because I know that the person who did the research is in the audience. It showed a large number of deaths within two weeks of release of people who have taken heroin. Professor, I will not try to pronounce your name, given that Keith has already gone through that process. What should be done to reduce that surplus death load on exit? I think the figure at the time was that one in 200 people who have ever injected heroin die within two weeks of leaving prison.

Professor McKeganey: There is no question but that if we do not have the best treatment available within our prisons, we have no prospect of dealing with our drug problem. We will witness major problems for the individuals. As they leave prison they will experience heightened risk of death. We will see our prisons gradually overtaken by drug problems and we will not address the drug problem in the wider society. I think the figures on the elevated risk of mortality on leaving prison have led to a reassessment of the nature of the treatment that should be available within prisons. If we get that right—if we have treatment that is oriented towards recovery, which ensures that prisoners get high quality treatment—we will do our best to reduce that level of mortality.

But we should make no mistake here. At the point at which an individual leaves prison, if they resume the previous pattern of drug use, they face an elevated risk of death—unquestionably. That arises because of the highly risky nature of the activity that they engage in. We must commit to ensuring that treatment is available in prison and does the most we can to reduce that risk, but does not take responsibility on behalf of the individual, where they go on to resume that pattern of highly risky drug use after leaving prison. We have clearer guidance now on how to ensure that the treatments available in prison are the best that they can be. That is a major step forward. We should not assume that treatment delivered in prison is an easy option. It is an environment that needs to balance issues of security with treatment and recovery. Those things do not necessarily sit easily alongside each other, but that is the challenge that we face.

I also think we need to recognise that it is important that methadone is made available to prisoners, and that it is contributing to their recovery, but we should not be in any doubt that the drug problem within prison is not answerable by the provision of the single treatment methadone. We are now seeing the development of new legal high drugs, new psychoactive substances, which the Chair drew attention to. They in turn will pose a massive challenge to prisons as they start to appear in the prison environment. Our responsibility is to ensure that we have the best available treatment in prison. That is not what we have been doing up until now, but it is a commitment that is increasingly now recognised.

Q22 Dr Huppert: You draw together the treatment within prison. I did not hear anything about the link between inside and outside. I worry that there will be a silo of one set of processes in prison and then a complete disconnect to what happens outside, with people falling between that crack. It happens for released prisoners in a range of areas such as benefit payments and other things.

Professor McKeganey: I apologise in that regard. You are right that we have to get the relationship between prison, the wider community and the family to work to optimum effect. We have to ensure that where an individual leaves prison, having benefited from the treatment services available in prison, that the progress they have made is not diminished, diluted and dissolved on exit from prison. That requires a very close working relationship between treatment services within prison and outside. That is more achievable now, I think, where you have the same treatment services working within prison as working in the community. We also need to draw upon the family and the wider community to ensure that those influences that can encourage the resumption of patterns of drug use on exit from prison are themselves addressed. Treatment can only do so much, even when it is well integrated between prison and the community.

Q23 Bridget Phillipson: I have a couple of questions on treatment that might be best addressed by Jan Palmer or Mark Johnson. First, I would like your views on the role of residential rehab. My experience in the north-east is that residential rehab is hard to access. There has been a move towards home detoxing and treatment in the community. That, of course, has its place but often appears to be a short intervention that leads to not much afterwards. People will often return to the habits they had before because they have

not received the right level of support. I appreciate that residential rehab may not be entirely the answer, either.

Secondly, I would like to hear your views on methadone maintenance programmes. The debate appears to have become quite polarised between those who think abstinence-based policies are the only approach and those who feel the Government are going too far in the other direction. I accept that moving people from methadone is often appropriate, partly because my experience prior to becoming an MP is that sometimes people end up parked on methadone for long periods. That might be right for some people, but others do not seem to be given the option whether they want to remain on methadone. They are just left, sometimes for five, six or seven years and the treatment is not properly reviewed. It is a question of reviewing people receiving methadone, not just the application of the policy.

Mark Johnson: A quarter of the NTA's clients were on state-sponsored methadone for a four-year period. More than half were on it for two years, which is called "parking people", without the option of moving on. As for how that relates to prison, given that drugs are illegal in this country and a person's crimes were attributed to problematic drug use, why does that person go to prison and have access to more drugs? I have always found that fascinating.

In 2009, the NTA spent £4 million on auto-dispensing machines of methadone in prisons. In my column in *The Guardian*, I called it the "saddest queue that I have ever seen", when I described a group of 100 prisoners at the top of a landing shuffling to get to the dispensary. Where did the supply of methadone in prison come from? In 2006, a group of prisoners took the Government or the Prison Service—I am not sure which, because it is difficult to get information on the issue—to the Court of Human Rights about the right to treatment. It was said that their human rights were breached because they could not have access to the same treatment inside prison.

There have been no recorded deaths from opiate withdrawal. *[Interruption.]* That is my information that I have collected for more than 12 years. It is probably worth having an inquiry into it. In 2011, 596 deaths were related to heroin and morphine use, but 486 deaths were the result of methadone. Returning to the use of methadone in prisons and retoxification, Professor McKegancy talked about treatment. I would like that defined. What is "treatment"? I have met people who had been on an abstinence-based programme and had been retoxed before release, too. On release, some have not been connected to an outside GP, in which case there is an inevitable risk of their resuming their previous pattern of behaviour.

Jan Palmer: I should clarify my role. Until March this year, I was the national clinical policy lead for substance misuse at the Department of Health. I had been working on and developing services in women's prisons since 1997, when I led the development of what was then the first ever detox service, but which gradually became more robust clinical substance misuse treatment service for women. That eventually underpinned the development of the whole integrated drug treatment system in prisons.

I am not therefore really in a position to answer the question about rehab, because my whole experience has been working with prisons and the criminal justice system. However, I can comment on methadone maintenance in prisons, and I am able to dispel any rumour about the automated dispensing of methadone in prisons. I can also comment on re-induction, which is the formal name for what has just been referred to as "retox". I am not quite sure what I am required to say, but I am happy to deal with such points.

The word "recovery" is being interpreted as abstinence, and we are desperately trying to make sure that that interpretation is not automatic in prisons, because of the risks of post-release death. Methadone maintenance and re-induction are both protected factors in preventing post-release overdose. People who have engaged on an abstinence-based programme in prison might well find it impossible to maintain that position at the point of release. In the past, we have been criticised by coroners for forcing people into abstinence in prison when people have died subsequently. Re-induction, which is permitted by the national guidelines in this country, not just for prisons, allows us to enable people who really cannot maintain that abstinence at the time of release to restabilise on to a dose of methadone, usually, but it could be buprenorphine, to prevent their death upon release. We would also automatically try to ensure that those people are then linked up with treatment services at the time of release.

Ongoing treatment at the point of release from prison is a critical factor in ensuring that people not only engage with treatment, but, frankly, don't just die at the point of release. Prison can, as Gary mentioned, be an excellent opportunity for people to stabilise and engage in treatment and to look at their options to work towards abstinence. We never lose sight of that fact. Prison may not be the right place for some of them to do that. There are negative effects of being in prison, as you can imagine, that make it harder and it is not necessarily the right time. There should not be a rush to get people to give up prescribed treatment when they come into prison. They should be able to work towards that, the same as they would in the community and over several years if that is necessary. We need to ensure that treatment services in prisons work in a similar way to the community, without people having time placed on their treatment options.

Mark Johnson: I strongly disagree with what has just been said. Coming back to the residential drug treatment—on average a quarter of those on methadone are parked for four years or more and half for two years—one year's supply of methadone, without all of the outside services, would pay for four to five weeks of residential drug treatment. So if you take that average of four years, you've got a really good treatment package for somebody. I do believe it is an emergency. I don't believe that people should be parked on methadone. Whether it is a quick or a long, slow death through the green liquid, I think that we should make an absolute commitment to get people off if they want it. A large proportion of the people I met, who are parked in prison and on methadone in the community, want to come off.

Q24 Chair: That is very helpful. Now, everyone is being very nice to each other and we would like them not to be. The way you make policy is through friction, I understand. So could we first see people who have not spoken yet who would like either to put a question or to make a brief statement?

Darryl Bickler: I am from the Drug Equality Alliance**.** I am a solicitor with former experience in human rights and criminal law. I am actually quite surprised that we have not yet at any juncture throughout this entire inquiry looked at the law and the way it has been administered. We seem to have started off with an artificial divide that is accepted as normal. When Professor Stevens talks about a drug-free world, we know he does not really mean that. They don't mean that in Switzerland. They mean a certain type of drug-free world. We have this artificial divide so firmly implanted in our psyche that somehow the problem is about people with methadone and cannabis and is not about the vast majority of people who are suffering problems from drugs misuse, which is prescription drugs, as you mentioned in your introduction and the so-called legal drugs of alcohol and tobacco. We seem to be shying away from looking at probably 90% of the entire drug misuse problem. We are avoiding that quite conveniently because we are not picking up on what the Home Office has set up. The Home Office has set up an artificial divide, which is not provided for within the Misuse of Drugs Act. It has set up an artificial divide between people who are given a free pass. They are allowed to produce dangerous drugs and sell them, but they're okay because they are making supposedly legal drugs—although you won't find that in law. Then you find people who have no human rights whatsoever. They could be the most peaceful self-medicating people who are using a herb at home and yet they could go to prison for 14 years, because they are using so-called illegal drugs, which means that there is no division or differentiation being made between peaceful use and misuse of drugs that is giving rise to social problems. The Committee is supporting that position, and I am angry about it.

At the beginning of this introduction, you said that you are looking at illicit drugs—that is what you said, Mr Vaz. There is no such thing as illicit drugs. They do not exist. It is as simple as that. It is not that we understand what they are by "controlled drugs"—that is the legal term, and I would be obliged if you would use the correct legal terminology for this inquiry. I am not being technical; I am just being exact, because it is important. There is a huge difference between talking about illicit drugs, which do not exist, and controlled drugs, because it is people who are supposed to be controlled with respect to outcomes. Those are antisocial outcomes caused by drug misuse. Those people are supposed to be regulated rigorously, whereas people who cause no problems should not even be within the purview of these Acts, and yet they are. Question after question is asked about whether we should decriminalise some drugs and legalise some drugs, but we cannot do that. It is impossible.

Chair: That is very helpful indeed. I think Sarah has not spoken, but, before you speak, may I also welcome Diana Johnson, who is a shadow Minister in the Home Office? Have I missed any other MPs who have slipped in apart from Caroline and Diana? James Clappison, who was here briefly, but who has gone, is also a member of the Select Committee.

Q25 ***Sarah Graham:*** I am director of Sarah Graham Solutions and a member of the Advisory Council on the Misuse of Drugs, although I am speaking in an individual capacity. Thank you for today. It has been very interesting.

I am standing here today clean and sober of all mind-altering substances for 10 years, and I am able to be here, in recovery, because I was able privately to afford eight months of residential rehab. Rehab does work. I am absolutely appalled by what Jan was just saying because that thinking leads to, for example, my colleague here, Dr Deborah Judge, being asked to retox a 17-year-old going back into the community from a detention centre, because we do not have the adequate residential rehab facilities in this country. We do not have a single residential rehab facility in this country for our young people. Instead, we demonise our young people. We call them hoodie yobs. We don't diagnose them, and we don't treat them. The NTA is happy to put those young people into care homes—and we have recently heard in the media what those care homes are actually like: young people are sent away far from their communities, given no actual support, and abused by paedophiles—and also into the criminal justice system. We happily spend in excess of £4,000 a week putting a young person in a criminal justice system environment, but we don't adequately treat them. Dr Judge has a fantastic model for treating those young people. There are many people in this country who think that we should have residential rehab, and I am one of them.

If you are interested in this subject, please google "Teen Rehab? Yes, Yes, Yes!" and you will see a short film about this subject. We have to change this policy. It is outrageous. If we invest in treating our young people, we can arrest this illness and we can save our society so much money in terms of welfare, criminal justice, health care costs, and the costs to the individuals and their families.

Q26 ***April Wareham:*** I am from the National Users' Network. We are made up primarily of current drug users, people who define themselves as being ex-drug users, and people who are using prescription drugs only, whether that be methadone or other forms of opioid substitution therapy.

When I speak to my members, I hear people talk about the fight that they had to get adequate doses of maintenance. I hear people talk about the relief it was when they got the medication that they felt enabled them to live their lives. It has enabled my members to attend university, to bring up children, to hold down jobs and to be productive, useful, happy members of society. I know that long-term opioid substitution therapy is not for everyone, and I will never say to somebody, "You have to have it if you want to give up." For the majority of my members, however, it has been a life saver and a lifeline.

Chair: Very helpful, thank you. Gosh, there is a forest of hands. I assume nobody has spoken before who is putting up their hands. We will come back. We will

have Baroness Meacher, a fellow parliamentarian, next, and then we will go to the back row.

Q27 ***Molly Meacher:*** I am the chair of the all-party parliamentary group on drug policy reform, and I thought I should just ask the Select Committee if they will try to take account of the new so-called legal highs. We have just done an inquiry into those, and we have been very struck by the evidence we have had from the regulatory authorities, ACPO and all sorts of other major organisations responsible for these and other related issues. They have said that the current legal framework simply cannot and will not be able to deal with these new psychoactive substances. It is absolutely essential, it seems to me, that the Committee raise that point and make it very clear, really seeking a completely new approach to dealing with drugs. We cannot go on the way we have gone on now for 50 years. The solutions are complex, but they have to be very different from what we have got.

Q28 ***Steve Brinksman:*** I am a GP in Birmingham and I am the clinical director of Substance Misuse Management in General Practice, which is a charity organisation designed to help our members be aware of the best evidence around all substance misuse, legal and illegal, prescription, alcohol—everything. I come to lots of these events and I wonder why everybody insists on painting themselves into ideological corners through polemic. It is about helping the people here who have the issues. This is not a case of, "It's abstinence or it's methadone." There is a spectrum. You take people in dire need, you work with them as an individual and you help them find the solution that is for them. I abhor the idea of anybody who has been left on methadone who wants to move on from that, but equally I abhor the idea of anybody who is forced to move on from that when they feel they have got their life in a reasonable sense of order. That involves ongoing review with people, but it is a spectrum.

Professor McKegany was recently part of the Medications in Recovery project, which produces a good report showing how we can use some of the tools that we have available to help move people on. Mr Vaz, you talked about not having consensus, but consensus is what we need in this area. If we can stop going on about our own little bit of the world and work together, we can produce something for the person who matters—the patient, the user, the client or whatever you want to call them.

Chair: Very helpful. Don't worry if you are not called, because we are having break-outs where you can speak for slightly longer than you can in the plenary session. I just want a word from the panel before we conclude, and our colleagues from Morocco are going to say a couple of words at the end. Could we have the gentleman who just stood up? When you have finished, please hand the microphone to the gentleman who has got his hand up immediately behind you.

Q29 ***David Hannay:*** I am a retired general practitioner who worked for 16 years in the centre of Glasgow, two years in rural practice, 10 years in Sheffield and then back into rural practice. During the 10 years in a rural practice, heroin addiction became rife; it was not there before. Last year, there were twice as many drug-related deaths in that rural area as there were the year before. The local prison has well over half its inmates there for drug-related offences. Prison is not the right place to put people who are on drugs, because the idea that they will get adequate treatment there is, in many places, a bad joke. We must stop criminalising possession. One very brief analogy: people on heroin are highly addicted and they require the drug—they need it. It is a bit like diabetes. You would not prosecute people for having insulin in their possession, but you would quite rightly prosecute people who tried to sell insulin outside the NHS.

Chair: You chose the right illness, because I am a diabetic myself. Did you know that before you said that? You didn't. Very good.

Sanj Chowdhary: I am from Normal. I am a drug user. I do not feel that I should be persecuted for my drug use. I do not harm anyone else in society. My question is quite simple: is all use misuse? If not, why should I be persecuted for my choice of substance over someone who drinks alcohol?

Q30 Chair: Since you have raised it—I am very interested in this—what drug do you use and why do you use it?

Sanj Chowdhary: I am currently a cannabis user. I use it for medicinal and recreational purposes. I have used all sorts of other substances in the past—cocaine, heroine, speed, MDMA; all sorts, really.

With the drugs on the black market, once the gateway has been opened with cannabis—it does not lead to harder drugs, but it opens a doorway into an illicit black market—you are offered all sorts. To be honest, I thought that the benefits I got from the illicit substances, in terms of enjoyment and the reduced negative effects—I did not get a hangover, as I would from alcohol—were better.

Chair: Thank you. Very helpful. If the gentleman at the back can be equally brief? I want to go to the panel, and then I want to take a quick word from the Moroccans.

Q31 ***Greg de Heodt:*** I am Greg from the United Kingdom cannabis social clubs. We are part of a European movement that wants to implement a bit more regulation and control over the cannabis market, rather than leaving it to the unscrupulous gangs that are currently growing and selling it at ridiculous prices, with it being contaminated with all sorts of problems, to anyone without any ID. Currently you can be 12 years old, have a £20 note, give it to a dealer, and they will give you a bag of weed, or anything, really. We want to stop that kind of market. We want to have a safer market for people who already consume cannabis, so that they can get it in a regulated way and know what potency it is and the strengths that are best for them. If they are a medicinal user, that would be much better than getting it from the black market, where it is contaminated and could cause more health problems. I wonder why the Government are currently spending £500 million to

police people who are consuming and growing cannabis.

Q32 Chair: Very helpful, thank you. I am going to stop the audience for the moment. Are there any burning issues that any of you want to pick up, very briefly? We are on time again, which I am pleased about. Is there anything that you want to pick up on? If not, that is not a problem. Is there anything that has come up in what you have heard that you want to respond to?

Jan Palmer: My two GP colleagues, perhaps not surprisingly, and I would like again to endorse the fact that we would not, in a prison environment, support just parking anyone on methadone, but nor would we wish to rush people towards abstinence. The diabetic analogy also demonstrates that. I think that is a middle-of-the-road, sensible approach to treating drug users who have other complex needs, because they are offenders as well. That is exactly the way we see it within prisons.

Mark Johnson: My burning issue is about metrics. We do not have a robust enough set of metrics to measure effective outcomes for people. I refer you to the current situation over residential rehabilitation and how the figures have shown that to be unsuccessful in getting people into long-term recovery. It is about the metrics failure rather than the treatment failure. It is measured on a three-month cycle of treatment, but three months is the highest rate of recidivism for an offender, and it is the highest rate of relapse for a drug addict. What it does not measure, however, is that it takes two or three attempts at getting into the recovery journey for it to be effective. It also does not measure the impact of a successfully rehabilitated offender or drug addict in his community and that is where metrics really need to go. It is about the effect on peer groups and the different environments that that person comes from.

Q33 Alun Michael: The three GPs have referred to the importance of review and movement and reflecting the wishes of the individual patient, and that is fine, but how do you ensure that you get that professionalism of review? It is not always present in the health service and that is not just related to harmful drugs.

Chair: Did you want an answer?

Alun Michael: Yes.

Chair: From whom do you want the answer?

Alun Michael: The GPs are recommending good practice, but how do you guarantee good practice when you are offering it as an alternative to other policies?

Chair: I have forgotten which of the GPs have spoken.

Dr Brinksman: I agree that there are issues in any area of medicine with variability. One of the things that we have got coming in is revalidation, which is looking at people's ongoing training. A big issue is that working with substance misuse and even alcohol-using patients is not a part of the core GP contract. Actually, that and putting it in there and using things like QOF to support that is the right way to drive the standards up. Setting minimum standards and getting people to adhere to them is what we need to do. At the moment, there is no pressure on many of my colleagues to do that.

Q34 Chair: Finally, we are going to have a short speech from the Moroccan delegation that is here. It will be translated for us by the Moroccan embassy. Could you please welcome Mr Mekki el-Hankouri, a member of the House of Representatives at the Moroccan Parliament?

Speaker: **Mr Mekki el-Hankouri**, Member of the House of Representatives, Morocco.

Mr el-Hankouri:*(Translation)* Thank you, Mr Chairman. Ladies and gentlemen, members of the audience, first and foremost I thank the organisers and the British authorities for this important event and their warm welcome today, for which six members of the Moroccan Parliament and authorities are present.

Morocco is aware of the inherent dangers of cannabis production and its long-term negative effects on those who use it, and has adopted a comprehensive approach in the struggle against it. Significant progress has been made by the Moroccan authorities and there have been huge advances in the fight against this scourge. The main results have been confirmed and corroborated by both national and international statistics. Among the main results has been the eradication of more than 10,000 hectares of cannabis in the past two years. The cultivated area of cannabis has been reduced by more than 65%, having gone down from 134,000 hectares in 2003 to 47,500 hectares in 2011. These figures are not only the Moroccan figures; they have been corroborated by UN sources—the OECS and the ONDC.

Given its geographic position, Morocco constitutes a barrier to drug-trafficking routes. For this purpose, the Moroccan authorities have put in place a strategy against trafficking networks by reinforcing border crossings, whether they are maritime, land or air borders. This has led to significant results. In 2011, the Moroccan security services seized 119 tonnes of cannabis, and in the first five months of this year 42 tonnes of cannabis.

Morocco would also like to point out that, in the past few years, we have been confronted with cocaine drug-trafficking organisations, coming either from certain west African countries and transiting through Morocco, or from Latin America and destined for Europe but also returning to Morocco. This seriously complicates the work of the Government.

In parallel with this security strategy, Morocco has put in place a strategy to deal with drug users—"toxicomanes", as they are called. It is a social strategy, and different centres have been opened to treat those who are recovering. There is co-operation in attempts at drug eradication among countries that,

like Morocco, are constantly fighting against the illicit use of all drugs. The co-operation that we have undertaken with different countries has led to different attempts, not only regional but also international, and to improving the capacity of services in this field, especially Moroccan services.

Finally, Morocco places particular importance on international co-operation, above all with neighbouring countries—Spain first and foremost, and the rest of Europe—to fight on all fronts. To that purpose we have, for example, signed many agreements on extradition with countries, but our co-operation with Latin America has become very important. We have also co-operated with countries that have decriminalised drugs, namely cannabis or hashish. Morocco is interested in putting forward an alternative scheme. Morocco has made many efforts and strides. We have had different policies, including large projects such as the national initiative for human development, which addresses issues such as crime and drug use.

Thank you very much for your help and time. We are counting on your help.

Q35 Chair: Thank you very much. That was very interesting. May we ask where the drugs come from—the cocaine that enters the country? How does it get to Morocco? We are interested in following it from Colombia.

Mr Abderrahim Habib: *(Translation)* First, thank you for that presentation. Analysts say that the cocaine comes from West Africa, and goes to Europe via Morocco. Last year and this year, another trend has been noted: cocaine from certain Latin American countries—

Q36 Chair: Is that Guinea-Bissau or Nigeria? You talked about West Africa.

Mr Abderrahim Habib: *(Translation)* In West Africa, the drugs come from Guinea-Bissau, Mali, and also commercial flights. Commercial flights are seen as a major problem as well.

Chair: Thank you all for participating in that first session. It was interesting to hear from the Moroccan delegation on what they are doing. We will now break up into workshops.

On resuming—

Q37 Dr Huppert: Thank you all very much. I hope you found the breakout sessions useful, and I hope we will now have a chance to hear summaries of those sessions. The group I chaired had a very interesting discussion, and it was hard to come to simple conclusions. I am looking forward to hearing the conclusions that have been drawn out. Can we start with a report from the group on whether drugs policy needs to be global, chaired by Nicola Blackwood? There will be a full transcript of what the rapporteurs report back to us, and this will be very helpful in our evidence. Notes were taken of everything said, but they won't necessarily be verbatim. Molly, could you briefly summarise what was said in your group?

Baroness Meacher: Yes, this is always the most difficult job, because people say about a thousand things and one is allowed to say about five. The key issue for us was that, of course, we need a global drug policy, but we know that global drug policy depends on the UN conventions. In our view, it will take many decades to change those conventions, and we cannot wait.

Secondly, if you are going to achieve good policy, countries have to have the freedom to try new and different policies. I do not think anyone feels that the world has the answer. We need individual countries to have policies suited to their own specifics, and we need to evaluate them. We need evaluation, evaluation, evaluation, and then we might achieve the right answers.

People wanted me to talk about the inequalities between nations. Many African countries are becoming more and more involved in this, with a huge amount of corruption threatening the integrity of the state. We in the west need to support countries that are struggling to deal with this incredibly difficult problem.

We cannot control the supply of drugs across the world. That is impossible. Perhaps we can control 1% of the supply, or 20%. Different percentages are controlled in different parts of the world, but we will never control supply effectively. We have to control demand. That means looking at education and demand-focused policies, but not through criminalising young people because, again, you have the balloon effect: if you try to criminalise people for using cocaine, they will use some new psychoactive substance that is more dangerous and more unknown. Those are some of the points that were raised, but I am certain that they are not all of them. We need new regulatory systems for controlling drugs. You cannot just have freedom of supply. Obviously, drugs need regulatory controls of one sort or another. We need to accept that there will always be considerable drug use across communities across the world. We cannot eliminate drugs.

Q38 Dr Huppert: Thank you very much. That was said in admirable time; you are clearly a practised parliamentarian.

We now move on to the second group: how do we determine the most effective methods of treating addicts? That group was chaired by Mark Reckless. You have about five minutes.

Mark Reckless: Thank you, Julian. I am extremely grateful to everyone who attended our group on treatment. I am not sure I am in a position to present conclusions from that group, let alone ones that everyone would agree with, but I shall try to identify some themes that emerged from our discussion.

First, we addressed these questions: what is the aim of treatment? What is recovery? Participants emphasised that that would depend on the patient. A successful result could take a great variety of forms, depending on the aims, objectives, personality and history of the particular patient. One participant stated that if we are talking about a health outcome, the objective has to be a happy, fulfilled life. The view of most in the group was that for at least some people, including those speaking for themselves, that might involve continued maintenance or use of some description. I was told that that might be opiate substitute therapy;

it is not always methadone maintenance, and that was an important distinction to make. Describing people as being "parked" on methadone might be pejorative, although I think some people would emphasise that it is very important for the individual to have the choice of coming off drugs entirely, if that is their objective. As part of that, reintegrating people into society, whether through education, employment or social life, was also an important objective, and individuals who continue treatment or maintenance of some description could well fall into that category.

We also discussed the importance of residential rehabilitation. I understand that 10% of spending was on that, but 2% of users come off in that area, so it is clearly a more expensive and resource-intensive treatment. There was perhaps an association between residential rehabilitation and a focus on abstinence, which may or may not have come from the providers running the residential treatment centres, a number of whom I know came from a religious heritage. It was said that there was often a life-cycle, whereby a drug user would have treatment in the community, but would then come into residential treatment and potentially go back to community treatment. Therefore, it was not necessarily helpful to posit a binary distinction between residential and community treatment.

There was, however, a degree of agreement that residential treatment was important and should be there. In particular, if someone was not coming off drugs through community treatment and wished to have that residential opportunity, it was important to provide that. A number of participants were almost angry that there was no option for residential treatment for teenagers and adolescents—many of whom come from chaotic backgrounds and families—who were developing addictive behaviours, often with social issues as well as health issues. At least providing the option of residential treatment for some people in that category was something important that we should aim for to save the next generation.

Finally, we discussed payment by results. A wide spread of people in the room were concerned that payment by results would be very bureaucratic, from what we were seeing in some pilots, and that it would not promote the results that the Government were looking for. Although there may be some tension between the Government's stated aim of abstinence and the views of some in the room, the payment by results model could not be expected to achieve the Government's goal because of the way in which it was being implemented. Some hoped that there might be different local approaches, and people in each locality may know best about the circumstances there. None the less, there would be great complexity, in terms of the commissioning decisions and how that would link into the payment by results agenda and tie back or otherwise to the Government's objective for their drug policy.

That is my attempt to bring forward a few themes that emerged from our discussion. Once again, I would very much like to thank everyone who participated.

Q39 Dr Huppert: Thank you very much, Mark. The next workshop was on the physical and ethical harms of drugs, and how we reduce demand. It was chaired by Alun Michael MP, who will summate it.

Alun Michael: I shall try to keep the focus on reducing demand, because it would be very easy for us to go over all the ground covered in each group and go nowhere. I have to say a great word of thanks to the members of the group; it was far more productive and informative than I had dared hope.

First, things came out about the need for reduction and prevention to be holistic and linked to the nature of the community and community development. It was said that starting with localised data and empowering communities to choose their priorities is the way to begin addressing the environment in which drug-taking can be a problem. It was suggested that programmes such as Communities That Care, in the US, and those run by Rowntree here have shown good results in public health terms.

Secondly, we should look at the comparison between the way we seek to reduce demand in relation to drugs and the way we seek to reduce demand in terms of tobacco and alcohol. You do not have to regard the legal status as being the same in order to look at the methodology of the approach. That is about education, media models—you don't see people with a fag in their mouth on our television screens nowadays, not even the hard-bitten detectives—advertising, and so on.

Thirdly, with regard to perceived harm, it was suggested that we needed to be very careful coming in from the outside, particularly to groups and environments in which drug taking is accepted or part of the norm. We need to be inside, offering data and so on and understanding the environment in which things are happening—in other words, looking at the environment in which drugs are used. It was suggested that we are not doing enough in terms of the club environment. We need to be there in order to influence what is happening. How effective are we in the night-time environment?

A director of a rehabilitation centre gave us evidence of having asked people how and when they started, and having found that the starting point was very often bad self-image, came a lot earlier—at the age of 12 or 13—than is often expected, and had very direct links to poor education and local problems of all sorts, rather than drug taking being the only problem in the environment or peer group. The peer group was mentioned several times. There was talk of the use of mentoring and working with youngsters to understand the impact on them of their choices.

It was suggested that we do not sufficiently ask this question: why did you stop? The point was made that the British crime survey demonstrated a reduction in use, and therefore that is a reduction in demand. Cannabis use halved in the 16-to-24 age group, and there was a drop in heroin use. The point was made very strongly that we do not know why, because that question is not asked, and the research is not undertaken. We might be able to be informative if we understood why the trends are developing.

It was suggested that we often underestimate our young people. They want to know how things work. They respond better to being treated intelligently, being given information and being engaged with. Too

often, however, schools are in denial. They may have a drugs policy, but they may also have drug taking and be in denial about that. The headline message there was: don't patronise young people.

Finally, the point was made that the Home Office leads on drug policy, and the priority statement, which is comparatively recent, did not refer to education or prevention. Incidentally, there is a move in the same direction with the Home Office lead on alcohol. We are talking about a narrower approach that does not include public health and with educational and community-based understanding of the environment being lower down the order of priorities. It was also said that we are not very good at cross-Department working in the UK. As a former Minister, I can tell you that is bloody true. The suggestion was that we should learn a bit from France.

It was a fascinating discussion, raising quite a lot of practical issues about how we put drug policy in the context of wider social policy, rather than seeing it as a separate strand. I was pleased by the extent to which references to the peer group came in, because as a former youth worker, I have always felt that we grossly underestimate the impact of the peer group. It is very often far more influential than the parents on the decisions that young people make.

Q40 Dr Huppert: Thank you, Alun. The question considered by the last of our groups to report back was: what are the alternatives to prohibition? It was chaired by me, I should admit, but I wasn't brave enough to try to present all the findings to you. Where is our rapporteur? You have about five minutes.

Dr Sue Pryce: Inevitably, with the title we had—what are the alternatives to prohibition?—our group attracted people who were already fairly convinced that prohibition was not the way we should continue, so we were already sold on the idea of some form of regulation and control, but the question was how that would come about. What are the alternatives to prohibition? Well, it was suggested by the group that there is a spectrum of alternatives, from regulation and control of some drugs to regulation and control, or legalisation and control, of all drugs. Obviously the level of support varied in those groups.

There was inevitably also a focus on cannabis. Many people felt that cannabis could be safely legalised and controlled, and they tended to shy away from our major problem drugs—perhaps not cannabis but heroin—and the impact of heroin and class-A drugs on families and users generally, and on society, in terms of crime and other issues.

All the alternatives seemed to have cost benefits. Decriminalisation step by step was favoured by some people, who felt that decriminalising different drugs at different times and evaluating the evidence that emerged would enable a better picture to be developed, because one of the key problems with the idea of going straight from prohibition to legalisation is how we would know what would happen. It is the unknown, and the question of whether there would be more users. Although some of the claimed evidence suggests that perhaps nothing, or very little, would change, that did not seem realistic to many people in our group. It seems likely that there would be an increase in use. Certainly, after prohibition of alcohol was removed in America, the immediate result was an increase in use, but it did eventually level out. There would be a period when a certain amount of increase in use would be inevitable.

Obviously a lot of the focus was on the benefits of some alternative to prohibition, such as more positive policing—the police would be able to divert their resources from the huge, costly drug-war prohibition enforcement to improving community relations. Money would also, of course, be diverted towards better treatment for problem drug users.

There were questions about whether drug legalisation would reduce crime. Part of our group felt it would reduce crime, but other people felt that that would not happen—that just as there are illegal imports of alcohol and tobacco, so there would still be an illegal trade in drugs.

I think I have more or less covered everything, except to say that most of the arguments did focus on cannabis. Our chair did a sort of straw poll at the end, and most people were in favour of change, but a lot of that change did focus more on cannabis than all drugs. I think that is about right. I think I have more or less summarised what our group said.

Q41 Dr Huppert: Thank you very much. It is a tough job to summarise most of these discussions. Part of the problem is that no two people in a room will remember a discussion in exactly the same way. Thank you to all the rapporteurs for reporting back. I hope it was helpful. If you feel there are things that should have been said that you did not have a chance to say, we will still take short comments—factual information, ideally, rather than opinions. I think we have a good sense of opinions, but if there are urgent facts that need to come in, they can still be sent in by e-mail quickly, in the next week or so.

Before I hand back to the Chair of the Committee to introduce our final session, I want to try something. A recent poll suggested that 75% of Members of Parliament thought that the drug policy was not working. Two questions have helpfully been drafted for me. This is a straw poll. It is not in any sense going to be indicative of public opinion or anything like that, because you are not a randomly selected group of people. These questions are massively over-simplified. Roughly how many of you would support something like the current policy? How many of you would support something like a decriminalised system? And how many would support something like a legalised and regulated system? Those are the three options, and you can vote for only one of them, though I know they are crude.

How many people would keep things roughly as they are? Is somebody counting? Roughly how many would go for some sort of decriminalisation? How many would go for some sort of legalised and regulated system? I realise these are not perfectly defined, and it would be a lot of work to write a law based on those words. I have one last question. How many of you think that we can have a drugs policy that is acceptable to everybody? Hands up if you think it is possible. We have a few people. Thank you very much.

Mr Mekki el-Hankouri

Q42 Chair: Thank you very much, Julian. I assure you that we are not going to write the report on the basis of that show of hands. I thank Julian Huppert in particular for chairing the session and for encouraging the Committee, along with Nicola Blackwood, to pursue the inquiry. Sometimes people say that Select Committee inquiries do not last long because of the current issues before the public. This inquiry has lasted a year, so it has taken a long time. It is going to take us a few sessions to agree on our report. As I said, we will have it ready in December.

Our final speaker is the Portuguese Health Minister, a former adviser to the President of Portugal. He was appointed by the Prime Minister to be the Health Minister in Portugal. Members of the Committee were able to go and see for themselves what was happening in Portugal, and we found it very interesting indeed. He speaks English better than I do, so there is no simultaneous translation. Please welcome the Minister for Health in Portugal.

Speaker: **Dr Leal Da Costa,** Portuguese Health Minister.

Dr Leal da Costa: Good afternoon. I am afraid you will be disappointed—the Chair's English is definitely much better than mine.

I have only 15 minutes. It is going to be difficult to talk about what we have been doing in terms of drugs control and policies in Portugal in 15 minutes, but I will do my best. For those of you who do not know Portugal, it is a small country of about 10.5 million people. It is the most western country of continental Europe and we have a lot of seaside—so any of you wanting to go to Portugal, please enjoy the beaches. That also creates a drug trafficking problem. We have close relations with south America, mainly Brazil and other countries, and obviously some African countries, so we are exposed to drug trafficking, and we know that.

The problems with drug use in Portugal started in the 1970s when we became a democracy. We had lots of people coming from Africa who had contact with drugs in some way—mainly the military who were coming back from the war. At one stage, we had a huge problem in Portugal with heroin and cannabis addiction. We then became aware, from several surveys, that the many problems with drug addiction were a major concern for the public as a whole. From a medical point of view, it was also becoming a problem because of the rise of the AIDS epidemic. We knew we had to do something very drastic to deal with the problem. We had policies in place that were similar to what other people did then, which was criminalisation of drug consumption and putting consumers in jail.

If we accept that for most of those people drug addiction was a disease—I am a medical doctor—we considered that it would not be proper to solve the problem by imprisoning all those diseased people. So we made this move, and we decided in 2000 under law 30/2000 to decriminalise the use of certain drugs that were then considered illegal. That does not mean that we have legalised all drugs according to international standards. As a matter of fact, we have just illegalised one more—methadone—which is becoming a problem for us, and I will talk about that later. In Portugal, we are now having a problem with ketamine, as I suspect are other countries in Europe.

There was huge confusion in society as we moved to decriminalisation. People thought we were legalising harmful drugs. I believe that illegal drugs are harmful. Make no mistake: they are harmful. The problem of whether to legalise them or not is a completely different story. Even if we consider them to be legal, we are not telling people that they are not harmful. Tobacco is harmful; tobacco is a major killer in Portugal, yet it is still legal.

When we looked into those problems, we decided to create a huge structure, the Institute for Drug Treatment—IDT. We had a strategy whereby imprisonment was no longer an option for people who had a certain amount of drugs, which was considered to be a 10-day allowance. That allowance varies. For example, it may go up to 25 grams of cannabis down to 1 gram of heroin, 1 gram of methadone, 2 grams of morphine, or 10 grams of opium. It varies a lot, depending on the drug.

Then you have to ask what you do to the people who are caught with that amount of a drug, because it is illegal. They are brought before a commission that decides what sort of penalty they will get, and it varies a lot—from community service to compulsory treatment. There is one good thing about that. We have a problem with youths taking drugs, like everywhere else, so it is a way for parents to know what their children are up to, and it has been shown to be very effective.

Our policy is to achieve dissuasion, which is important as part of our prevention programme, and a big component of treatment in harm reduction. Through decriminalisation we have achieved one of our major goals: harm reduction. We have people coming forward and looking for treatment, which they would not do otherwise. We now have a community of well-identified heroin users who are in substitution programmes if they want that. Some were put into rehab programmes, and quite a lot of them have come off heroin. Through those programmes, some people have been able to find jobs and get on with their lives. In the old days, when they would have been pursued as criminals, that would not have been possible.

We obviously realise that from our point of view decriminalisation is a way of trying to prevent further harm, and of getting the message through. We are absolutely convinced that the biggest problem with drug use, at least in our country, is misinformation about its harm. That is very clear when we deal with the younger population, among whom we also have a big problem with alcohol consumption. I believe that we must tackle both at the same time. It is not just a question of looking at cannabis users among our youth population nowadays; it is probably even more problematic if we look into the use and abuse of

alcohol among youngsters. It is actually a new fashion, I would say, in Portugal; being a wine producer, we had not seen it before, but now we are witnessing a change of behaviour among our youth.

It would take me quite a long time to go through all we have done under this policy, so I am just going to give you some examples of sanctions, like periodic presentation to drug addiction dissuasion commissions, sometimes warnings, community service, forbidding attendance at certain places, apprehension of objects, interdiction on travel, interdiction on receiving subsidies or other military and social grants and, in some cases, even fees. Obviously, if people are caught with higher quantities, they are actually taken to court and prosecuted by law.

Let us talk about some of our results. You heard Dr Stevens presenting them, and they were absolutely correct. I am with him; I am not saying that it was an enormous success. We are humble enough to admit that we have attained most of our objectives but that the most important part is yet to be done, which is to prevent people from starting to use drugs. So the important questions that should be addressed are why do people take drugs, why do people get drunk, why do people need these sorts of substances for recreation? Basically, that is what matters. What are the social conditions? What is the context that people live in? Are schools interesting enough for the students? Are students' hopes for the future reasonable enough to have courage in their decisions? These are the important questions, and we are addressing them too. To give you an interesting number, we realised recently that 30% of our university student population is taking some form of psychoactive prescription drug. This is a matter to think about; we should all think about it, because it tells us something about society nowadays. People probably need to take anti-anxiety or anxiolytic medicines for the same reason as they drink or have cannabis. The problem should be addressed as a whole.

We believe that with decriminalisation we have created opportunities for treatment, but prevention is complex and we must do something new about it. Just to give you some numbers, in Portugal lifetime consumption of cannabis is still, on average, lower than in the rest of Europe, although it has been rising a little. Our lifetime consumption of all other drugs including cocaine, ecstasy, amphetamines and opioids is much lower than the European average, despite decriminalisation. We had a sharp decrease in HIV-related deaths for drug users; unfortunately, we have not been as fortunate with sexual transmission, so we have seen a tremendous rise in the heterosexual population and also, lately, in the gay community. In Government now we are obviously very worried about it and will do our best to avoid it.

We have problems, as you also mentioned, with drug consumption in prisons. We are doing our best to tackle the problem. We decided not to ignore it; we accept that it exists and that we must do something to prevent it, including getting better treatment for inmates. I have to be honest, however; I believe that another measure we have taken that would not be possible had the use of heroin not been decriminalised is a big—very expensive, by the way—programme of needle exchange for drug users. This is one of the most effective ways we have found to reduce HIV infection in Portugal. It has been working and is worth every penny it costs.

I could speak about decriminalisation for a long time, and I hope you believe that what I have told you is absolutely true. We have not seen a rise in drug consumption in Portugal. We have not seen any cause for social alarm. People are not killing each other because of drugs; not as much as because of jealousy, which is actually the main cause of murder in Portugal—passionate killing, not drug homicide. So beware if you fall in love in Portugal and think about betrayal; it is better to have cannabis—or safer, I should say.

Nevertheless, I must end my talk by re-emphasising one of the biggest problems we now have. I am just going to take one minute more, because I am in the UK and I cannot afford to lose this opportunity. According to reports, the UK is the largest source of internet legal highs in Europe, and probably the world. We must address that with courage. In the past year, our authorities seized €431,446.70 of material from smart shops, including fertilisers, detergents and a few other things that people ingest or inhale.

Being a doctor, while emphasising that drugs are harmful, that I am not keen on having them and there are lots of studies to be done, I believe that I am today actually more afraid of the so-called legal highs of which I know nothing. It is better to deal with the problem we know, with substances we have known for years, and which in some cases we have been using medically, than be faced with the scourge that is the use of toxic substances used as substitutes for drugs. That is something we must all face, and, again, it needs a very important, co-ordinated effort all over Europe. Thank you very much.

Q43 Chair: Thank you very much. I know that you have your own Select Committee to appear before.

Dr Leal da Costa: Yes.

Chair: But that is the Health Committee, and there are a couple of questions from Home Affairs Committee members. Alun Michael wants to ask you a question.

Q44 Alun Michael: Thank you very much for an excellent talk. It was very informative. At the end, you threw us a challenge. May I reciprocate by asking, what co-ordinated action? What steps are needed? Your challenge to the UK is entirely reasonable. Would you like to go a stage further and give us the solution?

Dr Leal da Costa: Thank you very much; I knew something like this would come up. I believe that this is not just a question for the UK and Portugal. It is a European question. I am just going to tell you about the experience we had recently in Madeira, which is an autonomous part of Portugal. They decided to pass a law that would prohibit smart shops, and it was deemed unconstitutional in Portugal.

This is a huge problem, because the major problem is defining the object. The greatest challenge, and for this I do not have a quick answer, is defining the

object we are chasing. What people do, at least in my country, is say that they do not sell the substances for human consumption, so when we go into a shop—we have two authorities that do that with the police—and see a small flask containing something with an invented brand name that says that it contains fertiliser and is not suitable for human consumption, we have to use the laws that regulate fertiliser sales in order to deal with it.

Obviously, sometimes policemen disguise themselves as buyers—we have quite a few of them. They try to buy, and then people are caught in the act of selling something—"Oh, but how do I take this?"—and they explain very thoroughly how one takes the thing. Then they are caught because they are actually doing something illegal, which is selling something for human consumption outside a pharmacy. But that is as far as we can go.

It is a big challenge, and I think we should all go back to the drawing board and do something about it, but I do not have a straight answer now. Believe me, the biggest challenge is defining the object. With ketamine, it was relatively easy, but there are too many other things that are difficult to trace.

Q45 Mark Reckless: Minister, because of the d-word—decriminalisation—many people in this country assume that Portugal has a lax or tolerant approach to drugs. I understand that you prevent dealing and that the police have stopped it. Can you clarify what happens in circumstances when a user refuses to engage with one of your commissions to stop people using drugs? What sanctions are there, if any? What do you do when people seek to ignore the dissuasion commission?

Dr Leal da Costa: That is the biggest problem. Although we also have ways of getting people into treatment, we clearly know that the majority of people who buy and use drugs regularly sometimes get involved in other criminal activities, and that is how they are caught. But if someone goes on taking drugs, does not harm anyone, does not sell drugs and does not produce any harm to society or to those around him, there is no reason why one should go after this person. We simply do not do it. I am a medical doctor myself. Although I believe that using drugs is not good and that drugs are harmful, I think that the problem of drug use is never going to be solved by prohibition. We have that experience in Portugal.

I am not telling you it is going to be less expensive. This is another thing that I must warn you about. If you agree and accept that you are decriminalising the use of certain harmful substances and give opportunities for treatment, you must have in place good structures to attend to everybody who needs treatment. It is not necessarily going to be cheaper than putting people in jail, but apart from the humane principles that rule medicine and politics in general, one has also to consider that from the technical point of view we prefer to spend money that way.

I will give you an idea. We are going through a big challenge now. We have made a crucial and risky decision. We have transformed drug care in Portugal. We have separated the people who do the planning, health promotion and prevention from the people who do the treatment. We have moved treatment into the NHS, because we believe that it is better to have all the facilities together, and have treatment co-ordinated with alcohol treatment and the other facilities that we need to have in place, and even with mental health structures. We had a system where the treatment of drug addiction was separated from the rest of the NHS, and I believe that was the wrong idea. One of the consequences was that the people involved in treatment had less time to devote to prevention. Prevention is the key in what drug use involves. Prevention is the key, believe me.

Chair: Thank you, Minister. I thank all of you. This is a brief thank you to all those who have come from abroad, especially our friends from Portugal, Colombia, Morocco and all the other countries represented, to all those who have come from throughout the United Kingdom and to our speakers, who have been extremely helpful to us as a Committee in fashioning our views on what we should do in the report. We must continue this dialogue. Please keep in touch through our website. As we said earlier, if you have new submissions, let us have them. We are going to make decisions on this very shortly, so please let us have your views as soon as possible.

My final thanks go to our staff—Tom Healey, Ellie and all the Select Committee staff—for all the hard work that they have done. It is unusual for Select Committees to have seven hours of conferences of this kind. Normally, as you know, our witnesses sit in front of us and are very politely treated by members of the Select Committee. This is a slightly different format, and it has been very helpful in enabling us to canvass a wider range of views. Thank you to Alun Michael, Nicola Blackwood and Mark Reckless for staying through to the very end.

May I ask people to leave their name badges? In this time of austerity, I am afraid we are going to recycle you. You will become someone else for the next seminar. In the meantime, thank you very much, and please keep in touch.

ISBN 978-0-215-05095-3

9 780215 050953

PEFC PEFC/16-33-622

Printed in the United Kingdom by The Stationery Office Limited
12/2012 019847 19585